Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	No.1 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	28 June 2023
Centre ID:	OSV-0004574
Fieldwork ID:	MON-0035169

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This centre is located on a campus in close proximity to Cork city. A full-time residential service is provided to three adults with intellectual disability and autism diagnoses. The designated centre has been adapted to meet residents' assessed needs and is a single-storey, semi-detached premises. The designated centre has three resident bedrooms, a staff bedroom with an ensuite bathroom, a kitchen, dining room, a large day room / living room, two relaxation rooms and two bathrooms. There is also a staff office and utility room. Part of the designated centre, comprising a bedroom, bathroom and relaxation room, is for the exclusive use of one resident. Residents are encouraged to live an active, meaningful, everyday life by participating in household tasks, and social and leisure activities. There is an outside garden area behind the designated centre. The centre is staffed at all times. By night there is one waking, and one sleeping staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 28 June 2023	09:00hrs to 19:05hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This centre is located on a campus in close proximity to Cork city. A full-time residential service is provided to three adults with intellectual disability and autism diagnoses. The designated centre is a single-storey, semi-detached premises. It has three resident bedrooms, a staff bedroom with an ensuite bathroom, a kitchen, a dining room, a large day room / living room, two relaxation rooms and two bathrooms. There is also a staff office and utility room. Part of the designated centre, comprising a bedroom, bathroom, and relaxation room, is for the exclusive use of one resident. There is a paved garden area behind the centre. This is accessed from the kitchen and living room.

This was an unannounced inspection. On arrival the inspector was greeted by the person in charge. There was one other staff member on duty. The inspector was informed that a staff member had called in sick that morning and ordinarily there would be a third staff on duty. Management had arranged for an additional staff to work in the centre from 2PM. Shortly after the inspector arrived, one resident left the centre to attend their day service. A senior manager also came to the centre to provide support to residents during the morning which supported the person in charge to facilitate this inspection.

The premises was noted to be bright, homely, and decorated in a modern style. New couches and chairs for both the hallway and living room had been bought recently. One resident was a talented artist and some of their artworks were on display. Canvas prints with residents' photographs had been put on a hallway wall recently. When reviewing documentation later, the inspector saw that residents had been involved in choosing these photographs and one resident had ordered a second canvas with their photo for their bedroom. Each resident had their own bedroom which had been personalised to reflect their assessed needs and preferences. These were seen by the inspector. Each bedroom had suitable, accessible storage for residents' belongings. One resident chose to show the inspector their bedroom and while there pointed to various things on display that were important to them, such as family photographs and some of their belongings. This resident's bedroom was in part of the centre that was not accessible to the other two residents. It was accessed through a door fitted with a mechanical code lock. The resident was independent in using this lock. They also chose to lock their bedroom door and the door to the relaxation room. They were observed to be independent in accessing these rooms and appeared happy to show them to the inspector.

It was noted that since the last inspection completed on behalf of the Chief Inspector of Social services (the chief inspector) a second door from one bedroom had been sealed. This resulted in a change to the floor plans of the centre, as although there appeared to be a door when in a communal area of the centre, this was a wall on the bedroom side. The provider was asked to submit an application to

vary the registration conditions of the centre to reflect this change to the floor plans.

There were a number of environmental restrictions in place in the centre. These will be referenced in more detail later in the 'Quality and safety' section of this report. These included a code lock on the kitchen door. Throughout the inspection management displayed a commitment to reducing these restrictions and explained how residents were being supported to spend more time in the kitchen with staff support. The inspector saw this in practice on a number of occasions. The centre's kitchen was well-equipped and had supplies of fresh and frozen food. The kitchen and all equipment were generally clean and well-maintained. Some damaged surfaces were observed, including on the base of a seat and the kitchen counter. It would therefore not be possible for them to be cleaned effectively. Management requested that these be addressed by the provider's maintenance department during the inspection. There was a dining room, separate to the kitchen, available to residents. A sideboard and storage units had been recently fitted in this room, and further painting work was planned. There was room for all residents to sit in this room together but due to residents' assessed needs and to keep each resident safe, mealtimes were staggered in the centre. The centre also had a utility room used to store laundry equipment and some cleaning supplies. Residents were involved in managing their laundry and the equipment in this room was accessible to them. This utility was clean and well-organised. There was a poster on display which indicated that a colour-coded cleaning system was in use where different coloured equipment was to be used to clean specific areas of the centre so as to prevent cross contamination. Equipment was stored according to this system. Beside this room was a bathroom used by two residents. It was noted that there were no handles on the taps in the bath. Management explained that these were stored in the utility room and that residents could freely access, install, and use the handles independently. All residents had access to a large living room. This room had a wall-mounted television, a table and chairs, and a variety of comfortable seating options. Photographs of the residents and some of their artworks were displayed. The outside area could be accessed from this room. The person in charge spoke with the inspector about recent improvements made to this area and future plans. New solar lights, a potting table, and freshly planted herbs were in place. It was hoped that residents would participate in painting a fence and picnic table in the coming weeks.

