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:	Community Residential Service Limerick - Group G
Name of provider:	Avista CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	19 January 2022
Centre ID:	OSV-0004963
Fieldwork ID:	MON-0030729

About the designated centre

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

The centre is located within a small town, in a mature residential setting in Co. Limerick. The centre is located close to public transport services, shops, recreational services and employment opportunities for the residents. The centre can provide a community residential service to 11 residents with a mild to moderate intellectual disability. The aim is through a person centred approach to improve the residents' quality of life by ensuring they are encouraged, supported and facilitated to live as normal a life as possible in their local community.
The centre is comprised of 2 houses located close to each other. One house can support five residents and the other house can support a maximum of six residents. Each resident has their own personalised bedroom and both houses have garden and parking facilities. One of the houses has a conservatory area, both houses have kitchen and bathroom facilities to support the needs of the current residents.
The intention of the centre is to provide residential and day supports for the independent and/ or older residents who are retired, semi-retired or in the pre-retirement stage of their lives. The intention is to provide minimal staffing supports to support their age related needs and wishes. The centre is managed and supported by social care staff and the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 19 January 2022	10:00hrs to 18:00hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

Residents living in the centre enjoyed positive relationships with each other and the staff team supporting them. Residents had opportunities to engage in activities that interested them while also choosing when not to participate. Areas for improvement were identified in the course of this inspection. These included protection against infection, risk management and the management oversight systems in place in the centre.

This was an unannounced inspection. On arrival, the inspector met with the person in charge of the centre. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The centre comprised of two houses within a short distance of each other in a suburb on the outskirts of Limerick city. The person in charge was based in one of the houses. The inspector had the opportunity to meet with all nine residents living in the centre at the time of the inspection. There were four residents living in one house and five in the other. The house with four residents was staffed 24 hours a day, seven days a week. There were two staff from 8am to 10pm and one sleepover staff. One resident had moved from this house to another designated centre run by the same provider in November 2021. The inspector was informed of a planned admission to this house in the coming weeks. A transition plan to support this resident was in place. The prospective resident had already visited the centre and was looking forward to the upcoming move. The current residents were also looking forward to this person moving in.

Five residents lived in the other house independently. They were aware that, if required, staffing support was available to them and spoke with the inspector about how, and why, they would request this. Staff regularly spent time in this house with these residents. Although this staff support was not funded, it was built into the centre's roster where possible. Management informed the inspector that a request for additional funding had been submitted to provide staffing supports in this house. It was identified that this would be of benefit to the residents following the provision of extra staff while day services were closed during the COVID-19 pandemic.

As will be discussed in the quality and safety section of this report, on occasions, when staff support was assessed as necessary, one resident temporarily moved within the centre from living independently to the house with staffing support. Rather than the required supports being temporarily provided in their usual home, the resident was required to move to another house. This had most recently occurred for number of weeks over the Christmas period in 2021. This will be discussed further in the quality and safety section of this report.

During this inspection, it was identified that the bedroom this resident moves to when unwell had been converted into an office space and fitted with a desk. As a

result of the repurposing of this room there were no storage facilities in the bedroom for the resident's own belongings. Boxes of administrative files also continued to be stored on the floor of this room when the resident stayed there. This room was labelled as a bedroom on the floor plans submitted to the Health Information and Quality Authority (HIQA) as part of the provider's application to renew the registration of the centre. However it was evident during this inspection that this was no longer the primary purpose of this room. When in the other house in the centre it was noted that a room labelled on the floor plans as a sleepover room was not used for that purpose. The upstairs rooms in that house were no longer in use or accessed by residents or staff. The inspector requested that updated floor plans be submitted to HIQA.

The inspector walked through both houses with a person in charge. Both houses were decorated in a homely manner, reflective of the people living there, their interests, and who and what was important to them. Each resident had their own bedroom. Bedrooms were personalised and were decorated with residents' choices of soft furnishings, photographs, art, personal items and in some cases a television. Areas for improvement were identified in both premises. Most notably there was mould evident in several areas in both houses. These included on the blinds and around external windows and doors in one house and in parts of a conservatory in the other. One resident told the inspector that one part of their bedroom can develop mould. This information was shared with the inspector when the resident spoke about cleaning their own bedroom. There was no mould evident in this bedroom on the day of inspection, although there was a slight gap evident around the bedroom window. Areas that required cleaning were also identified. These included the conservatory and the utility room in the staffed house, and the communal bathrooms in the house where residents lived independently. It was also evident that additional storage was required. These matters will be discussed further when the findings regarding the premises and protection against infection are outlined in the quality and safety section of this report.

