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:	Aoibhneas/Suaimhneas
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	15 November 2021
Centre ID:	OSV-0004782
Fieldwork ID:	MON-0027049

About the designated centre

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

In this centre the provider provides accommodation, care and support to a maximum of 13 residents; 12 residents live in the centre on a long-term basis and respite supports are provided to a further one resident. The centre is staffed full-time and the staff team is comprised of nursing staff and care assistants. A 24 hour nursing presence is maintained and the service provided is designed to meet the needs of residents with complex medical needs including end of life care needs. The provider aims through the care and support provided to promote independence, well-being and quality of life. The premises are purpose built to meet the needs of residents with high complex needs in terms of its design and layout and the equipment provided. The centre is comprised of two separate buildings while there is a third building where residents can access day-services and where the person in charge has an administration office. The centre is located in the heart of the local community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Monday 15 November 2021	09:40hrs to 18:45hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

All 12 residents who met with the inspector appeared at ease and comfortable in the centre. The staff team were committed to providing a quality service to residents and positive relationships between staff and residents were evident. Improvements were required to ensure there was effective oversight of all aspects of care and support provided in the centre.

This was an announced inspection. On arrival, the inspector met with the person in charge of the centre and walked through both houses, Aoibhneas and Suaimhneas, that make up this designated centre. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The inspector was informed that there were 12 residents living in the centre at the time of this inspection, seven in one house and five in the other. The inspector had an opportunity to meet with all 12 residents at various points throughout the day. One bedroom in Suaimhneas was designated to provide a respite service, however this service was suspended at the beginning of the COVID-19 pandemic in March 2020. One resident, who had previously accessed respite in the centre, had been staying full-time in this bedroom since then.

Both houses were clean and warm. At the centre of each house was a large living area where residents watched television, ate meals, and engaged in other activities. In Aoibhneas, residents had access to a small multisensory room. Each resident had their own bedroom. Where required, these were fitted with appropriate moving and handling equipment. The bedrooms had been individualised, with family photographs on display in some. A sensory wall had recently been installed in the bedroom of a resident with a visual impairment. Another resident had recently bought their own voice-controlled speaker which allowed them to listen to music in their bedroom. This resident loved music and was clearly enjoying watching a Dubliners concert with a peer, while the inspector was there.

The bedroom designated to provide a respite service had its own ensuite bathroom. All other residents had access to an ensuite bathroom that they shared with one other resident. As these bathrooms were accessible from two sides, the inspector asked about the measures in place to ensure residents' privacy. The person in charge explained that the majority of residents living in the centre required full staff support to access the facilities and as such, staff were able to ensure residents' privacy and dignity were maintained.

Shortly after arriving in the centre, the inspector was informed that one resident had recently returned to the centre following a stay in hospital. On the advice of public health, this resident was isolating in the centre, pending COVID-19 test results. This had not been notified to Health Information and Quality Authority (HIQA), as is required. The person in charge informed the inspector that only one staff on each

shift was supporting this resident and enhanced personal protective equipment (PPE) was in use by these staff. When walking around the centre, this resident's bedroom was pointed out to the inspector. The bedroom door was wide open and opened onto a communal area of the house. This approach to isolation was ineffective and not in keeping with infection prevention and control isolation protocols. When highlighted to the person in charge, this door was closed. Later in the inspection, this resident's results were received and they were able to spend time in the communal areas of the house with their peers.

Given the shared bathrooms, the inspector asked how residents could safely isolate from staff and their peers in the centre, if required. Management had identified that two residents would need to leave the centre to isolate. However, it became clear that the provider's existing contingency plan for the other residents living in this centre required further planning and detail.

