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:	Unannounced
Date of inspection:	30 March 2023
Centre ID:	OSV-0004782
Fieldwork ID:	MON-0036843

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 there is one respite bed which provides support to a number of other residents for pre-planned short breaks each month. 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:	13

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
Thursday 30 March 2023	08:40hrs to 17:30hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to monitor the provider's compliance with the regulations and to follow up on the provider's progress with actions identified from the previous inspection completed in November 2021. In addition, ensuring residents were being supported to have a good quality of life in a safe environment while being supported as per their assessed needs.

The inspector was introduced to one resident who was in receipt of planned respite at the time of the inspection before they left the designated centre to attend their day services. The resident availed of respite services regularly each month. They informed the inspector that they liked their room and enjoyed their time in this designated centre. Staff were observed to encourage the resident to explain what they liked to do. This included particular table top activities which were shown to the inspector. Staff also explained that the other residents living in the house were shown a photograph of who would be staying in their home for planned respite in advance of the person arriving. This enabled the residents to be informed of which person would be availing of the service. At the time of this inspection seven individuals were frequently availing of respite services each month. Short breaks usually varied between three to four nights.

The inspector was introduced to all of the other residents at times during the day that suited individual routines. Staff were observed to take time to explain to residents the reason for the inspector's visit.

The inspector was introduced to three residents in the communal dining room of the first house. The residents had been supported by staff with their morning routine and were enjoying some refreshments together. Another resident was seated in their adapted wheelchair relaxing while listening to music. The inspector was introduced to two other residents living in the house later in the morning after they had completed their morning routine. Staff explained that both of these residents benefitted from a relaxed, un-rushed morning routine. This was observed by the inspector to take place during the inspection.

The inspector was invited by one of these resident's to sit with them as they spoke about their life. They were watching a concert of a favourite Irish singer on the television at the time. They spoke of how much they had enjoyed attending a concert in another town a week before this inspection. They also explained how they had regular contact with family representatives every week. They enjoyed socialising with their relatives regularly. They informed the inspector that they were very happy with their home and the support given to them by the staff team. They also enjoyed meeting a peer from the adjacent house regularly whom they considered to be their friend.

The inspector met with three residents initially in the second house just before lunch time. They were being supported by two staff who were very familiar with each

resident. They provided the inspector with up-to-date information on the changing mobility needs of one resident. These changes had occurred suddenly in the days before the inspection and staff were monitoring the resident closely. In addition, there was an occupational therapist (OT) also present at the time who outlined changes that had been made to support the resident while sitting in their comfort chair and additional use of aids to ensure staff were able to support the resident with all mobility and transfer needs.

The inspector was introduced to another resident who was encouraged to recite their favourite poem. They smiled as they recited the poem stating they had known that poem for many years. The OT also encouraged the resident to demonstrate the gentle hand exercises that they had completed together earlier. In a jovial manner the resident demonstrated their 'royal wave'.

Just before lunch, two residents returned to the house after attending a pre-arranged appointment in another town located nearby. Staff were then observed to support the five residents to have their midday meal. The inspector had been informed that the midday meal came pre-cooked from a local shop. Staff were observed to ensure the food was of the correct consistency and temperature before serving the residents. One resident was observed enjoying their meal independently with staff located nearby supporting another resident who needed assistance. The atmosphere was relaxed and un-rushed during this time. The two staff present engaged with the group in a professional and friendly manner while ensuring the safety of the residents.

The inspector met one more resident later in the afternoon after the person in charge asked the resident if they would like to meet the inspector. The resident greeted the inspector with a smile. The resident used sign language and short sentences during the conversation. The staff had explained the resident liked spending time every day in the day service building which was located on the same site as the designated centre. Also staff explained how the resident had recently started to spend time in the evenings with a staff member in the building before commencing their night time routine. This was having a positive impact for the resident who looked forward to this time. The resident spoke about their family representatives, including young relatives whom they met regularly. They were supported to visit their family representatives in the community each week for a few hours and enjoyed visitors to the designated centre. The resident demonstrated some of the household chores that they completed in the kitchen and stated they were very happy in their home.

