



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

Issued by the Chief Inspector

Name of designated centre:	Carra Mor
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	23 November 2021
Centre ID:	OSV-0004887
Fieldwork ID:	MON-0027017

About the designated centre

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

In this centre a full-time residential service is provided for six older adults with an intellectual disability and additional physical and health needs. The care and support provided aims to meet residents' assessed needs while ensuring that they continue to enjoy a good quality of life. Carra Mor is located in a pleasant cul-de-sac residential area of a large, busy town within walking distance of amenities such as shops, cafes and the providers main administration offices. Given the needs of residents, wheelchair accessible transport is provided. The premises is a purpose built bungalow-style house with its own well-maintained grounds. Six accessible bedrooms with attached en-suite facilities are provided; two residents share each en-suite facility. Residents also have access to a communal bathroom with a whirlpool type bath. Communal facilities include a kitchen/dining area and two sitting rooms. Residents have access to garden facilities to the front and rear of the house. Given their assessed needs, residents are supported by a team of nursing, social care and support staff. At night-time, residents' care needs are supported by two staff members both of whom work a waking night duty.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5
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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 - 2015 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
Tuesday 23 November 2021	9:45 am to 5:30 pm	Mary Moore	Lead

What residents told us and what inspectors observed

Based on what the inspector observed, read and discussed this was a person-centred service where residents received a good standard of support and care appropriate to their needs. The inspector saw that COVID-19 restrictions, advancing age and declining health may have altered how residents lived their lives but staff supported each resident to enjoy a good quality of life.

The provider had addressed the non-compliance with the regulations identified at the time of the last HIQA (Health Information and Quality) inspection. The action taken by the provider reduced risk and improved the quality and safety of the service. For example, the provider had increased staffing levels and regularised the consistency of staffing. The provider had significantly improved its procedures for evacuating residents in the event of fire or other such emergency. However, this inspection did find that improvement was needed in the management of medicines so that residents were at all times protected by safe practice. The provider also needed to improve some infection prevention and control arrangements.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. Given the needs of the residents and the high risk to their health presented by COVID-19, the inspector limited the amount of time spent with residents. The inspector had ample opportunity however throughout the day to meet with each resident, observe the routines of the house and the support and care provided to each resident.

The inspector saw that despite the predominant need for physical support and care staff were equally attentive to the social needs of each resident. While busy, there was a very relaxed and easy atmosphere in the house with strong evidence of individualised routines. For example, one resident liked to attend to the garden and spent part of the afternoon cutting the lawn. The resident was equipped with appropriate safety equipment. Another resident went to visit family in the afternoon while staff took another resident for a short walk. A resident spent most of the day at home and chatted at intervals with the inspector. The resident told the inspector that everything was fine in the house and he was happy. The resident said that he had regular contact with his family. Staff and residents participated in some table-top activities that were clearly enjoyed. The particular game played had been adapted by a staff member to suit the needs of the residents. A staff member spoken with confirmed that they had completed their Sonas (an evidence based multi-sensory therapeutic activity) refresher training. The staff member confirmed they had the time to implement the programme into the routines of the service and reported the programme was most beneficial when used on an individualised rather than group basis.

As this inspection was announced staff had supported residents to complete a HIQA questionnaire. Staff recorded what residents said or how residents communicated

their answer. For example, nodding their head when asked if they felt safe and if they were happy to live in the centre. The recorded views were positive and reflected what was found on inspection such as the importance of family, looking after the garden, enjoying board games and having the privacy of their own room. The inspector did not meet with any resident representatives but saw that they were invited to provide feedback to inform the provider's annual review of the service. This feedback was very positive with all respondents rating the service as excellent.

A common theme in the resident and representative feedback was the importance of family and family contact. The person in charge confirmed that visits to the centre were facilitated. There were reasonable controls to ensure visits were safe. For example, visitor well-being was ascertained on arrival, there was signage advising visitors of these controls and visits were facilitated in a specific room so as to reduce contact with other residents. On the day of inspection a staff member left the centre to spend some time with a resident who was in hospital and to support their family members. This was indicative of the relationships that had developed in this centre between staff, residents and their families.