It was very clear that positive relationships existed among the resident groups in each house and between the residents and members of the staff team. There was a very friendly atmosphere in the first house the inspector visited. Residents and staff were heard laughing and joking together. The residents had lived together for a long time and clearly knew each other well and were happy to live together. At one stage residents could be heard singing along to music and thoroughly enjoying themselves. A hen lived in the back garden of this house. One resident had a particular interest in caring for the hen and spoke with the inspector about this. Another resident was interested in gardening and had a raised bed which they enjoyed tending to. Many residents were artistic and their works were displayed throughout the centre.

Later in the inspection the inspector visited the second house. The residents were all sitting together at the kitchen table and welcomed the inspector to join them. This group also knew each other very well and shared each other's stories about upcoming events, past holidays, and their friends and families. Residents had been supported to go on holidays to various places both in Ireland and overseas. Some of these trips had been to meet with friends or relatives, others had been to see the

sights and go shopping. The COVID-19 pandemic had impacted on travel plans and some were looking forward to planning more holidays. The conversation also included reference to the news at the time, programmes they liked to watch on television and how they spend their days. It was noted that residents were very considerate of those they lived with. One resident spoke with the inspector about their love of animals and their wish to have a dog of their own. They emphasised to the inspector the need for those they lived with to be open to the idea of a pet in the house. Although they lived in a house without any assigned staffing hours, the residents were very positive about the staff team. They spoke with the inspector about who they would to speak with if they had a problem, when they may contact staff for support, and how safe they felt living in the centre.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. This included the complaints log in one house, fire safety documentation, the risk register, and infection prevention and control (IPC) documentation, including the contingency plan to be implemented in the event of a suspected or confirmed case of COVID-19. The inspector also looked at a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. Areas for improvement were identified and will be outlined in more detail in the remainder of this report.

As there were no staff working in the house when the inspector met with the residents who live independently, the office was locked. As a result the inspector was not able to review documentation relating specifically to this house and those that lived there. Some documents relating to this house were requested at feedback on the day after the inspection and were provided. The inspector also requested the most recently completed governance reports and multidisciplinary reviews of residents' personal plans. Management advised that although these had been completed, there was no associated documentation available. These shortcomings will be discussed in more detail later in the report.

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

Capacity and capability

While there was evidence of good oversight in some areas, overall improvement was required in the management practices in the centre to ensure that the service provided was safe and appropriate to residents' needs. Improvements were required in a number of key areas including governance oversight, risk management, protection against infection, premises, staff training and ensuring residents' assessed needs were being met in the centre.

There was a clearly-defined management structure in place that identified lines of

accountability and responsibility. Members of the staff team reported to the person in charge who reported to the person participating in management who was based nearby. The person in charge had been in this role since March 2020 and fulfilled the role for this centre only. They demonstrated a very good knowledge of the residents and their support needs and clearly knew them well. The person in charge had eight supernumerary hours a week to focus on administrative duties.

The inspector was informed that an annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. However the reports relating to the annual review completed in October 2021 and the most recent unannounced visit were not available for review at the time of this inspection. Similarly, the inspector was informed that a medication audit had been completed in late 2021 but a report regarding this was also outstanding. As a result it was not possible to review what if any issues had been identified, or if any identified actions were completed or were in progress.

The inspector reviewed the report written following an unannounced visit completed in April 2021. This outlined positive initiatives introduced to the centre during the pandemic including increased access to electronic tablets, the introduction of window visits (when required due to public health advice) and the benefits to the residents living independently of additional staff support provided. It also made reference to the need for additional storage and a review of the conservatory by the maintenance manager. The majority of actions identified had been completed while others remained relevant and consistent with the findings of this inspection. The absence of recent governance reports and the levels of compliance with some regulations identified during this inspection indicated that the oversight of the safety and quality of care and support provided in the centre required improvement.