Staff informed the inspector of a number of activities that residents enjoyed each week within the designated centre. These included massage, canine therapy and music. Residents had enjoyed the return of these activities once the public health restrictions had eased. Staff did acknowledge that there had been a cautious return to community activities for some vulnerable residents initially but that all residents were now supported to engage in regular community activities, in –line with their expressed wishes. In addition, staff also spoke of assisting family representatives to meet their relatives in social community settings to ensure regular contact with important persons in the residents' lives was maintained. For example due to a

change in circumstances, a family representative could no longer visit the designated centre as frequently as they would like. Staff supported the resident to meet their relative in a pre-arranged community location

Throughout the inspection staff were observed to support the residents in a respectful and professional manner while ensuring individual preferences and routines were supported. The core staff team was comprised of nursing and social care staff. The inspector met with additional personnel during the inspection which included a clerical staff member and an external contractor who was attending to some of the household duties in the designated centre. In addition, the inspector noted that a practice nurse from the local general practitioner's centre, was in attendance to take routine blood samples for some of the residents. As previously mentioned the OT was also present in one of the houses. All staff spoken too demonstrated their knowledge of individual residents' preferences and routines. Some staff members spoke about how they supported residents to re-engage in community activities such as attending the local hairdressers and restaurants. Members of the local community were also encouraged to attend mass in the designated centre with the residents each week on a Tuesday. Some residents were also supported to attend religious services in the local community at the weekends if they wished.

During the walk about of the designated centre there were a number of issues identified. Both houses were found to be warm and clean and decorated to reflect the personal choices of individual residents. However, staff had not ensured fire containment measures in one house were consistently in place. This included the absence of a self-closing mechanism on one fire door and an extension panel on another fire door was found to be opened back at the time of the inspection. Issues identified relating to fire safety will be further discussed in the quality and safety section of this report.

In addition, the facilities available for residents to store personal belongings and toiletries were limited and inappropriate in some cases. For example, one resident had some personal toiletries placed in an open container on the floor next to their bed. Another resident required a specific sleep positioning system which was observed to be stored on top of their laundry basket. Another resident had personal items that they required while resting in bed placed on their laundry basket. This was being used as a table. These and other issues identified regarding the premises will be discussed in the quality and safety section of this report.

The inspector also observed the storage of some cleaning equipment in both houses was not in-line with the provider's own policy on infection prevention and control (IPC) measures or current public health guidance. In addition, not all centre specific risks had been identified and some control measures documented as being in place were not reflective of actual practice within the designated centre. This included re-use of personal protective equipment (PPE) such as goggles.

In summary, residents were being supported by a dedicated core group of staff and regular relief staff were in place to provide assistance. A number of residents had complex needs that required ongoing support from familiar staff. However, further

improvements were required to ensure compliance with fire safety, personal possessions, risk management procedures, infection prevention and control measures.

The next two sections of this report will 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 provided.

Capacity and capability

Overall, the inspector found that there was a governance and management structure with systems in place which aimed to promote a safe and person-centred service in this designated centre. The previous Health Information and Quality Aurthority (HIQA) inspection took place in November 2021. The provider's compliance plan response following that inspection regarding regulation 8: Protection, regulation 23: Governance and management and regulation 31: Notifications had not provided adequate assurance to the chief inspector that the actions outlined would result in compliance with these regulations. The findings of this inspection demonstrated that the provider had taken actions to strive to improve compliance with these regulations.

The person in charge worked full time and their remit was over this designated centre. They were supported by a clinical nurse manager (CNM). Both of whom the inspector met during the inspection. Throughout the inspection both staff members demonstrated their awareness of their roles, responsibilities and the assessed needs of the residents in the designated centre. The provider had ensured staff on extended planned leave were replaced. In addition, pre-planning for future months regarding staff planned leave was also evident.

The provider had ensured an annual review and six monthly audits had been completed in the designated centre in line with regulatory requirements. The annual review had been completed in March 2023 and identified some positive outcomes for residents which included an increase in the frequency each week residents accessed community activities. Also, there was some limited return for residents to day services during 2022. The provider also re-commenced respite services in the designated centre in February 2022.