Overall, the inspector's observations reflected a service that was focused on each resident and committed to providing residents with a safe quality service. Support and care was provided in a dignified manner. For example, staff sat when providing residents with assistance at mealtimes and all personal care was provided in residents' bedrooms with the door's closed. When walking about the inspector was advised that if a door was closed this meant that personal care was being delivered. This advice ensured the inspector did not compromise resident privacy.

Staff spoken with confirmed the amended and improved staffing levels and arrangements. Staff were positive about these changes and were satisfied they were able to provide a safer and better quality service to residents. For example, there had been manual handling risks as four residents required the assistance of two staff for most of their activities of daily living and for safe transfers. This was now addressed by improved and consistent staffing levels. The provider had also installed additional ceiling track hoists.

The centre was purpose built and designed to meet the needs of residents with higher needs including residents with reduced mobility or residents who were wheelchair dependent. The centre was well-maintained, welcoming and homely. Residents were seen to be provided with the equipment that they needed for their safety, well-being and comfort. Equipment was provided following an assessment of each resident's needs by the appropriate clinician such as occupational therapy. The premises presented as visibly clean and there was evidence of infection prevention and control measures. For example, the inspector observed appropriate face mask use by staff and there were procedures setting out the use and maintenance of clinical and care equipment. There has been no outbreak of COVID-19 in this centre. However, there were inspection findings that were not fully consistent with infection prevention and control guidance. These findings will be discussed in detail in the body of this report.

The primary matter arising on this inspection was a pattern of medicines incidents

and errors that had emerged in the centre. The provider was aware of this and there was evidence of corrective actions taken including the implementation of controls such as daily and weekly counts of medicines. However, the inspector was not assured that these measures were satisfactorily addressing the matter given the ongoing occurrence of errors. What the inspector found was monitoring that identified errors but not robust review such as a root cause analysis of each error.

In summary, this was a good person-centred service. There was solid evidence that residents received and benefited from the care and support provided. The provider had addressed the failings identified by the last HIQA inspection in relation to the overall governance of the centre, staffing, staff training, fire safety and risk management. However, further improvement was needed to ensure consistent safe medicines management practice and robust infection prevention and control arrangements. 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 delivered.

Capacity and capability

There were management systems in place focussed on ensuring the service provided was safe, consistent and appropriate to residents' needs. The provider had responded positively to the previous HIQA inspection findings. The action taken by the provider had improved the provider's compliance with regulatory requirements and had improved the quality and safety of the service. However, while actively seeking to manage and improve the safety of medicines management practice this matter was not satisfactorily resolved. While there was evidence of good practice, the provider also needed to take action to improve its compliance with Regulation 27; Protection against infection.

There had been changes to the governance structure since the last HIQA inspection. However, there was no evidence of instability and the current governance structure was working well. For example, the person in charge had other areas of responsibility but was based in this centre for much of the week. The person in charge spoke of the benefits of this arrangement as did staff spoken with such as access, supervision and the opportunity for face to face discussions. The person in charge had practical support in the delivery and management of the service from two experienced members of the nursing staff. This model of governance reflected the assessed needs of the residents. At verbal feedback of the inspection findings given the areas where improvement was needed, the inspector did recommend consideration of specific responsibilities such as for medicines management and infection prevention and control.

The person in charge had access as needed and good support from their line manager who was a person participating in the management of the service. The

inspector saw from records such as the records of accidents and incidents that had occurred, that oversight of the management of the service by senior management was in place and was consistent. In addition there was evidence of an active comprehensive service review and action plan developed by the local and senior management team.

This service review collated the evidence and findings of other reviews such as the compliance plan from the last HIQA inspection, the findings of the annual review and the six monthly unannounced reviews required by the regulations and, other findings such as from the monitoring of accidents and incidents. The review recognised what was positive but also any challenges and action that was needed to ensure and assure the quality and safety of the service provided to residents. Effective governance was evident in this standard of oversight and in the progression of the action plan. For example, the resolution of staffing deficits and actions taken in response to falls. It was evident that internal monitoring had also identified a pattern of medicines errors in the centre; the provider had and was taking action to improve practice. However, further action was needed to ensure that residents were protected at all times by consistently safe medicines management practice. This will be discussed again in the next section of this report.