Staffing in the centre was provided in line with the staffing complement outlined in the statement of purpose. The person in charge had identified a group of three staff to provide relief cover as required. When speaking with the inspector residents were very positive about the staff and the support they provided. From time spent in the centre it was clear to the inspector that the residents were comfortable with the support provided and enjoyed positive relationships with staff.

The inspector reviewed staff training records. Some gaps were identified. Two staff required refresher fire safety training. They were booked to attend this mandatory training later that month. Three staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques. Two of these staff required refresher training while there was no record that the third staff had ever completed this mandatory training. One staff required refresher training in the safe administration of medication. At the time of this inspection training sessions in the management of behaviour that is challenging and the safe administration of medication were not planned. It was also identified that four staff required refresher training in infection prevention and control. The person in charge advised that they would request staff to complete this training online.

Residents reported to the inspector that they would feel comfortable making

complaints in the centre and identified who they would go to if any issues arose. When reviewing the log for one house it was noted that complaints were addressed promptly and measures required for improvement were put in place. The satisfaction of the complainant was also noted, as is required by the regulations.

The statement of purpose is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. The statement of purpose available met the majority of the requirements of the regulations. However, as outlined previously, the labels of some rooms on the floor plans contained in the statement of purpose were not consistent with the primary function of these rooms, as observed during this inspection.

Regulation 15: Staffing

Staffing was provided in the centre in line with the staffing levels as outlined in a statement of purpose. Many of the staff had worked in the centre for many years providing a continuity of care to residents. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Two staff required refresher fire safety training. They were booked to attend this mandatory training later in the month. Four of the eight staff required refresher training in infection prevention and control. This was to be completed online. Three staff required training in management of behaviour that is challenging (two required refresher training, there was no record that one staff had ever attended this mandatory training) and one required refresher training in the safe administration of medication. Attendance at these trainings was not planned.

Judgment: Substantially compliant

Regulation 23: Governance and management

Improvement was required in the management, and oversight, of the quality and safety of care and support provided in the designated centre. Actions proposed to address issues with the premises following the last HIQA inspection had not been completed. The lack of sufficient storage facilities in the centre needed to be addressed. Although the inspector was informed that they had been completed in

October 2021, the annual review and most recent six-monthly visit report were not available on the day of inspection. Similarly, records of the most recent multidisciplinary reviews of residents' personal plans were not available. Improved oversight was required in staff training needs, the cleaning of the centre and in the implementation of other infection prevention and control procedures and processes. An improved understanding and implementation of risk assessment was also required. The plan in place that required a resident to leave their usual home to access staff support at times of poor mental health indicated that the centre was not sufficiently resourced.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

A prospective resident had an opportunity to visit the centre and more visits were planned prior to them moving into the centre. Signed written agreements were in place regarding the terms of residency in the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

A statement of purpose was available and had been recently reviewed. The descriptions of some rooms in the centre, including their primary function, were not accurate.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

An effective complaints procedure was in place. A review of the complaints log in one house demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded.

Judgment: Compliant

Quality and safety

Residents were happy living in the centre and enjoyed a good quality of life. Positive relationships had been developed among the groups of residents living in both houses. Residents were encouraged to have choice and control over their daily activities and in the running of the centre. Improvements were required in the areas of risk management and infection prevention and control. Longstanding issues with the premises, including areas requiring maintenance and the provision of suitable storage, needed to be effectively addressed.

Residents in both houses attended nearby day centres and activity groups during the week. Due to the COVID-19 pandemic and the high national infection rates at the time of this inspection, not all of the residents' usual services had resumed. Residents attended these groups and participated in activities in line with their preferences. The inspector was informed by staff, and observed first-hand during this inspection, that residents' wishes were accommodated if they preferred to stay in the centre. One resident was hoping to return to their day service at reduced hours. The person in charge was liaising with day service management to try and facilitate this request. Residents were looking forward to getting back to all of their preferred activities. One resident spoke about their wish to go to the Lisdoonvarna festival again.

Residents were very involved in the running of the centre. The inspector reviewed the residents' meeting minutes for one of the houses. From these it was clear that residents were regularly consulted about the running of the house and any upcoming events or changes. These included the upcoming move of a new resident into the house, changes to the name of the service provider and everyday activities such as outings, menu planning and fire drills. It was evident throughout the inspection that residents were supported and encouraged to exercise choice and control in their daily lives, for example whether or not they attended or participated in any planned activities.