Shortly after they arrived in the centre, the inspector greeted two residents in the large hallway. This area had a number of seats and residents appeared very at ease in their home. Another resident was spending some time in a relaxation room and left the centre shortly afterwards to attend their day service. The inspector had an opportunity to spend some time with this resident in the afternoon. Each resident greeted the inspector. As outlined previously, one resident showed the inspector the rooms in their area of the centre. The residents of this centre cannot rely on speech alone to be heard and understood. Throughout the designated centre there were visual supports available to aid staff and residents when communicating with each other. Some of these, such as a display showing who was working in the centre, were in place to support all three residents. Others were more specific to residents' individual needs and included prompts regarding mealtime plans, individual activities, and food preferences. Each resident also had an electronic tablet.

Management advised that these were also used at times to facilitate communication.

Throughout the inspection the inspector saw residents engage in various activities in the centre. These included watching television, making coffee, listening to music, and household activities such as bringing their dishes to the kitchen. On the day of the inspection, residents attended their day service, went for walks on the campus, brought items to the recycling bin on campus, went to the local shop, and went for coffee and to a bookshop in a nearby shopping centre. Residents appeared comfortable in their homes and with the staff support provided to them. Staff interactions observed and overheard by the inspector were calm, supportive and warm.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review questionnaires completed by residents with staff support and input. These were completed to inform the annual review of the designated centre. Management advised that residents' relatives had been invited to participate but chose not to. Overall, this feedback was positive, however there were areas for improvement documented. There was reference to a complaint made on one resident's behalf regarding the lack of access to a day service. Complaints, and identified improvements required to meet the requirements of the regulations, will be discussed in the next section of this report. Another survey referenced that the centre can be noisy and that one resident may prefer to live in a quieter environment where their belongings did not need to be locked away. The suitability of this centre to meet the needs of each resident will also be discussed further later in this report.

As well as spending time with the residents in the centre and speaking with management and staff, the inspector also reviewed some documentation. Some of these documents were reviewed when the inspector spent some time in an administrative building on the campus in the late afternoon / evening. The inspector moved to this area in response to a request made by management to try and limit any disruption to residents' routines. Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Staff training and the centre's complaints log were reviewed. The inspector looked at the medication management practices in the centre. The inspector also read a sample of residents' individual assessments and plans. These included residents' personal development plans, healthcare and other support plans.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Overall, good management practices were seen, the provider adequately resourced the centre, and it collected and used information in order to improve the quality of life of residents. Management systems ensured that all audits and reviews as required by the regulations were being conducted. Some improvement was required in the documentation and review of the action plans developed as a result of these audits. It was also identified that the provider's complaints policy had not been implemented in this centre.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Support staff reported to the person in charge, who reported to an area manager, who reported to the person participating in management.

There had been some changes to the management arrangements in the centre since the last inspection completed on behalf of the chief inspector in August 2021. The current person in charge was appointed in December 2022. They fulfilled this role for one other designated centre which adjoined this one. The person in charge worked from Monday to Friday and dedicated 80% of their working week to this centre. They told the inspector that they had eight hours a fortnight supernumerary time and provided direct support for the remainder of their working week. Management presence in the centre provided all staff with opportunities for management supervision and support. The person in charge held the necessary skills and qualifications to carry out the role and was both knowledgeable about the residents' assessed needs and the day-to-day management of the centre.