However, some actions identified in the six monthly provider –led audit in August 2022 remained outstanding. This included food safety training for staff. While the inspector acknowledges the person in charge demonstrated ongoing liaising with the provider's training department, the issue remained unresolved at the time of this inspection. The most recent six monthly audit completed in February 2023 identified a fire door being held open. At the time of the audit staff were advised this was not

in keeping with fire safety regulations. However, during this inspection the inspector observed a side panel on a fire door leading to the hallway in one of the houses to be opened back. This did not provide effective fire containment measures if the fire alarm was activated. There was no reason evident for the panel to be opened back at that time, such as a resident requiring additional space to safely navigate the door opening. This will be further discussed in the quality and safety section of the report.

To ensure compliance with regulation 31: Notifications, the provider had measures in place if negative peer to peer interactions occurred, consultation with the designated officer took place. In addition, if an incident was deemed not to be abusive the reason for this was to be documented in the incident reporting system. The inspector reviewed the incident log since the last inspection. There had been no incident which had resulted in negative peer to peer interactions during that period. This in part was due to changing needs of some residents who no longer presented with behaviours that adversely impacted their peers.

On review of some documentation during the inspection, gaps in up-to-date information relating to residents or evidence of review were not consistently documented in some residents personal plans which was identified in the provider's own audit and annual review. An action following these findings included personal plans were to be subject to quarterly review by each resident's keyworker with oversight by the person in charge. The inspector noted that one resident had three different identification numbers within their personal plan. In addition, the provider was required to ensure oversight regarding services being provided were reflective of information submitted to HIQA to support the renewal of registration of this designated centre. A room identified as being a bathroom in one house, was not being used for that purpose and was being used as a store room. Other issues that were identified regarding documentation will be further discussed in the quality and safety section of this report.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full time and they held the necessary skills and qualifications to carry out their role.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual rota in place. However, the hours of work for the person in charge was not identified on the rota unless they were working on the

front line with the residents. A core staff team was available to support the needs of the residents. External contractors were employed to complete household duties each week. Following a recent recruitment drive by the provider there were no vacancies at the time of this inspection. There were regular relief staff available to ensure staffing resources were in–line with the statement of purpose and the size and layout of the designated centre. In addition, the person in charge was actively seeking to have a staff resource in place in advance of another staff member taking extended planned leave in the months after this inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was evidence of ongoing review of the training requirements of staff within the designated centre. Staff supervisions had taken place during 2022 and were scheduled for 2023. The provider had completed a training needs analysis in January 2023 where gaps in training including mandatory training in fire safety had been identified. While, training was scheduled for 2023, at the time of this inspection not all staff had up-to date training in fire safety. In addition, not all staff had attended other training that had been identified as being required to support the assessed needs of the residents. These included manual handling and food safety.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the designated centre was resourced to ensure the effective delivery of care and support to residents. The registered provider had also completed an annual review and internal provider led audits. However, further improvement was required to ensure consistent safe services were being provided and effectively monitored. Not all actions had consistently been implemented which included reviews by keyworkers of residents personal plans to ensure up-to-date

information and oversight by the person in charge. In addition, further review of the function of a bathroom in one house was required to ensure it is reflective of the purpose of the room as per the statement of purpose.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. Some minor changes were made during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The chief inspector was notified in writing of all quarterly reports and adverse events as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints in the designated centre at the time of this inspection. Staff were aware of the provider's complaints policy. The inspector was unable to review all complaints that had been made since the last inspection as the previous full log book had been archived centrally in the months before this inspection. This was discussed with the person in charge during the inspection who advised and confirmed as per the annual review report that no complaints had required to be escalated in 2022.

Judgment: Compliant

Quality and safety

Overall, residents' well-being and welfare was maintained by a good standard of care and support to provide a person-centred service where each resident's individuality was respected. However, further improvements were required to ensure

compliance with the regulations regarding fire safety, personal possessions, protection against infection and risk management.

As previously mentioned the inspector observed an extension panel of a fire door to be opened back in one of the houses during the inspection. These panels allow increased space to manoeuvre equipment such as wheelchairs through a doorway. However, the panel should be placed in the closed position immediately after use to ensure an effective compartmentalisation of the space in the event of the fire alarm activating. When the panel remains in the open position automatic closure of the fire door would not create an effective seal. The inspector did not observe anyone to use this extra wide space for approximately 30 minutes before bringing it to the staff's attention. The panel was placed in the closed position immediately.