When reviewing documentation in the centre, records indicated that, due to the public health emergency, staff in consultation with management had decided that a resident not attend an important family event early in the COVID-19 pandemic. It was not documented if the resident was consulted regarding this decision. The inspector sought additional assurances from the provider following the inspection regarding this matter in consideration of the resident's individual rights. Additional information was provided indicating that management had made this decision in light of medical advice received regarding this specific resident.

Contact with friends and family was very important to many of the residents in the centre and this was supported by the staff team. Visitors were welcome to the centre in line with residents' wishes. Residents also visited friends and family. Residents told the inspector about visits they had made in the past to other counties in Ireland and abroad to maintain these important relationships.

The inspector reviewed a sample of residents' personal plans which outlined the supports that residents required. Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of regular appointments with medical practitioners, as required. There was also evidence of input from allied health professionals such as occupational therapists, speech and language therapists, and a clinical nurse specialist with expertise in dementia. Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. When reviewing these plans, it was noted that not all goals were regularly reviewed, for example there was no progress documented in achieving goals to visit a named castle or attend a reflexologist in the five months since they had been developed. Other goals, that involved in-house activities, had been reviewed monthly. Similar to the issues identified regarding access to governance reports, the inspector was informed that annual multidisciplinary review meetings had taken place however the documentation regarding these was not yet available for review. The most recently recorded multidisciplinary reviews of the residents' personal plans reviewed by the inspector were dated July 2020.

As referenced in the first section of this report, one resident spent time living in both houses in the centre. It was identified that at times of poor mental health, this resident was required to move to the other house in the centre to access staff support, rather than this support being provided in their usual home. It was identified during this inspection that the bedroom they moved to had been repurposed as an office and no longer had any storage facilities for the resident's belongings. A support plan was in place that described the resident's presentation when staff supervision and support were required. It did not outline when the resident could return to their usual home, or who was involved in making that decision. There was no reference to multidisciplinary input regarding the decisions to move between houses or the resident's supports during these identified times of poor mental health. This arrangement had been discussed at the most recently recorded multidisciplinary review of their plan in July 2020. Evidence of a more recent review was not available. This arrangement required review to ensure that the centre was suitable to meet the needs of this resident, to assess the effectiveness of the plan in place, and to take into account the changes in circumstances in the centre.

As outlined in the opening section of this report many areas of the premises required maintenance. Actions to be completed by the provider to come into compliance with the premises regulation following the February 2021 HIQA inspection had not been completed. These included painting and renovations to a bathroom. The person in charge advised that this planned work was delayed due to the ongoing pandemic. They told the inspector that work had been done in the conservatory since the last inspection however this did not address the ongoing damp in this room. Damp and mould were observed in both houses. The person in charge told the inspector that they had directed staff not to clean mould due to the associated health risks. The inspector did not see any evidence that specialist cleaning input was requested. In the first house that the inspector visited, flooring was observed to be lifting and torn in the corridor leading to the shower room.

Fittings in one bathroom were observed to be rusted. Repainting was required in some areas and others were observed to be unclean. A cleaning checklist was in place and all copies seen by the inspector had been completed in full. This was not consistent with the level of cleanliness observed on the day. The cleaning checklist did not include each room in the centre, it was therefore possible to omit rooms in error. At the close of this inspection, management committed to reviewing this system.

It was also observed that there was insufficient storage available in the centre. One room, identified on the floor plans as a resident's bedroom, had been fitted with a desk and furnished with office equipment. There were documents to be archived in boxes on the floor of this room. There was no storage available for resident's belongings. A room in the unstaffed house was labelled a sleepover room on the floor plans. This room did not have a bed and was instead used as an office. Boxes and plastic bags of documents were stored there. A room labelled as a relaxation room was observed to be used for storage of furniture and unwanted clothes. Some items belonging to residents were stored in staff offices in both houses which were routinely locked when staff were not there. When asked if this was to restrict residents' access to these items, the person in charge advised that it was due to lack of suitable storage in the communal areas. It was also noted that boxes of personal protective equipment (PPE) were stored on top of an open sharps box in a cupboard in one of the staff offices. This was not consistent with recommended good practice regarding the management of sharps and infection prevention and control (IPC) standard precautions. In the utility room of this house, laundry was drying on a clotheshorse over buckets typically used for cleaning floors. As well as indicating that there was inadequate storage, this also posed an IPC risk. As outlined in the previous section of this report four staff, half of the staff team, required refresher training in infection prevention and control. The person in charge advised that a monthly audit was completed regarding hand hygiene in the centre. This did not involve a practical review or assessment of hand hygiene practices.