The person in charge advised that they had regular telephone contact with their line manager and met them in person approximately once a week, with more formal one-to-one meetings taking place every three months. In addition they attended a monthly meeting with their line manager and other centre managers who reported to them. Both the person in charge's line manager and the person participating in management visited the centre during this inspection and attended the feedback meeting at its conclusion. Staff meetings took place fortnightly in the centre with one scheduled for the day following the inspection. The inspector read a sample of the records of these meetings. Topics discussed referenced the day-to-day running of the centre, and both the needs of residents and the staff team. Management presence in the centre and the various meetings routinely taking place provided staff with opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents.

The inspector was informed that there were currently no staffing vacancies in the centre. Management advised that there was an identified group of staff who worked in the centre on a relief basis. These staff knew the residents well, and were familiar with their assessed needs and corresponding support plans. According to the statement of purpose, there were a minimum of three staff working in the centre by day. During the week, one of these staff was a day services staff who supported one resident who received an integrated day service, based from the designated centre.

Management advised that there could be up to five staff on duty in the evenings and at weekends, depending on residents' planned activities. At night there was one staff member who remained awake and another who completed a sleepover shift.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in February 2023 and, as referenced in the opening section of this report, involved consultation with residents, as is required by the regulations. Although an action plan was included in this review, it did not include any actions generated in response to residents' feedback. An unannounced visit had taken place in June 2022 and again in December 2022. Both visit reports included an action plan. From reviewing these action plans it was not always clear what progress had been made in addressing areas identified as requiring improvement. Other evidence seen on the day of inspection demonstrated that some of these actions had been completed, for example, each resident now had a written service agreement with the provider, and the staff training matrix had been updated.

The inspector reviewed staff training records for 14 staff, including the person in charge. Staff had access to a wide variety of training, including refresher training. Bespoke training in the use of Lámh (a sign system used by children and adults with intellectual disability and communication needs in Ireland) had been provided in the centre. Staff had completed online training in autism, and an in-person training session was scheduled for the month following this inspection. The staff team had also completed online training in a human rights approach to health and social care. When reviewing the training areas identified as mandatory in the regulations, it was identified that two relief staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques. Although requested, this training was not planned at the time of this inspection.

The inspector reviewed the complaints log in the centre. Two complaints had been made since the centre was last inspected in August 2021. One of these was made in October 2021 on behalf of residents. It was noted that this had been received by a member of the management team and while there was a learning log completed, this did not address all of the matters raised in the complaint. Details of the investigation completed, the outcome of the complaint, and the complainant's satisfaction were not recorded, as is required by the regulations. The second complaint was made in June 2022 and remained open at the time of this inspection. This related to the lack of access to a day service for one resident. Although other evidence seen by the inspector during this inspection indicated that this matter was being progressed, the last documented review of this complaint was in July 2022. Therefore the record of complaints had not been maintained, as required. Also, there was no evidence that this complaint had been escalated and addressed in line with the provider's own complaints policy.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the chief inspector. It was noted that two of these notifications had been submitted outside the timeframe specified in the regulations. It was also identified that records in the centre that referenced the

negative impact of a power cut on residents were not consistent with information outlined in the notification submitted to the chief inspector regarding this adverse event.

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The majority of the staff team had recently attended the trainings identified as mandatory in the regulations.The staff team had also completed a variety of other training courses, including online training in a human rights approach to health and social care. Two relief staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques. This training was not scheduled at the time of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had sufficiently resourced the centre to ensure the effective delivery of care and support. There was a clear management structure in place. Management presence in the centre provided all staff with opportunities for management supervision and support. Staff meetings and one-to-one meetings were regularly taking place which provided staff with opportunities to raise any concerns they may have. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. Although the associated action plans were not completed in full, there was evidence that where

issues had been identified, actions were completed to address these matters. However it was noted that actions were not generated in response to issues raised by residents, or on their behalf. Additional oversight of complaints was required to ensure that these were addressed in line with the requirements of the regulations and the provider's own policy and procedures. Information recorded in the centre regarding the negative impact a loss of power had on residents was not consistent with the information provided to the chief inspector in a notification regarding this adverse event. It was also identified that the provider had not submitted an application to vary the registration conditions of the centre despite changes made to the floor plans.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a written agreement regarding the terms on which they lived in the designated centre. These outlined any fees to be charged or costs associated with living in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

Two allegations of abuse had not been reported to the chief inspector within three working days, as is required by this regulation.