Management and staff had worked together to resolve the staffing deficits identified by the last HIQA inspection. Staff had input into and co-operated with a review of their work rota. The resultant changes provided for consistency of staffing across the week. Additional staff had also been recruited so as to convert the previous sleepover night duty to two staff members on waking duty. A review of the staff rota and staff spoken with confirmed that three staff members came on duty every morning at 08:00hrs, there were four staff members on duty from 09:00hrs until 17:00hrs and three staff on duty until 22:00hrs. Based on what the inspector observed, read and was told these staffing levels were appropriate to the number of and the assessed needs of the residents. At verbal feedback of the inspection findings the provider confirmed the additional staffing put in place was unfunded and there was an open business case and risk assessment with the funding body, the Health Service Executive. The provider assured the inspector that while the requested funding had not yet been received these staffing levels would remain in place.

Since the last inspection a staff training matrix had been put in place and maintained. A review of this matrix indicated that all staff listed on the staff rota had completed all mandatory and required training. This included recently recruited staff. Refresher training that was due was planned. Staff had completed a baseline programme of infection prevention and control training and all staff had completed updated training on hand hygiene, the use of personal protective equipment (PPE) and a HIQA training module on Regulation 27; Protection against infection. The scope of the programme of training also reflected the assessed needs of the residents. For example, the Sonas training mentioned in the opening section of this report, training on falls prevention, end-of-life care and dementia care.

The complaints procedure was displayed in the main hallway. It was concise and centre specific. The person in charge said there were no open complaints and this

was reflected in other records seen such as internal reviews. Other records such as contact logs indicated open, regular and good communication. For example, representatives were in regular contact with residents and with staff. If any issue was raised, such as a concern about general well-being there was evidence of reassurance given and responsive action taken by staff such as referral for further input and advice from the multi-disciplinary team (MDT).

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the experience, skills and qualifications needed for the role. The person in charge clearly understood their management and regulatory responsibilities. The person in charge was committed to supporting the staff team in the provision of a safe quality service to each resident.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, staffing arrangements and staffing skill mix were currently all suited to the number and the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a training programme that consisted of mandatory and required training and, training that reflected the assessed needs of the residents. There were no gaps identified in staff attendance at training and any refresher training that was due was planned.

Judgment: Compliant

Regulation 21: Records

Any of the records requested by the inspector were in place and made available to the inspector. The records were well maintained and from the records the inspector readily informed and verified these inspection findings. There was good co-relation between records such as between risk assessments, the findings of reviews and residents' personal plans.

Judgment: Compliant

Regulation 22: Insurance

With the application seeking renewal of registration, the provider submitted evidence of having the appropriate insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

The governance system worked as intended by the provider and as set out in the statement of purpose and function. The provider had addressed the non-compliance identified by the last HIQA inspection. This had improved the quality and safety of the service. There was evidence of regular and consistent monitoring at all levels of the governance structure. There was a service specific quality improvement plan. The focus of management was the provision of a safe quality service to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the required information such as the range of needs that could be met in the centre. The statement of purpose was an accurate reflection of the service.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on records seen in the centre there were adequate arrangements that ensured HIQA was notified of certain events that occurred in the centre. For example, the use of any restrictive practice.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had notified HIQA of the absence of the person in charge. This notice included the arrangements for the appointment of a person in charge for the duration of that absence.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider advised residents and their representatives of its complaint management procedures. There were no open or recent complaints. There was evidence of regular and open communication between representatives, residents and staff.

Judgment: Compliant

Quality and safety

This was a good person-centred service. The care and support provided and the routines of the house were individualised to the needs, wishes and preferences of each resident. Age and declining ability did not prevent residents from having a good quality of life. Residents with greater ability were not limited by the higher needs of their peers. The staff team was committed to achieving a good balance each day between the physical and healthcare needs of the residents and their psychosocial needs. Improvement was needed in the area of medicines management. This failing required further exploration by the provider as the errors that occurred were not in keeping with the overall standard of care evidenced. The provider also needed to review and amend some practices so as to improve

compliance with *the National Standards for infection prevention and control in community services (2018)*.