The inspector reviewed the contingency plan to be implemented in the event of a suspected or confirmed case of COVID-19. Given the staffing arrangements in the centre and the fact that only one resident had the exclusive use of their own bathroom, it was unclear from this plan how residents could safely isolate from their peers in the centre, if required. When asked, the person in charge was unclear if the isolation hubs referenced in the plan were still open and available for use. The plan required further detail to reflect the specific needs and arrangements in this centre. Management advised the inspector that when a number of residents had tested positive for COVID-19 staffing was provided in the house where residents lived independently. This arrangement was not outlined in the contingency plan.

The inspector also reviewed the provider's risk register. The scoring of risk assessments required review to ensure that they were reflective of the risk posed by identified hazards in the centre. The majority of hazards had been assessed as posing a very low risk, with scores of three or less. The risk assessment rating regarding infection control in the centre was one. Not all hazards in the centre had been identified. These included the use of sharps in the centre and the lack of safe, suitable storage for the sharps box. It was also noted that risk assessments stored

in residents' individual files had not been reviewed within the stated timeframes.

Systems were in place and effective for the maintenance of the fire detection and alarm system and emergency lighting. When walking through the centre a fire door in the utility room, a high risk area, was observed to be damaged. It required review by a competent person to provide assurance that it could act as an effective containment measure in the event of a fire. Each resident had a recently reviewed personal emergency evacuation plan (PEEP) in place. Evacuation drills were completed monthly in both houses in the centre. These drills reflected a variety of possible evacuation scenarios including the location of the fire in different parts of the houses and in both day and night time staffing conditions. This was a noticeable improvement from the findings regarding evacuation drills when the centre was last inspected by HIQA in February 2021. Records reviewed indicated that residents evacuated promptly and without difficulty, with support from staff where required.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with their wishes, interests and assessed needs. Staff had a good knowledge of residents' preferred activities. Residents were looking forward to resuming a number of preferred activities.

Judgment: Compliant

Regulation 17: Premises

Parts of both houses were observed to be unclean and requiring maintenance. Areas required repainting and mould was evident in parts of both houses. There was insufficient storage throughout the centre, including in one of the resident's bedrooms.

Judgment: Substantially compliant

Regulation 20: Information for residents

The guide prepared in respect of the designated centre met all of the requirements of this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

A review of the risk register in place identified a poor understanding of risk assessment. The scoring of risk assessments required review to ensure that they were reflective of the risk posed by identified hazards in the centre. Not all hazards in the centre had been identified and risk assessed. It was identified that some of the documented control measures to mitigate against risks were not in place, for example it was noted that all flooring was in good condition to mitigate against the risk of slips, trips or falls.This was not consistent with observations during this inspection.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider's contingency plan to be implemented in the event of a suspected or confirmed case of COVID-19 required review to ensure that it was up-to-date and specific to this centre, this group of residents, and their living arrangements and individual needs. The areas identified that required cleaning, the arrangements for drying residents' laundry and the recurrent mould throughout the centre posed a risk to residents' health and wellbeing. Some surfaces in high risk areas, such as a shared bathroom, were damaged so could not be cleaned effectively. The management of sharps in the centre was not consistent with standard precautions. As referenced in the findings regarding Regulation 16, half of the staff team required refresher training in infection prevention and control.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. Monthly evacuation drills had taken place reflecting a variety of scenarios. A

fire door required review to ensure that it was fit for purpose as a containment measure.Training gaps in fire safety are referenced in the findings regarding Regulation 16.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Improvements were required in the review of residents' personal development goals. Records were not available regarding the most recent multidisciplinary reviews of this residents' personal plans. Of the sample reviewed, those available were dated July 2020.