When walking through Suaimhneas it was identified that one door was held open by a chair and another was prevented from closing due to the placement of a laundry basket. This meant that if required in the event of a fire, these doors would not be able to act as effective containment measures. These items were moved immediately. Later in the inspection, it was identified that the door to the room where medication was stored in one house was visibly damaged and the door closing fixture was broken. Oxygen was also stored in this room, making it a high risk area for fire. Although stored in both houses, there were no signs to indicate the location of oxygen in the centre. Storage of oxygen in the centre had not been risk assessed. At feedback at the close of this inspection, the person in charge advised that they would consult with the fire expert used by the provider regarding these identified issues.

The person in charge had an office in a day service located on the same grounds as the designated centre. The inspector spent some time in the office reviewing documentation before returning to the two houses that comprise the centre. Two residents regularly spent time in this building. Staff advised that it gave them the opportunity to spend time alone away from the house at busy times of the day. One resident came over for a cup of coffee shortly before the inspector was leaving to go back to the houses and another resident was supported by twilight staff to spend some time there later in the evening. The person in charge informed the inspector that it was proposed that other residents would start to access the multisensory room in the day service with staff support. Another resident accessed the hydrobath there. Prior to the COVID-19 pandemic, residents from both houses regularly spent time in the day service. Throughout the pandemic, visits from residents' family and friends, and residents' physiotherapy sessions, took place in the day service rather than the designated centre.

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 rosters and training records were also reviewed. The person in charge demonstrated good oversight of these and was aware of outstanding training and times when staffing

had not been provided in line with the planned roster. There had been recent recruitment in the centre which was welcomed as at times the person in charge was required to work in the centre, resulting in insufficient time to complete other planned activities, such as one-to-one staff supervision sessions.

The inspector also reviewed the record of incidents that had occurred in the centre. The regulations require that the person in charge notify HIQA within three working days of specified adverse incidents occurring in the designated centre. As part of this review, the inspector read several incidents where other residents were described as very scared, anxious, frightened, in need of reassurance, and on one occasion were woken during the night due to the behaviour of a peer. These adverse incidents had not been notified to HIQA. It was not documented that either the provider's or the national safeguarding policy had been implemented in response to these incidents. Following a request for assurance regarding a separate safeguarding matter in this centre in 2019, HIQA had been informed of the provider's ongoing commitment to ensuring a zero tolerance culture to the occurrence of abuse. These findings indicated that further work was required to embed that culture in this centre. Safeguarding will be discussed further in the 'Quality and safety' section of this report.

The inspector then returned to the two houses where they spent time with residents, looked at a selection of residents' individual files and spoke with members of the staff team working that day.

As was identified on the last inspection of this centre, although some improvement had been made, some residents still had very broad goals in their personal development plans, for example 'Socialisation'. Improvement was also required in the reviews of these goals and the support provided to progress them. The person in charge informed the inspector that a new rights based approach to personal planning was to be implemented across the service in the coming year.

When the inspector returned to Suaimhneas, a group of four residents were making scones with staff support. While two residents were more physically involved in this activity, all four were supported to participate in some way. Residents were encouraged to make choices around whether to have fruit in their scones or not and both options were accommodated. There was a concert on the television in the communal area at the time and some other residents were watching this. The residents who communicated verbally were speaking to each other, staff and the inspector about the next steps in the recipe, their families, places they had spent time before and how they felt about living in this centre. When baked, residents were supported to enjoy the scones in line with their assessed food texture requirements. Residents were preparing for and having supper when the inspector visited the second house, Aoibhneas. There was a calm atmosphere in the house at the time and residents appeared very much at ease. It was clear that residents and staff in both houses enjoyed positive relationships with each other. Staff had a very good understanding of residents' needs, preferences and individual communication styles. All interactions observed were warm, unrushed and respectful.

As this was an announced inspection, questionnaires were sent in advance to be completed. Ten were returned. Some of these were completed by residents with staff support and others by either staff or relatives on behalf of residents. The feedback received was very positive with one respondent saying that they 'wouldn't change a thing' about the service provided. The staff team received high praise and were described as 'very kind', 'good to me' and 'excellent'. Residents reported enjoying outings, music, and one-to-one time with staff. One resident reported that they would like to do more during the day and two expressed a wish to go out more. The person in charge had spoken with the inspector about additional planned activities such as canine therapy which was due to begin in December. Staff meeting minutes also outlined the planned reintroduction of music sessions and a plan to identify a reflexologist following a recent retirement.