The inspector reviewed one personal plan in full and a purposeful section of another. These plans reflected the assessed complex needs of residents and provided assurance that the care and support provided was evidence based. For example, each personal plan contained a detailed healthcare specific section. Each assessed need had a plan of care that provided good and appropriate guidance for staff. The plan was updated as needs changed and increased. For example, from the accident and incident log the inspector noted that a resident had had a number of falls. The inspector found in response an overarching risk assessment, a clinical falls risk assessment and a falls prevention care plan. Efforts had been made to investigate and establish the cause of the falls and to devise preventative strategies. Another resident had in line with their increasing dependency developed a risk for pressure sores. The inspector saw a wound prevention care plan. There was evidence of the cited controls in practice such as the provision of falls alert alarms, mobility aids, regular chiropody, the monitoring of blood pressure levels and the provision of pressure relieving mattresses and seating. However, while there was a wound prevention care plan there was no wound management plan.

The inspector saw that staff supported residents to have access to the clinicians and services that they needed in response to their assessed and changing needs. The care provided was informed by nursing knowledge from within the staff team and community based nursing resources, the relevant general practitioner (GP), occupational therapy, physiotherapy and specialist falls services. Residents benefited from the care that they were provided with. For example, the satisfactory clinical findings found and reported by clinicians on clinical review confirmed the effectiveness of the care provided by staff.

However, records seen such as the centre specific review referred to in the last section of this report, discussed the emergence in the centre of a pattern of medicines errors. Based on other records seen such as incident records and risk assessments this was not satisfactorily resolved. Three further medicines errors were reported in October 2021 one of which was a potentially serious incident. Therefore, the inspector was not assured that residents were protected by consistently safe medicines management practice. There was evidence of corrective actions taken including feedback to staff and the introduction of controls such as medicine counts. However, the review of each incident was not sufficiently robust and did not identify and establish more conclusive findings that may have led to better and safer practice. For example, the person in charge confirmed that the review did not include the review of medicines administration records to establish if medicines had been signed for but not administered or to establish other possibilities such as a pattern to the errors or failings in the medicines systems. For example, the inspector noted that a combination of original containers and compliance aids were used and most errors were in relation to the medicines supplied in their original containers. The prescription and the administration record while satisfying regulatory requirements were not a good fit and some residents were on a large number of medicines. These were all matters to be considered

when reviewing the pattern of errors in addition to the matter of staff competency.

There was evidence of practice that was consistent with *the National Standards for infection prevention and control in community services (2018)*. For example, the provider had prescribed for staff the training to be completed and it was completed by staff. The inspector saw procedures setting out for staff the care of clinical equipment such as nebulisers and catheters. Nebulising therapy was administered in the resident's own room and not in communal areas. Staff confirmed that equipment such as seating and slings for transferring residents were supplied individually to each resident. The sharps container was stored securely and dated as to when it was opened. There was regular access throughout the house to PPE and hand sanitising products. There were systems for reviewing infection prevention and control facilities, practices such as environmental cleaning and staff use of PPE. These included structured quarterly reviews and spot checks. However, the inspector noted that these separate reviews were completed at the same time meaning that the frequency of review was reduced to quarterly. No deficits were noted in the reports of these reviews and this would not concur with the findings of this HIQA inspection. For example, the inspector noted that all bins provided were not pedal operated and the operating mechanism of two pedal bins was broken. There was soap but no hand towels provided at the sink in the laundry. However, the provider did need to risk assess the use of each sink, agree the purpose of sinks including sinks to be used for cleaning equipment and sinks for the purpose of staff hand-washing. Two mops and buckets (one of which was for high risk areas) were stored adjacent to clean laundry that was drying. Two residents shared each en-suite facility. There was evidence of segregated toiletries but the person in charge confirmed there was no risk assessment setting out the necessary day-to-day infection prevention and control measures for these shared facilities. Reusable oral syringes were used to administer medicines; staff described their cleaning in hot soapy water. However, the syringes were stored in an open container on a counter. There was a paper stapler in the container with the syringes. There was a schedule for frequent, daily and weekly cleaning. However, there were evident gaps in the records of completed cleaning. Cleaning instructions and procedures required review. The terms cleaning, disinfecting and sterilising were all used and required review to ensure they were the appropriate descriptors for the task. For example, sterilising was used in the context of items such as chairs, tables and couches.