The inspector also observed a fire door into a utility room in the same house did not have a self-closing mechanism. There were electrical appliances in use in this room and the door was observed by the inspector not to be consistently closed. The person in charge had identified this as an issue prior to the inspection and provided assurance to the inspector in the days after this inspection that the mechanism was in place. However, no risk assessment or controls were in place at the time of this inspection to mitigate the absence of the self-closing mechanism. Staff spoken to outlined the regular fire safety checks that were completed which included weekly fire door checks. However, the inspector was unable to review the relevant documentation for one of the houses at the time of the inspection to establish how issues such as the missing self-closing mechanism were being managed and actioned.

The inspector also noted that the room numbering on the floor plans in the fire evacuation information in both houses did not reflect the room numbering visible on the doors in the designated centre. For example, in one house bedroom number five on the floor plans was labelled on the door as bedroom number one. No minimal staffing fire drill had taken place during 2022 in either of the houses. This was discussed during the inspection. Staff outlined that local fire service personnel were located nearby, were familiar with the layout of the designated centre and would provide a quick response in the event of an emergency. However, the inspector was not assured that fire drills with the minimal number of staff on duty had been undertaken by core staff team members to ensure effective evacuation of residents could take place in a timely manner.

The inspector observed there was limited storage in a number of bedrooms. As previously mentioned personal possessions for some residents were being stored on top of their laundry baskets. For one resident items were being placed on the laundry basket for them to access the items while they were lying in bed. Residents' personal toiletries were stored in their bedrooms. However, the inspector observed these items for one resident to be stored on the floor next to the resident's bed which adversely impacted on the ability to effectively clean the area.

A number of areas internally in both houses required maintenance, these included damage flooring in one of the staff rooms and kitchen presses displayed evidence of general wear and tear. There was also some damaged surfaces to a number of

chairs which would adversely impact the effective cleaning of the surfaces. The findings of the recent annual review in March 2023 had identified furniture in both houses required updating. In addition, as previously mentioned in this report a bathroom in one of the houses was not being used for that purpose and had a number of items stored in the space including wheelchairs. This required further review to ensure the statement of purpose and floor plans submitted as part of the renewal of registration accurately reflected the purpose and function of each room in the designated centre. This will be actioned under regulation 23: Governance and management.

There was evidence of ongoing support for individual's specific health care needs which included immediate responses to the rapidly changing mobility needs of one resident in the days prior to this inspection as a result of illness. Another resident was in receipt of additional support from the palliative care team. All comfort measures were being provided with ongoing consultation with family representatives. However, following a review of some documentation another resident was not supported to return to a consultant specialist for a 12 month review. The last appointment documented for the resident attending that specialist was 21 January 2020. Another resident had been waiting five years for a consultant review of an ongoing medical issue. While the resident was scheduled to attend in the weeks after this inspection, the person in charge did not demonstrate effective measures were in place to ensure residents were consistently supported to attend necessary allied healthcare appointments in a timely manner when required.

A key worker was identified to support each resident within the designated centre. The most recent internal provider led audit had identified gaps in the documentation completed for some residents in their personal plans. Keyworkers were to ensure priorities for residents were being progressed and all personal plans were to be subject to quarterly review by the keyworker. The inspector reviewed one personal plan that had been audited by the person in charge in January 2023. The audit findings clearly outlined actions that were required but it was not documented if all the actions had been completed by the keyworker at the time of this inspection.

The use of restrictive practices within the designated centre had been subject to regular and recent review. A number of restrictions had been reduced or eliminated since the previous inspection. This included the use clinical holds to support a resident if they became anxious. The staff team ensured familiar staff supported the resident during planned venepuncture procedures. This resulted in no clinical holds being required by the person in the previous 12 months. The staff team also had support and input from the clinical nurse specialist (CNS) in behaviour support. One resident had experienced a decline in their health in recent months. The resident was experiencing difficulties expressing their emotions and staff were providing tactile support. The CNS in behaviour support was reviewing the behavioural support guidelines for the resident at the time of this inspection.

Residents had been supported to remain safe during the pandemic. A staff member was identified as the COVID-19 lead and all up-to-date information was available for staff to access. Residents in one house were supported by a core group of staff during a recent outbreak of COVID-19. All those affected recovered from the illness.