Rather than additional staffing being provided when needed, one resident was required to leave their home to stay in the other house in the designated centre at times of poor mental health. As there was no evidence of a recent review of this resident's personal plan, it was not clear if the designated centre was suitable to meet this resident's needs or if the plan in place to meet these needs was effective.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required. The plan in place for one resident at times of poor mental health is referenced in the findings regarding Regulation 5.

Judgment: Compliant

Regulation 8: Protection

There were, and had been, no recent safeguarding concerns in the centre at the time of this inspection. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the residents' individual needs. Residents were encouraged and supported to exercise choice and control in their daily lives.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Community Residential Service Limerick - Group G OSV-0004963

Inspection ID: MON-0030729

Date of inspection: 19/01/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that all staff complete required training including refresher training. The training matrix will be reviewed by PIC and PPIM monthly, which identifies when training is scheduled and attended.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider has ensured that the annual review and most recent six monthly audits are available in the centre. The registered provider has ensured that reports of multidisciplinary reviews are available in the centre. The PIC will ensure that all staff complete required training. This will be reviewed monthly by PIC and PPIM. The PIC and registered provider will review storage in the centre to ensure residents have adequate storage in bedroom. The registered provider and PIC will continue to monitor and review the requirements for additional supports for one resident who requires additional support at intervals and update their plan of care The registered provider will continue to engage with the HSE on additional staffing requirements for this centre and will submit a business case to the HSE seeking additional resources to meet the needs of the resident identified in this	

report.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The registered provider will ensure that the Statement of Purpose and Function is reviewed and updated to ensure that description of rooms is accurate.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider will ensure that outstanding maintenance work in the centre is identified and costed. This includes painting throughout the centre, flooring, replacement of damaged grab rails and a further review of the conservatory to establish required remedial works.
The PIC and registered provider will review the cleaning checklist to ensure it provides clarity regarding hygiene standards.
The PIC and registered provider will ensure that the centre is regularly checked to ensure hygiene and cleanliness standards are maintained.
The registered provider will ensure an IPC audit is completed.
The PIC and registered provider will review storage in the centre to ensure adequate storage is available throughout the centre and in residents bedrooms.
The registered provider will ensure that bathroom upgrade will be completed in one house, following approval of Housing Assistance Grant from Local Authority.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider will ensure that all risk in the centre are reviewed and assessed in line with organisational policy. All risk assessments will be reviewed to ensure risk ratings are reflective of the risks posed in the centre and that all documented control

measures are in place. A full review of the centre's risk register will be undertaken by the PIC and PPIM with the support of the Quality, Risk and Safety team to ensure that all hazards have been identified and that there is good understanding of risk management processes. The PIC will ensure that risk is a standing item on the agenda for all staff meetings.

Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The registered provider will ensure that the centre specific contingency plan for covid 19 is reviewed to ensure it is centre specific. The registered provider and PIC will ensure that damaged items are replaced to ensure effective cleaning. The PIC will ensure that all staff complete required training. The registered provider will ensure that maintenance team reviews areas of mould in the centre and complete required remedial works. The PIC and registered provider will review the cleaning checklist to ensure it provides clarity regarding hygiene standards. The PIC and registered provider will ensure that the centre is regularly checked to ensure hygiene and cleanliness standards are maintained.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PIC will ensure that all staff complete required training including refresher training. The PIC has ensured that the fire door was reviewed by a competent person and deemed to meet the required standard.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The registered provider has ensured that annual multidisciplinary reviews have been completed for each resident.
The registered provider has ensured that that a copy of the multidisciplinary review is available in the centre.
The PIC and registered provider will ensure that PCP goals are reviewed in line with policy.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	02/02/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/05/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/04/2022
Regulation 17(7)	The registered provider shall	Substantially Compliant	Yellow	30/05/2022

	make provision for the matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/05/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/05/2022
Regulation 23(1)(f)	The registered provider shall ensure that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	21/02/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six	Not Compliant	Orange	28/02/2022

	months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Not Compliant	Orange	28/02/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Not Compliant	Orange	30/04/2022

	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	30/04/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/01/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/04/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident,	Substantially Compliant	Yellow	30/05/2022

	as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	21/01/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	21/01/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	21/01/2022