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

The provider needed to further improve the overall governance and management structure of the centre in order to ensure effective oversight and sustainable and safe delivery of all aspects of care and support provided in the centre.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. All staff were aware of their responsibilities and who they reported to. At the time of this inspection there was a vacancy in the management level above the person in charge. As a result the person in charge reported directly to the director of services, who in turn reported to the chief executive. Recruitment for this vacant position was underway.

The person in charge had been in this role since 2014 and fulfilled the role for this centre only. They were also involved in the management of the day service located beside the centre. The person in charge demonstrated a very good knowledge of the residents and their support needs and clearly knew them well. Although their role was supernumerary, due to staffing issues in the centre, the person in charge also provided direct support to residents at times. Throughout this inspection, various findings indicted that greater oversight was required in some areas of the service provided in this centre. Examples included the improvements required to the centre's COVID-19 contingency plan and its implementation, the oversight of safeguarding issues, review and progress of residents' plans, and maintenance of the risk register and residents' records. Given these findings, the planned provision of additional management support and oversight of the centre was welcomed.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is

required by the regulations. There was evidence that follow up actions to address many of the issues identified were developed, implemented and reviewed. The annual review involved consultation with the residents and their representatives. The action plan incorporated areas to improve as a result of this feedback.

There was reference in both the annual review and the most recent unannounced visit report to the incidents referenced in the first section of this report where residents were negatively impacted by the behaviour of a peer. In the annual review, it was discussed that some of these should be recorded as incidents rather than complaints. This had been completed. However, these incidents were not reported to HIQA, as required by the regulations. In the unannounced visit report the impact on residents was highlighted, however there was no direct action involving the implementation of safeguarding policies. As part of that visit, staff were spoken with and asked about any safeguarding issues in the centre. The staff member spoken with made a distinction that the peer in question would not physically attempt to hurt other residents while acknowledging that being frightened was difficult for them. Again this indicated that the culture of zero tolerance to abuse, promoted by the provider and outlined in their policy, was not fully embedded in this centre. Safeguarding will be discussed further in the 'Quality and safety' section of this report.

As highlighted in the opening section of this report, staffing was not always provided in line with the planned roster. A risk assessment was in place regarding the number of nurses working in the centre. While the ideal was that two nurses and one care assistant worked in each house each day, often there was only one nurse working with two care assistants. The provider had effective control measures in place to reduce this risk which included the possibility of the person in charge, a registered nurse, providing direct support if needed, and the option to redeploy two nurses who worked in the day service to the designated centre if required. In addition, recent recruitment had been successful and a nurse was due to start working in the centre the day after this inspection. Another nurse was also scheduled to return to work on a phased basis that week. Outstanding staffing issues related to the provision of twilight staff. The planned roster included one additional staff member to work in each house from either 5pm or 6pm. This staffing facilitated activities and one-to-one support for residents, examples included two residents attending evening mass and another spending part of the evening in a calmer environment (this busy time in the house had been identified as a challenge for them). This staffing was not consistently provided in both houses.

Staff had opportunities to access appropriate training, including those specified in the regulations. Since the last inspection of this centre the staff team had received training in Lámh (a sign system used by children and adults with intellectual disability and communication needs in Ireland). This had been recommended to meet the assessed needs of one of the residents. The person in charge also informed the inspector that it was planned for the non-nursing staff in the centre to complete online training in epilepsy. However, at the time of this inspection, 20 staff, 63 percent of the team, required training in the management of behaviour that is challenging including de-escalation and intervention techniques. The person in charge explained that this training was delivered in person and had been impacted

by the COVID-19 pandemic. Although one staff member was booked to attend in December, there were no training sessions planned for the other staff. A management decision had been made to prioritise staff working in centres where more residents required these supports. The person in charge continued to follow up training availability. The provider's policy stated that staff receive one-to-one supervision four times a year. Due to the staffing issues in the centre, this goal was not met. The person in charge had planned for each staff to participate in three supervision meetings in 2021.