A centre specific contingency plan was in place which identified specific actions to be taken. For example in the event of a particular resident contracting COVID-19 they were identified as requiring to be supported in an isolation unit for their safety.

Regular auditing of IPC measures had identified gaps in some documentation which was discussed at staff meetings. However, similar findings regarding gaps in cleaning schedules were found in Feburary and March 2023. As previously mentioned in this report, the inspector also observed the storage of cleaning equipment was not consistently in line with the provider's own guidelines. Colour coding protocols for the cleaning equipment present in the designated centre were not consistently adhered to in both houses. In one utility room, used mop heads identified for cleaning three different areas were observed in one bucket. One oven had evidence of residue build-up and required additional cleaning. While staff were aware of the risk of legionella and completing weekly flushing of unused water outlets the process was not in line with public health guidance. This was discussed with the person in charge during the inspection to clarify the requirements of both hot and cold water taps to be flushed weekly.

Residents were supported to actively engage in the running of the designated centre. One resident was identified as the advocate representative for the designated centre and had attended a national advocacy conference in a hotel in a large town in January 2023 which they enjoyed. The provider had identified that the advocacy structure within the designated centre required additional input. A CNM1 was identified to attend regional advocacy meeting held by the provider. In addition, local advocacy meetings were to be scheduled to take place in the area by the end of June 2023.

All residents had access to their personal finances. Staff provided support when required with managing some financial transactions. While the person in charge had oversight of all residents finances, one resident was experiencing barriers with a financial institution. The family representatives and provider were actively seeking to resolve this issue to ensure the resident's rights to access to their personal finances were not being adversley impacted.

The inspector reviewed risks that had been identified for individuals and the designated centre. However, a number of risks required further review. For example, the re-use of some PPE goggles was identified as a risk. But the controls in place stated adequate supplies were available. The inspector was informed the re-use of PPE was not a practice in the designated centre. The controls in place to reduce the risk of legionnella infection also required review to reflect public health guidance and protocols. In addition, the risk of residents leaving the designated centre without staff knowledge had not been identified as a risk as required by the regulations.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to visit their family representatives regularly and to have visitors to the designated centre.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge had ensured all residents were supported to manage their financial affairs and individual arrangements were in place to ensure all residents had access to their personal finances with support as required. One resident who was experiencing barriers from a financial institution was being supported by the provider and family representatives to resolve the issue.

Not all residents had adequate space to store their personal possessions and property.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The provider ensured residents were provided with opportunities to participate in activities in accordance with their interests, maintaining personal relationships and links with the wider community.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured the design and layout of the designated centre met the assessed needs of the residents. Ongoing maintenance was required to ensure the

premises was kept in a good state of repair internally.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate format. It had been updated to reflect the current services provided in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured that they were systems in place for the assessment, management and ongoing review of risk in the designated centre. However, further review of current risks in the designated centre was required, including the re-use of PPE and the risk of a person leaving the designated centre without staff knowledge.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had procedures in place to protect residents from the risk of healthcare associated infections. However, not all cleaning schedules had been completed in-line the provider's own protocols as identified in two recent internal IPC audits. In addition, the storage of colour coded cleaning equipment was not consistent with the provider's own IPC policy. The controls in place to reduce the risk of legionnella infection were not consistent with public health guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place. However, not all measures in place to contain a fire were evidenced as being consistently used, for

example, the extension panel of one fire door remained open back for a prolonged period of time. No minimal staffing fire drill had taken place in either house in the previous 12 months. The room numbering on the fire evacuation floor plans were not reflective of the actual room numbering observed on the bedroom doors in either house. A self closing mechanism on a utility room door was replaced in the days after this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The registered provider had in place a personal plan for each resident that reflected the nature of their assessed needs and the supports required. Personal goals were identified which included social inclusion and re-connecting with family representatives. However, not all actions identified in the provider's most recent six monthly audit had been addressed at the time of this inspection. These included the documentation of the progression of goals for some residents. In addition, inconsistent personal information for one resident was contained in their personal plan. The resident had three different identification numbers contained within their personal plan.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported with appropriate health care within the designated centre. However, not all residents had been supported to attend consultant reviews in a timely manner. In addition, the requirement of one resident to have a specialist consultation had been identified in 2018, the prolonged waiting period had not been escalated by the person in charge. The inspector acknowledges that the same resident is scheduled to meet with the particular consultant in the weeks after this inspection.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that all staff had attended training and had up-to-date knowledge and skills to respond to behaviours that challenge. In addition, ongoing review of restrictive practices ensured restrictions were reduced or