As referenced in the findings regarding Regulation 7: Positive Behaviour Support, not all restrictive practices used in the centre had been recognised. Therefore the chief inspector had not been informed of their use, as is required.

Judgment: Not compliant

Regulation 34: Complaints procedure

Records regarding complaints made in this centre were not well-maintained. Improvement was required to clearly document details of any investigation completed, the outcome of the complaint, any actions taken on foot of a complaint, and whether or not the complainant was satisfied. There was no evidence available that complainants had been informed promptly of the outcome of their complaint and details of the appeals process, as is required by the regulations. It was

identified that the provider's complaints policy was not implemented as outlined regarding the two most recent complaints made in the centre.

Judgment: Not compliant

Quality and safety

The inspector found that residents living in this centre received a person-centred service that ensured they were safe and supported them to be involved in activities that they enjoyed. Residents' rights, wellbeing, and independence were promoted. There were identified incompatibilities in the centre which posed challenges in ensuring the centre was suitable to meet the needs of each resident. Some areas requiring improvement were identified and these are outlined further in the remainder of this report.

It was evident that there was a focus in this centre on supporting residents to try new things, and to resume activities, in a gradual and supportive manner. This included activities in the centre, such as gardening and baking, and increased opportunities for residents to spend time in their local community. An example of this was the now daily routine for one resident to go to a local shop and use their money to buy things. Another resident was due to start attending a day service in the coming weeks. They had not attended day services since before the beginning of the COVID-19 pandemic in March 2020. One resident had also resumed going to the barber, rather than having their hair cut in the centre. A resident had also been supported to get and use their own bank card. All residents living in the centre went swimming at least weekly, either with the support of residential or day service staff. Management also advised that residents regularly went for walks on the campus, and at times in local parks. Residents also received massages while in the centre, with scheduled appointments in place. Residents were also provided with more opportunities to be involved in household tasks and the preparation of food and drinks.

The inspector was informed that a consistent approach was essential in supporting residents to try, and to enjoy, new experiences or changes to their established routines. Management put an emphasis on ensuring this consistency was provided. As outlined in the opening section of this report, it was also clear that work was ongoing to reduce the use of some environmental restrictions in the centre.

A review of documentation, including notifications of adverse events to the chief inspector and residents' input into the annual review, indicated that there were resident incompatibilities in this centre. This was also reflected in staff views gathered by the provider regarding the quality and safety of care and support provided in the centre. Evidence on the day of inspection indicated that this incompatibility was managed locally through the use of environmental restrictions and monitors, one-to-one staffing ratios, staggered mealtimes, and scheduling

external activities for one resident at identified challenging time for their peers, and other measures. Management and staff appeared very familiar with these measures, and were vigilant to ensure they were implemented. The inspector was informed that the provider was considering long-term alternatives to address this issue. Management advised that initial queries had been made regarding possible changes to the premises to provide a separate living area for one of the three residents. Another resident had been referred to provider's inappropriate placement forum. At the time of this inspection there was no plan in place for them to live in another setting. It was noted as a goal in this resident's personal plan for them to live in a house in a community setting.

Contact with family was important to the residents living in this centre and this was supported by the staff team. Staff supported residents to regularly meet with their relatives, most often spending time in their family homes. One resident also met with members of their family from time to time in restaurants or local parks. Residents had also been supported to attend important family events and celebrations.

The inspector reviewed a sample of the residents' assessments and personal plans. An assessment of residents' health, personal and social care needs was completed annually. This assessment informed each resident's personal plan. These provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare, and other person-specific needs such as mealtime support plans. A number of activity-specific protocols had been developed for residents. These supported staff in implementing a consistent approach. There was evidence that a multidisciplinary review of each plan had been completed in the previous 12 months, as is required by the regulations. Recommendations arising out of these reviews were documented, however it was not always clear if these had been followed up, for example, it was a recommendation in October 2022 that an assessment be completed to determine the impact, if any, of noise made by peers on one resident. It was not clear if this assessment had been completed, and if so, what the outcome was. At the feedback meeting held at the close of this inspection, a senior manager advised that there was a working group in place to develop a system to track and monitor any recommendations made in annual reviews.