The inspector reviewed the centre's statement of purpose. The statement of purpose is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos, and both governance and the staffing arrangements. This document had been reviewed in the previous 12 months, however required some revision to ensure that the whole-time equivalent of the person in charge was accurate and to clarify the admissions criteria for this specific centre and the facilities for day care.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with the requirements 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 15: Staffing

The registered provider had not ensured that at all times the number of staff was appropriate to the number and assessed needs of the residents, as outlined on the planned roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

63 percent of the team, required training in the management of behaviour that is challenging including de-escalation and intervention techniques. Staff supervision sessions had not been held at the frequency outlined in the provider's policy.

Judgment: Substantially compliant

Regulation 21: Records

Not all records in relation to each resident had been accurately maintained. This posed a risk as the most up-to-date and accurate information about residents was not readily available to the staff team supporting them.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

Although there was evidence of strong oversight in some areas of service provision, this was not the case in all areas. Improvements were required to the centre's COVID-19 contingency plan and its implementation, the oversight of safeguarding issues, review and progress of residents' plans, and maintenance of the risk register and residents' records. As a result the management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. The staffing issues identified indicated that the centre was not sufficiently resourced.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the whole-time equivalent of the person in charge and to specify the admissions criteria for the centre and the facilities for day care.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all adverse incidents, as specified in this regulation, that occurred in this centre were reported to the chief inspector. It was also identified that the use of keypads had not been reported as a restrictive practice.

Judgment: Not compliant

Quality and safety

The inspector found that some aspects of the quality and safety of care provided were of a good standard. A review of documentation and the inspector's observations indicated that residents enjoyed living in this centre and their healthcare needs were well met. Improvements were required to support residents in achieving their goals and to ensure residents' safety in the centre by improving the practices relating to safeguarding residents, protection against infection, medication management, risk management, and fire precautions.

Many of the residents in this centre required staff support and or specific equipment to support them with their mobility. Residents' healthcare needs were well met. There was evidence of access to allied health professionals including physiotherapists. The input of a clinical nurse specialist in age related care was also evident on inspection. One resident had been supported to transfer into this centre in the past year. This move had gone well and the resident appeared very settled and at ease when the inspector met with them. Weekly multidisciplinary meetings were held to support this move and during the initial weeks of their stay.

The maintenance of residents' files and records required improvement. When looking at residents' individual files, it was identified that different systems were in place. Some residents had an age related care plan or a dementia care plan which incorporated many areas where support was needed. This resulted in duplication of some support plans in their files and in some cases these plans were not consistent with each other. Parts of one resident's file, including the healthcare appointment

summary record, were incomplete. These and other identified issues indicated that records were not well maintained in the centre. This posed a risk as the most up-to-date and accurate information about residents was not readily available to the staff team supporting them.

As was outlined in the opening section of this report, the contingency plan to be implemented in the event of a suspected or confirmed case of COVID-19 required additional information specific to this group of residents and their individual needs. Improvement was also required regarding the implementation of isolation protocols in the centre.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Each resident had a current plan in place. Residents' goals were reviewed quarterly. The quality of these reviews varied. While in some cases the inspector could see the progress made and the positive impact on residents as a result, in others it was not possible to tell what, if anything, had been achieved to meet each goal since the last review. This was also a finding of the last HIQA inspection of this centre. It was also not always evident that residents were being supported to achieve their goals. One resident had a goal to travel more regularly on the bus as part of a larger goal to return to swimming. Despite this, the last time this resident had been on the bus was on the 01 July 2021, over four months before this inspection. Another resident's goal was to live in a more suitable setting. Despite this, discussion regarding an alternative placement was not documented at their subsequent multidisciplinary review meeting.