The provider demonstrated increased capacity to evacuate all residents from the centre in the event of fire or other emergency. Each resident's personal emergency evacuation plan and the central emergency plan were updated to reflect any changes in the centre and any change in resident circumstances. For example, the altered staffing arrangements at night or an increased risk for falls. There was a schedule for the completion of simulated drills and these were managed to ensure that all staff participated in a least one drill. The simulated drills were undertaken to replicate different scenarios including varying staffing levels. Simulated drills brought residents (or staff simulating residents at times given residents' high needs and risk for injury) to a safe area but also to the external assembly point. Given the dependency levels in the centre staff had to utilise evacuation devices. From the records of these drills the inspector saw that the provider had significantly reduced the amount of time it took two staff (minimum staffing levels) to evacuate all six

residents. The time taken was reducing with each simulated drill and the most recent time achieved was almost half that evidenced at the time of the last HIQA inspection. The provider should however continue to safely practice, refine these drills, and continue to aim to reduce the evacuation time. In line with HIQA guidance the provider should identify and agree the best possible time within which residents can and should be evacuated.

Fire safety measures such as the fire detection and alarm system, the emergency lighting and fire-fighting equipment were all inspected and tested at the required intervals.

Improvement was also noted in the identification, management and review of risk. The risk assessments reviewed by the inspector were active documents that were reviewed and updated to reflect incidents that occurred and the effectiveness or not of controls that were implemented. For example, the residual risk rating for possible medicines errors was increased following the recent errors and additional controls were put in place. Conversely, the residual risk rating for evacuation and staffing were both reducing given the enhanced staffing levels and improved evacuation times.

Regulation 11: Visits

Reasonable controls to prevent the accidental introduction of infection ensured that visits to the centre were safely facilitated.

Judgment: Compliant

Regulation 13: General welfare and development

Based on the records seen and the care observed, the care provided to residents was evidence-based and informed by regular MDT input. Age and declining ability did not prevent residents from having a good quality of life. Residents with greater ability were not limited by the higher needs of their peers. The staff team was committed to achieving a good balance each day between the physical and healthcare needs of the residents and their psychosocial needs. Residents had the access to their family that was important to them.

Judgment: Compliant

Regulation 17: Premises

The premises was purpose built, designed and laid out to meet the assessed needs of the residents. The premises was well-maintained. Residents were provided with the equipment that they needed for their safety, comfort and well-being.

Judgment: Compliant

Regulation 20: Information for residents

The residents guide contained all of the required information such as how and where to access any inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

There were improved systems in place for the identification, management and review of risk. Good oversight was maintained of risk.

Judgment: Compliant

Regulation 27: Protection against infection

There was evidence of good infection prevention and control practice and residents have been protected against the risk of COVID-19. However, the provider needed to review facilities, procedures and its systems of oversight to ensure practice was fully consistent with *the National Standards for infection prevention and control in community services (2018)*. For example, improvement was needed in cleaning procedures, the maintenance of reusable equipment and the frequency of formal reviews.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider demonstrated increased capacity to evacuate all residents from the centre in the event of fire or other emergency. The time taken to fully evacuate the centre was reducing with each simulated drill and the most recent time achieved was almost half that evidenced at the time of the last HIQA inspection. The provider

should however continue to safely practice, refine these drills and aim to further reduce the evacuation time. The provider in line with HIQA guidance, should identify and agree the best possible time in which residents can and should be evacuated.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector was not assured that residents were protected by consistently safe medicines management practice. A pattern of medicines errors had emerged and while there was evidence of corrective actions taken errors continued to occur. The review of each incident was not sufficiently robust and did not identify and establish more conclusive findings that may have led to better and safer practice.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Overall the personal plan was a comprehensive document. Each assessed need had a plan of care that provided good and appropriate guidance for staff. The plan was updated as needs changed and increased. However, while there was a wound prevention care plan and evidence in practice of preventative measures, there was no wound management plan.