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from dentists, and allied health professionals such as psychologists, dietitians, and occupational therapists. Some residents had been assessed as having swallowing difficulties. There were documented, recently reviewed recommendations made by a speech and language therapist regarding supports to be provided when residents were eating and drinking. Staff spoken with were familiar with these.

Residents' personal plans also included plans to maximise their personal

development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests. Examples included an overnight stay in a hotel, subscribing to an online music streaming service, developing some household skills such as cooking, regularly going to the cinema, and living in a community-based house. Although there were regular documented reviews, it was not possible to determine what, if any, progress had been made in achieving some goals. In some cases, only some of the resident's goals were referenced in the reviews, and on other occasions the review was vague, for example, that the resident went to the cinema when possible. No update or progress was noted at any time regarding one resident's goal to live in the community.

As outlined previously parts of the centre were designated as being for the exclusive use of one resident. Therefore two residents were restricted from accessing these areas, which included a relaxation room. It was noted on inspection that all residents had access to communal recreational spaces. The inspector also identified two locked cupboards in the large communal area and a locked press in the utility room. A plan also outlined that child locks were used for some residents while travelling. The provider had not recognised these as environmental restraints, and as result had not subjected them to the provider's restrictive practices policy and procedures, or notified their use to the chief inspector, as required by the regulations. The other restrictive practices used, including door alarms and locks on a kitchen cupboard, and on the kitchen and front doors were reviewed regularly, and their use approved by the provider's oversight committees.

The inspector reviewed the medication management processes in place in the centre. This included a review of medication errors made since December 2022. Two of these errors, which occurred within one month of each other, related to a resident being administered medication prescribed for another resident. There were also four incidents where the administration of medicines was missed. In one of these incidents this error was not identified until two days later. Management advised that in response to these incidents a new shift plan system was introduced which assigned medicine administration responsibilities to one staff member at the outset of each shift. Four audits regarding medication management arrangements in the centre had been completed in the previous 12 months. All actions, as outlined in the three most recent audits, had been completed.

Medicines were stored in a secure, dedicated area of one room in the centre. Each resident's medicines were stored in assigned spaces. PRN medicines (medicines used only as the need arises) were stored separately. There were recently reviewed protocols available to guide staff when to administer these medicines. When reviewing one resident's PRN medicines it was noted that a container used to store one was damaged, the label on another was faded, and others were due to expire within two days. The person in charge contacted the pharmacy to arrange replacements during this inspection. A medication fridge was available and in use in the same room. Records indicated that the temperature was monitored daily by staff. The inspector was shown a separate storage area for out of date, or other,

medicines to be returned to the pharmacy, as is required by the regulations.

There were clear processes in place regarding the ordering, receipt, prescribing, storing, disposal and administration of medicines. A member of staff guided the inspector through these processes and the checks implemented to reduce the risk of any medication errors. Management advised that PRN antipsychotic medicines were counted nightly, and other PRN medicines were counted weekly. Stocks in the centre on the day of this inspection were consistent with the records available. When reviewing the documentation completed on receipt of medicines, it was noted that on one occasion the receipt of a blister pack containing a resident's medicines was not recorded. Other documentation, including prescriptions and medication administration records, looked at by the inspector had been completed in line with the provider's own medication management policy.

Regulation 10: Communication

Staff had a good knowledge and awareness of residents' individual communication needs. Aids to support communication were available throughout the centre. Staff had completed training in the area of communication and there was evidence of regular liaison with speech and language therapists. One resident had been supported to develop a folder outlining their own idiosyncratic signs, to support staff in communicating effectively with them. Communication supports had been put in place to support one resident when going to the dentist.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. The layout of the centre provided a number of private areas, other than residents' bedrooms, to receive visitors.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. The staff team had successfully supported residents to resume some community-based activities and this continued to be a focus for the team. Residents were also offered more opportunities to be involved in activities while in the centre. These included baking, gardening, recycling, painting

furniture, making their own coffees and participating in household activities.