Family contact was very important to many of the residents in the centre and this was supported by the staff team. As well as in-person visits, residents were supported to maintain contact using the telephone, video calls and by sending cards and letters for special occasions throughout the year. One resident had been supported to connect with a previously unknown relative and this relationship was continuing to develop.

Only nursing staff administered medication in this centre. Following a number of identified errors, nurses had been required to complete online refresher training. The incidence of medication errors continued to be under review. There was evidence that residents had access to and received support from a pharmacist. Each house had a dedicated room for the storage of medication. A nurse advised the inspector that out of date or other medicines to be returned to the pharmacist were not stored in the centre and were instead returned immediately. The inspector identified that some residents were routinely being administered a medication in a crushed format. This was not specified on the residents' prescription charts. This practice and these charts therefore required review.

As highlighted in the previous two sections of this report, the inspector reviewed a number of incidents that had occurred in the centre where residents were negatively impacted by another resident's behaviour. It was not documented that the provider's, and the national, safeguarding policies had been implemented in response to these incidents. The person in charge told the inspector that after a

number of similar incidents they had identified a trend and as a result discussed them with the person appointed by the provider to be responsible for receiving concerns or allegations of abuse regarding vulnerable persons. While there was evidence that this took place, there was no evidence of preliminary screenings or that reporting obligations, as outlined in the policies, were met. As the safeguarding policies were routinely not implemented in this centre, the inspector was not assured that the provider had sufficient oversight and systems in place to protect residents from all forms of abuse.

The inspector reviewed the fire safety systems in place in the centre. Work had been completed in recent years to improve the fire safety systems and infrastructure in the centre. At the time of this inspection drills had been completed throughout the year and an evacuation drill with the night-time staffing complement was planned. Review of the drill records demonstrated that staff could support residents to leave the compartment where fire was detected in a timely manner. It was also evident that different scenarios had been used in each drill. As outlined in the opening section of this report, a door closer and some damaged fire doors in the centre required review and possibly replacement to ensure that they were still fit for purpose. The practice of keeping doors open with furniture was also observed on inspection. This was immediately addressed by the person in charge.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. Due to the ongoing COVID-19 pandemic, there were specific guidelines in place to facilitate visitors.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with their wishes, interests and assessed needs. It was planned to both introduce and reintroduce a number of activities for residents in the coming weeks.

Judgment: Compliant

Regulation 17: Premises

The premises were clean, accessible and equipped with the equipment required by residents. Parts of the centre were in need of maintenance such as painting. An area of the wall in the multisensory room needed to be re-plastered. .

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Food provided was wholesome and consistent with each resident's dietary needs. Choice was facilitated and efforts were made to ensure residents could eat the foods they wanted while also meeting the requirements of their assessed needs.

Judgment: Compliant

Regulation 20: Information for residents

The guide prepared included all of the requirements of this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register required review to ensure that all hazards were identified and their associated risks were assessed. The risk assessments that were in place required review to ensure they were accurate and reflective of the current situation.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The practice of leaving the bedroom door, where a resident was isolating, wide open onto the centre's communal area was not consistent with the standards for the prevention and control of healthcare associated infections. This and other findings indicated that the Covid-19 outbreak contingency plan in place was not detailed or specific enough to this setting and the residents living there.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. Drills had been completed in both houses. Fire doors in the centre required review to ensure that they were fit for purpose as containment measures. Staff practices regarding keeping doors open prevented some doors ability to close if required in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

A pharmacist was available to support the residents and staff team in the centre. A review was required of the medication prescription systems in place to ensure that all required information was included and that medications were administered in line with these documents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Improvements were required in the development and review of residents' goals and the arrangements in place to support residents to achieve these goals.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 8: Protection

A number of incidents where residents were negatively impacted by another's behaviour were not recognised as safeguarding issues. There was no evidence that requirements, including preliminary screenings, investigations or reporting obligations, as outlined in the provider's and national safeguarding policies, were met. Safeguarding policies were not consistently implemented in the centre. It was not documented that every incident, allegation or suspicion of abuse was investigated.