discontinued when no longer required.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding concerns at the time of this inspection. The registered provider had ensured all staff had been provided with training to ensure the safeguarding of residents.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had ensured residents were supported to exercise choice and control in their daily lives. Residents were supported to have flexible routines in line with their expressed wishes and preferences. The provider ensured residents privacy and dignity were respected, this included oversight of the use of appropriate language being used in personal documentation at all times.

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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially 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	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Aoibhneas/Suaimhneas OSV-0004782

Inspection ID: MON-0036843

Date of inspection: 30/03/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is a planned and actual roster in place with regular relief staff available to support the residents in line with the Statement of Purpose . • Since the 07/05/2023 the Person in Charge hours are now inputted on the roster and available to staff in the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Fire training: the two outstanding staff have been booked on training and will be completed by 30/06/23. • Food Safety : All staff who are due refreshers have been booked on training and will be completed by 30/06/23. • Manual handling staff who are due refreshers have been booked on training and will be completed by 30/06/23.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • There is a system in place for addressing maintenance issues as they arise. These are prioritized by the Person in charge and are scheduled in consultation with the facilities management. • The facilities manager meets with the Head of Integrated services on a fortnightly basis to discuss maintenance and progress works to be completed. This process will be discussed at next PIC meeting on 17/05/23. • Meeting held with Facilities manager on 09/05/23 in relation to the premises.	

• The bathroom which is currently used for storage in Aoibhneas is currently being reviewed by the facilities manager, PIC and Head of Integrated Services manager. Floor plans will be updated in the Statement of Purpose to reflect any changes.
• Outside shed in back area will be cleaned to allow for extra storage that is currently in the bathroom to be completed by 02/06/23.
• Self-closing mechanism has been installed on utility room door and inspector informed following inspection by email on 03/04/23.
• 1/04/2023 weekly check of internal doors commenced and is reviewed by the PIC.
• Staff meeting held on 11/5/23 where all staff were notified about the extension panel on one fire door which was left open. This panel is now closed. Following investigation with staff the side panel had been opened to allow one resident in a large moulded chair to access the multisensory room. 12/05/23 risk assessment has been put in place in relation to times the door may be required to be open for egress and access to the multisensory room. A notice has been displayed near the side panel to ensure door remains closed.
• 03/4/23 the room numbers on the fire evacuation floor plans have been updated and now reflect the actual numbers on the doors.
• Reviews of PCP's will be carried out by PIC in consultation with keyworkers to ensure residents personal plans are up to date and the information included is up to date.
• Personal plans and goals were discussed at the staff meeting on 11/05/23.
• The Head of Integrated Services will review with the PIC six monthly internal audit including progression of outstanding actions.
• A meeting with the PIC and Head of Integrated Services has been scheduled for 18th May.
• 26/04/23 inconsistent personal information (L numbers) in one residents personal file has been checked and updated by CNM1 and is now corresponding.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• 12/05/23 meeting held with the finance department. Resident now has arrangements in place to access her personal current account with support.
• The finance department are contacting the bank on 15/05/23 in relation to the progression of opening of the resident's deposit account.
• Meeting held with Facilities manager on 09/05/23 in relation to storage.
• Outside shed in back area will be cleaned to allow for extra storage for both houses to be completed by 02/06/23
• Storage was discussed at the staff meeting on 11/05/23
• Bottoms of all wardrobes to be cleaned out and extra personal possessions to be stored.
• Bedside locker to be purchased for one resident to store her personal belongings that she may require near her at night.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• There is a system in place for addressing maintenance issues as they arise. These are prioritized by the Person in charge and are scheduled in consultation with the facilities