Judgment: Compliant

Regulation 17: Premises

The centre were observed to be clean and well-decorated. There had been recent maintenance works completed in the centre and further painting was planned. The outdoor area had been enhanced and new furniture bought since the centre was last inspected. When in the centre it was noted that some surfaces, including those on a kitchen counter and on some furniture, required repair or replacement. Due to the damage observed it would not be possible to effectively clean these items. Management contacted the provider's maintenance department to address these matters during the inspection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was evidence that residents were offered a choice of wholesome food while staying in the centre. Residents were also being provided with opportunities to try new flavours and cuisines. The kitchen in the centre was well-equipped and stocked with a variety of fresh and frozen food. Residents had increased opportunities to be involved in food preparation, in line with their wishes. There were recently reviewed plans in place for residents who had been assessed as having swallowing difficulties. These were stored in an accessible location and staff spoken with were familiar with these plans.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had ensured that appropriate practices relating to the ordering, prescribing, storage, disposal and administration of medicines were implemented in the centre. There was evidence of learning from and reviewing systems following patterns of medication errors. Some improvements were required to ensure that, in line with the provider’s own policy, all documentation was completed in full and medicines were safely stored in undamaged containers.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs had been completed for each resident. Each resident had a comprehensive personal plan. An annual review, involving multidisciplinary professionals, had taken place. Improvement was required to ensure that recommendations made were completed and reflected in residents' personal plans. The review of residents' personal development plans required improvement to ensure that all goals were reviewed, and progress, or barriers to progress, were clearly outlined. The provider had recognised that there were challenges in ensuring that the designated centre was suitable for the purposes of meeting the needs of each resident. Although there were local arrangements in place to manage the resident incompatibility, the provider was considering long term options to address this issue. No definite plans were in place at the time of this inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Staff were aware of residents' healthcare needs and how to support them. Residents were supported to receive care from general practitioners, medical consultants, and other health and social care professionals, as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one, had a behaviour support plan in place. These plans outlined proactive approaches to prevent or reduce the likelihood of an incident occurring, and also response plans to be implemented if required.

Not all restrictive procedures used in the centre had been recognised and subjected to the provider's restrictive practices policies and procedures.These included locked cupboards in the large communal living room and laundry room, the use of child locks while travelling, and the keypads in place to limit two residents' access to parts of the centre. Management demonstrated a commitment to reducing the use of restraints that limited residents' access to the kitchen. Accessible information had

been prepared to support residents' understanding of this restriction.

Judgment: Substantially compliant

Regulation 8: Protection

All safeguarding concerns had been addressed in line with the provider's and national safeguarding policies. There was evidence of liaison with the provider's designated officer and the local safeguarding and protection team, as appropriate. Actions, as outlined in safeguarding plans, were in place on the day of inspection. The delay in notifying the chief inspector of two allegations of abuse is reflected in the findings for Regulation 31.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence of a focus on providing a service consistent with a human rights based approach in this centre. This was reflected in the work done to increase residents' opportunities for choice and control, and everyday experiences in their own home and local community. The staff team were supporting residents to have increased access to, and control, over their finances. This approach was also reflected in the language used in the centre, as outlined in documented reminders to the team to remain conscious that all three residents living in the centre are adults, and to be mindful of the language used in reports. Residents' meetings were held approximately three times a month to consult with residents regarding the running of the service and their supports. Accessible documentation was used to support residents' understanding of the topics discussed. A resident had been supported to develop the skills to independently access their own area within the centre. The finding that residents' feedback did not inform the action plans developed following internal reviews is reflected in Regulation 23.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No.1 Seaholly OSV-0004574