Judgment: Not 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 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Aoibhneas/Suaimhneas OSV-0004782

Inspection ID: MON-0027049

Date of inspection: 15/11/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC endeavors to cover all rosters in the designated centre. • There is ongoing recruitment of staff with the support of HR. • Staff nurse will return from other centre 31/12/2021. • One staff nurse has returned from long term sick • The above measures will free up the care assistant for twilight hours. • Currently one twilight is maintained at all times in one house and this will be enhanced by the 2nd twilight.	
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 third session of Support and Supervision to be complete for all staff by 23rd Dec 2021. • Support and Supervision has been scheduled for 4 sessions in 2022 in line with policy. • Contact was made with the CNSp/Team Leader Behaviour Support Team in relation to training on MAPA. • Currently the MAPA programme is being changed over to SI (Safety Intervention) as MAPA is being phased out. The instructors have been now trained up on this programme. • In consultation with the Lead in Behaviour and based on the findings of a recent audit of physical interventions it is determined that staff working in this designated centre may only a shortened programme of training.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • All records to be reviewed by keyworkers with over sight by PIC and CNM1. This will be completed 28/02/2022.	

• All relevant records will be archived as appropriate.
• Care plans are developed in response to the individual needs of each resident e.g. dementia care plan, age related care plan.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Updated Covid 19 contingency plan, developed by Steering completed, has been circulated and local information has been included in this.
• Specific section in the plan to deal with household management in the event of a Covid Outbreak in the centre here.
• Contingency plan to be discussed at staff meetings on 13th and 14th December 2021.
• All PCP's to be reviewed by the keyworker to ensure that priorities identified for the resident are being progressed. Where priorities cannot be progressed due to covid then alternative priorities will be identified. Achievement of priorities will be evidenced by the keyworker. PIC will oversee this review.
• Any barriers to the achieved of priorities will be escalated to the PIC or PPIM as appropriate.
• PIC has received training in new PCP procedure. This training is currently being rolled out to all PICS, PPIMS and members of MDT.
• All front line staff to get training on new PCP procedure over the next 3 years. This is more a rights based procedure.
• All risks will be reviewed by PIC and will be streamlined as appropriate and risks that can be closed will be closed.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Statement of Purpose and Function for the Centre has been up dated to take into account the WTE of the PIC and the criteria for admission to the centre.
• The PIC will review the SOP and consult with PPIMs and update as appropriate in terms of further clarifying criteria for admission.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Key pads were not put in as a restrictive practice for residents. They were originally put in as a security to the houses.
• The majority of residents require staff support to enter and leave the house.
• The one resident who can choose to leave the house on their own is facilitated to do so