Judgment: Substantially compliant

Regulation 6: Health care

Staff supported residents to have access to the clinicians and services that they needed in response to their assessed and changing needs. The satisfactory clinical findings found and reported by clinicians on clinical review confirmed the effectiveness of the care provided by staff.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan was kept under review as were any restrictions

needed for the safety and well-being of residents. These were minimal and MDT review had resulted in the recent removal of two restrictive practices.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector saw that the care and support provided and the daily routine in the house recognised and respected the age, disability, ability, wishes and choices of each resident. Residents and-or their representatives as appropriate were consulted with about their care. Residents were seen to have the support from staff that they needed but were also given independence where it was safe to do so. Residents had choice and control and staff sought to support residents to make good decisions, for example to use their mobility aid and to wear their falls alert alarm.

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 - 2015 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Carra Mor OSV-0004887

Inspection ID: MON-0027017

Date of inspection: 23/11/2021

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 27: Protection against infection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>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. This will be ensured by:</p> <ul style="list-style-type: none"> • The PIC will ensure functional laundry processes and appropriate storage of cleaning equipment and cleaning products is actioned. [Complete] • The PIC will review risk of shared facilities and implement controls to manage and reduce the risk of infection spread. [Complete] • The PIC will ensure compliance with cleaning schedules by carrying out regular monitoring and auditing of records; and will ensure completion of daily, weekly and monthly scheduled cleaning. [Planned completion 28/02/2022] • The PIC will create site specific local infection prevention and control protocols/procedures (To include the cleaning instructions and care of all equipment in use) and ensure staff are supported to implement same. [Planned completion date: 28/02/2022] • A RNID within the team will be delegated responsibility as the IPC lead within the centre. • An IPC specific team meeting will be held with the team, to discuss the aforementioned protocols and to ensure staff’s understanding of IPC and standard precautions. The difference between cleaning, disinfecting and sterilizing will be discussed at this meeting. • The PIC will carry out frequent announced and unannounced reviews of the premises to ensure correct use of PPE, hand hygiene compliance and that staff are adhering to infection prevention and control arrangements in place to ensure safe and effective provision of service. A schedule will be maintained by the PIC of these reviews to ensure their regularity and effectiveness. 	

- In addition, a member of the SMT will carry out an additional, unannounced IPC specific audit in the centre by the end of Q3 2022 to assess the effectiveness of the above actions and to ensure that practice is consistent with the National Standards for infection prevention and control in community services (2018).
[Planned completion 31/03/2022]

Regulation 29: Medicines and pharmaceutical services	Not Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Regulation 29 (4) The PIC shall ensure that the designated center has appropriate and suitable practices relating to the ordering, receipt, prescribing storing, disposal and administration of medicines. This will be ensured by:

- An investigation has been carried out into a recent, possibly serious error reported within the centre. This investigation was carried out by the PIC & PPIM. [Complete]
- A number of recommendations have been made arising from the aforementioned investigation, which will be actioned in a timely manner. These recommendations include:
 - o One RNID to be delegated overall responsibility for medication management within the centre.
 - o Site-specific medication management protocol to be introduced to guide staff on appropriate procedures that must be adhered to, as per the organisation’s Medication Management Procedure.
 - o Review and update systems regarding the ordering, receipt, prescribing, storing, disposal and administration of medicines prescribed to the resident; including a full review of prescription and administration records in use.
 - o Review medication management protocol, medication error investigation report, and procedure for reporting medication errors at next team meeting.
[Planned completion date 31/01/2022]
- The PIC will examine the work environment in order to identify, define and eliminate possible distractions to enhance resident safety.
[Planned Completion date: 31/12/2021]
- The PIC will review the requirement for ongoing medication management training and education for all team members.
[Planned completion date: 28/02/2022]
- The PIC will carry out quarterly unannounced medication audits within the centre to assess the effectiveness of the above actions.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:</p> <p>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). This will be ensured by:</p> <ul style="list-style-type: none">• The PIC, in conjunction with the RNIDs, will implement a wound management plan, to ensure appropriate guidance in place for staff in the event it is required. [Planned completion date: 31/01/2022]• Thereafter, the PIC will ensure that individuals assessed as having a skin integrity/wound risk, have an up-to-date individualised prevention and management plan with evidence of regular review and health professional oversight.	

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 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.	Substantially Compliant	Yellow	31/03/2022
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	Not Compliant	Orange	28/02/2022

	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.			
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	31/01/2022