management.
• The facilities manager meets with the Head of Integrated services on a fortnightly basis to discuss maintenance and progress works to be completed.
• Meeting held with Facilities manager on 09/05/23 in relation to the premises
• The bathroom which is currently used for storage in Aoibhneas is currently being reviewed by the facilities manager, PIC and Head of Integrated Services manager. Floor plans will be updated in the Statement of Purpose to reflect any changes.
• Outside shed in back area will be cleaned to allow for extra storage that is currently being stored in the bathroom to be completed by 02/06/23.
• Timber flooring will be replaced with marmoleum on a phased basis.
• The floor in the staff room will be replaced by 30/06/23
• Kitchen unit doors and counter tops to be upgraded by 8/09/23
• New furniture to be purchased for both houses, to ensure that effective cleaning of all surfaces

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All risk assessment are reviewed quarterly.
• 03/04/23 risk assessment completed for person leaving the designated centre without staff knowledge.
• 3/04/23 the re-use of PPE (i.e. goggles) was identified as a risk at the start of Covid but is now not in practice in the centre as per public health guidance. This risk has been closed.
• 3/04/23 the controls in place to reduce the risk of legionella infection has been reviewed to reflect public health guidance & protocols.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Meeting held with Facilities manager on 09/05/23 in relation to the premises.
• Two sheds to be purchased for outside kitchen area to store colour coded equipment.
• BOCSI Infection Prevention Control Manuel PC manual is available to all staff on the BOCSI shared drive.
• IPC was discussed at staff meeting on the 11/05/23.
• CNM1's will check cleaning lists on a weekly basis and they will be reviewed by PIC on a monthly basis when the audits are carried out.
• 03/04/23 the risk and controls in place to for Legionnaires disease had been updated to include the running of both cold and hot water on a weekly basis.
• New furniture will be purchased to allow for effective cleaning.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Staff meeting held on 11/5/23 where all staff were notified about the extension panel

on one fire door which was left open. This panel is now closed. Following investigation with staff the side panel had been opened to allow one resident in a large moulded chair to access the multisensory room. 12/05/23 risk assessment has been put in place in relation to times the door may be required to be open for egress and access to the multisensory room. A notice has been displayed near the side panel to ensure door remains closed. The Head of Integrated and Services Facilities in conjunction with the PIC will be reviewing the purpose of this room .
• A minimal fire drill was carried out in both houses on 03/04/23 and it is planned to carry out one more in Q2 2023. After Q2 a fire drill will take place quarterly.
• Self-closing mechanism has been installed on the utility room door and inspector informed following inspection by email on 03/04/23.
• 1/04/2023 weekly check of internal doors commenced and is reviewed by the PIC.
• 03/04/23 all room numbers have been changed on the doors to reflect the fire evacuation floor plan in each house.

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:
• Reviews of PCP's will be carried out by PIC in consultation with keyworkers to ensure residents personal plans are up to date and the information included is up to date
• Personal plans and goals were discussed at the staff meeting on 11/05/23.
• The Head of Integrated Services will review with the PIC six monthly internal audit including progression of outstanding actions.
• A meeting with the PIC and Head of Integrated Services has been scheduled for 18th May.
• Inconsistent personal information (L numbers) in one residents personal file has been checked and updated by CNM1 on 26/04/23 and is now corresponding.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Since the 12/05/23 appointments are a standing item on the agendas for the weekly meetings.
• Following an appointment the staff supporting the resident at the appointment will email the PIC with feedback on the appointment and any further actions that are needed.
• Keyworkers and CNM1s will review external consultant's summary sheet in MP/MP on a monthly basis.
• One resident who was waiting for an appointment has received an appointment 26/05/23 for a procedure.
• The keyworker in consultation with the CNM1 has made contact with the ENT department in relation to getting an appointment for the other resident and an appointment is to follow.
• Any delay in receiving appointments will be placed on MDT agendas to get advice on how to progress same and this may be escalated to the Head of Integrated Services if required.

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 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Substantially Compliant	Yellow	02/06/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/05/2023
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	30/06/2023

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	08/09/2023
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 safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	28/07/2023
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Substantially Compliant	Yellow	03/04/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	03/04/2023

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	30/06/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	03/04/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	12/05/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in	Not Compliant	Orange	03/04/2023

	so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	30/06/2023
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	12/05/2023