using assistive technology.
• On the day of the inspection a notifiable re PSS in isolation following hospitalization was sent in to HIQA following it being brought to the attention of the PIC.
• The BOCSILR operates a policy of zero tolerance in respect to abuse.
• In this regard any behavior that impacts on a resident is reviewed by the PIC with a view to onward referral to the designated officer as required and appropriate action is taken to ensure the safety of the resident.
• Further review occurs monthly to look for any concerning patterns and trends using the AIRS system.
• Consultation occurs with designated officer where such trends are identified
• In the instance of negative peer to peer interactions, such incidents are reviewed mindful of the definition of abuse.
• With regard to the AIRS forms reviewed by the Inspector the PIC has taken appropriate action, in consultation with members of the MDT, to address these incidents and has treated them as behaviours that challenge.
• Following the inspection the PIC requested the Designative Officer to review these forms. The Designated Officer was in agreement with the course of action taken by the PIC and confirmed that she had provided consultation when incidents were occurring.
• The PIC ensures that staff are familiar with the residents behavior support plan and where there is learning from an incident that this learning is shared with the staff team.
• It is noted that the frequency of incidents has reduced significantly with no incident since June 2021.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Both Pharmacy doors will be replaced following inspection by Facilities manager. This inspection took place on 10th December.
• It is recommended that both doors will be replaced and this is currently being arranged by facilities.
• Multi-sensory room was also reviewed and this will be addressed in early 2022 as well as painting of sections of both houses.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Full review of risk register to be carried out to ensure all hazards are identified and their associated risks are assessed.
• Risk assessment has been carried out in respect to the storage of oxygen in both houses in the designated centre.
• Review will ensure that risk assessments are reflective of the current situation and where appropriate risks will be closed.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Updated Covid 19 contingency plan, developed by Steering group, has been completed and circulated and local information has been included in this.
• Specific section in the plan to deal with household management in the event of a Covid Outbreak in the centre has been included.
• Contingency plan to be discussed at staff meetings on 13th and 14th December 2021.
• Protection against infection was discussed at the staff meetings of the 13th & 14th of December, and support and supervision.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Holding Back of doors was discussed at the staff meetings on the 13th & 14th December and a clear message was communication that this practice is not acceptable.
• Both Pharmacy doors will be replaced.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Both kardex were reviewed following inspection by G.P and the ability to crush the medication was documented on the Kardex
• Both Kardex and Personal file to reflect on 1st page that the individual is allergic to wasp stings and may require an Epipen

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:
• All PCP's to be reviewed by the keyworker to ensure that priorities identified for the resident are being progressed. Where priorities cannot be progressed due to covid then alternative priorities will be identified. Achievement of priorities will be evidenced by the keyworker. PIC will oversee this review.
• Any barriers to the achieved of priorities will be escalated to the PIC or PPIM as appropriate.
• PIC has received training in new PCP procedure. This training is currently being rolled out to all PICS, PPIMS and members of MDT.
• All front line staff to get training on new PCP procedure over the next 3 years. This is more a rights based procedure.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The BOCSILR operates a policy of zero tolerance in respect to abuse.
• In this regard any behavior that impacts on a resident is reviewed by the PIC with a view to onward referral to the designated officer as required and appropriate action is taken to ensure the safety of the resident.
• Further review occurs monthly to look for any concerning patterns and trends using the AIRS system.
• Consultation occurs with designated officer where such trends are identified
• In the instance of negative peer to peer interactions, such incidents are reviewed mindful of the definition of abuse.
• With regard to the AIRS forms reviewed by the Inspector the PIC has taken appropriate action, in consultation with members of the MDT, to address these incidents and has treated them as behaviours that challenge.
• Following the inspection the PIC requested the Designative Officer to review these forms. The Designated Officer was in agreement with the course of action taken by the PIC and confirmed that she had provided consultation when incidents were occurring.
• The PIC ensures that staff are familiar with the residents behavior support plan and where there is learning from an incident that this learning is shared with the staff team.
• It is noted that the frequency of incidents has reduced significantly with no incident since June 2021.
• The PIC had carried out a full review of all AIRS (accident, incident reporting system) for the period May 2018 to August 2021 and confirmed that no incident o abuse has taken place that has not been reported as per safeguarding system.
• The monthly review of AIRS is undertaken by the PIC going forward.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	28/02/2022
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	30/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2022

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	30/09/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/03/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/03/2022
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 safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2022

Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/03/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	15/12/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/01/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2022

Regulation 29(4)(b)	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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	01/12/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/12/2021
Regulation 31(1)(b)	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: an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.	Not Compliant	Orange	15/12/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector	Not Compliant	Orange	15/12/2021

	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.			
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 incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	15/12/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/03/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/03/2022

	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.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/12/2022
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	31/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/12/2021
Regulation 08(3)	The person in charge shall initiate and put in	Not Compliant	Orange	15/12/2021

	place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			