Inspection ID: MON-0035169

Date of inspection: 28/06/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in charge has ensured that staff requiring training in the management of behaviour that is challenging including de-escalation and intervention techniques, have watched a demonstration video of low arousal/de-escalation approaches to behaviours that challenge, while awaiting for the in person training (11/8/2023). The training will be scheduled for completion by 30/11/2023) • Application for this training has been submitted to training department. 4/08/2023 • Risk assessment and control measures in place to support behaviour management in the centre. De-escalation and intervention techniques discussed at a staff meeting (11/08/2023). • On completion of training, the Centre's training matrix will be updated.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure • That the PIC completes action plans for all centre-based audits including six monthly unannounced provider visits and annual reviews in a timely manner. These actions will include issues raised by residents or on their behalf, if required. The PIC will escalate any risk through the line management system in line with Provider policy. • That a referral has been submitted to an advocacy service to support residents' rights and wishes. 16/08/2023 • That all complaints raised are responded to within the Services Complaints Policy timeframes and that appropriate documentation of the progress made to resolve all elements of complaints raised is maintained in the Centre, including escalation where	

necessary. This will record the outcome and the satisfaction of the complainant with the outcome.
• The PIC will ensure that the information provided in notifications is consistent and reflective of that recorded in the Centre including the impact on the residents. 16/8/23
• An Application to Vary will be submitted to reflect the change to the door in one bedroom in the Centre and to identify areas available to individual residents and communal areas. (31/08/2023)

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure that all three day notifiable events provide information consistent with that held in the Centre and are submitted to the Authority as per the regulation. (16.8.23)
• The Provider has ensured that the PIC has identified all possible restrictions in the Centre and these will be reported accordingly in Quarterly returns to the Authority. (16.8.23)

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The provider will ensure that all complaints raised are responded to within the Services Complaints Policy timeframes and are appropriately documented to include the steps taken to resolve, the outcome and the satisfaction of the complainant with the outcome. (16/8/23)
• Regarding the two most recent complaints made in the centre,
o The PIC has updated the complaints log and the first complaint is now closed. Learning from this incident was discussed at a team meeting on (11/8/23)
The PIC has documented the progress of the most recent complaint regarding residents return to their Day Service. There is a planning meeting on the 31/8/23 with the resident's Day Service with the view to close this complaint by the 30/9/2023. Progress of this complaint has been discussed with the resident using their preferred method of communication

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider has ensured a plan with the services facilities manager to address maintenance required within the centre. All maintenance will be completed by the 30/9/2023

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in Charge will ensure the gaps in the delivery and storage in the medication

management process is addressed.
- The damaged medication container and faded labels have been remedied with the pharmacy.
- All deliveries have been documented in line with the Medication Management Policy
- Learnings was discussed at a team meeting held on the 30/6/2023

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC will
• Ensure personal goals and actions to progress these goals are evidence in the plan

• Conduct regular audits of the personal plans to ensure they are reviewed annually or more frequently if changes are to occur. (30/09/2023)

The Provider has identified the changing needs and challenges within this centre for its residents. The centre is being supported by an enhanced Multidisciplinary inputs and the complex case forum. The person in charge has developed a plan for each resident to ensure the provision of safe service and to minimize the opportunity for residents behaviours to impact on each other.

• An interim plan of dividing the current house into 2 separate apartments will be developed by the MDT, PIC and staff team. This will reduce further any potential negative impact on peer residents. (30/9/2023)

• Once the plan is finalised, implementation will be completed within 6 months. 31/3/2024

• The provider together with the PIC and MDT will develop a plan for one resident to move to the community (4/6/2024). Once the plan is developed the Provider will work with the HSE to agree the plan. As this is subject to funding, acquiring of suitable property and staffing the provider will update the Chief inspector in Quarter 4, 2024 of timelines for implementation of the plan.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider has ensured that

• The PIC has completed a restrictive practice audit within the centre. Where restrictive procedures were identified, these have been referred to the services Behaviour Standards Committee for review and sanction. 16/08/2023
• A log of rights restrictions will be maintained in the Centre to support the review and work to reduce/eliminate restrictions wherever possible.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/11/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is	Substantially Compliant	Yellow	31/08/2023

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	30/06/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	16/08/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following	Not Compliant	Orange	30/09/2023

	incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	30/09/2023
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	16/08/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	16/08/2023
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the	Substantially Compliant	Yellow	15/12/2024

	purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/09/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	16/08/2023