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:	Comeragh High Support Residential Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	09 December 2024
Centre ID:	OSV-0005082
Fieldwork ID:	MON-0044699

About the designated centre

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

Comeragh High Support Residential Services consists of one detached bungalow and a smaller terraced apartment both located in an urban area. The centre provides full-time residential support for up to five residents with intellectual disabilities. Some residents attend day services or active retirement groups and others take part in activities from their home. Each resident had their own bedroom. Other facilities in the detached bungalow include a kitchen, a sitting room, a dining room, a utility room and bathroom facilities while the apartment has a bathroom with a kitchen/living area also. The current staffing compliment is made up social care leaders, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 9 December 2024	10:00hrs to 16:15hrs	Tanya Brady	Lead
Monday 9 December 2024	10:00hrs to 16:15hrs	Conor Brady	Support

What residents told us and what inspectors observed

In September 2024, the Chief Inspector of Social Services issued both a notice of proposed decision to cancel the registration of this centre and a notice of proposed decision to refuse the renewal of registration of this centre. This action was taken due to failure on the part of the provider to be in compliance with key regulations which significantly compromised the safety and welfare of residents. The provider's failure to meet the requirements of the Health Act 2007 and associated regulations and standards was found on an inspection completed 14/08/2024 which highlighted direct impacts on the lived experience of residents.

The provider responded to the notice with written representations, these outlined assurance including specific actions that the provider would take to address the areas of concern.

The purpose of this unannounced inspection was to review the actions outlined in the providers' representations and in their compliance plan submitted following the inspection in August 2024, to determine if sufficient progress had occurred in improving the quality and safety of care being delivered to residents.

This inspection was completed in one of the two premises that comprise this centre as this was the home where findings of concern were primarily identified previously. Overall findings indicated that while progress had been achieved in some areas, improving compliance, there remained a number of areas where other stated actions had not yet been achieved. As an outcome non-compliant findings were still made as outlined below.

As per the previous inspection findings, some residents presented as not being compatible and there were peer to peer safeguarding and behaviours that challenge present. For example where a resident had dementia, they were frequently triggering others behaviours resulting in incidents and/or outbursts in the centre.

Across the inspection day the two inspectors had the opportunity to meet three of the four residents who lived in the house visited. One resident had already left for their day service when the inspectors arrived. There were two staff on duty who welcomed the inspectors, one core staff member and one member of the day service staff who completed weekly hours of support in the centre and was familiar to the residents. The person in charge was on leave and so was not present. The service manager made themselves available for a period of time in the morning. In addition, the provider's quality manager and Waterford services manager also made themselves available to meet with inspectors.

When the inspectors arrived one resident was already out, as stated, one resident was up and sitting in the living room and two other residents were still in bed. Staff supported the residents with personal care and to have their breakfast. The home was calm and quiet at this time as residents engaged in daily activities at their pace.

Over the course of the inspection residents were supported to go out for a drive or to go to the shops to purchase preferred items. One resident told inspectors they particularly enjoyed art and colouring and had their work available to them next to the kitchen table. One resident sat and had a cup of tea with an inspector and said that while they were very happy and stated the staff and food was very good, they did not like other residents coming into their room and always messing with their things.

Inspectors found that residents' behaviours of concern continue to impact on the lived experience of other residents in the home. From reviewing incident and accident reports and speaking with staff it was evident that behaviours of concern such as shouting, entering each others bedrooms and unwanted physical engagement (slapping/grabbing/touching) were still occurring in the centre. At times over the course of the day the inspectors observed and were subject to residents making physical contact or raising their voices. The staff present on the day were observed to be very skilled in anticipating these behaviours and supporting or redirecting residents to engage in another activity.

While progress had been made in some areas such as premises maintenance, risk assessment, medication guidance and practice and in the recognition and response to safeguarding, progress was still required in the governance and management oversight arrangements and in the provision of core staffing support. The non-compliance in these areas continued to have an impact on the quality and safety of support offered to residents.

Capacity and capability

This inspection identified that there had been some improvement in staff training and development however, the centre remained in need of a core staff team. This was of importance as the presence of core staffing was necessary to ensure guidelines, care planning and systems of support were consistently implemented.

The previous inspection in August 2024 had identified a need for improvement in the effective oversight and governance of this centre. The provider's stated action of assessment and identification of residents' assessed needs to inform planning for resources remained incomplete. This did not provide assurance that the supports in place were as required for residents. This inconsistency or potential lack of knowledge regarding residents' needs remained an issue which was having a direct impact on the lived experience of residents.

Regulation 15: Staffing

The provider had not ensured that there was a core and consistent staff team in place to support residents in this centre. In addition the provider had not ensured that there was a roster available to review that reflected who was on duty or who had worked or was scheduled to work in the centre in subsequent days. It should be noted that the staff on duty on the day of inspection were observed to be very caring and respectful with the residents in their care.

Since the last inspection there had been a number of changes within the staff team with some staff having left and others on long term leave. A significant number of shifts were being covered by agency staff or as on the day of inspection by day service staff. It was not possible for inspectors to quantify how many shifts were filled with additional staff, due to the absence of the centre roster. On the day of inspection the roster that was present in the centre named staff who were all on leave and there was no record of the staff present nor that one shift was to be shared between two staff. The staff team stated that they worked day to day often splitting a shift between two staff to cover hours and would not always know who they were working with.

In staff meeting minutes reviewed, one dated 07 September 2024, recorded that the staff highlighted their concern that there were periods of time where only a single staff member was on duty. For example, one hour in the morning, this did not assure that they would be in a position to follow the control measures as identified in the risk assessments nor in the safeguarding plans.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors found that there had been an improvement in the level of training accessed and completed by the staff team since the previous inspection. In particular the provider had ensured that all core staff had completed up-to-date safeguarding training. Some mandatory training was still required for a small number of staff for example, one staff member required refresher training in the safe administration of medication, two staff required refresher training in the management of behaviour that challenges and two staff required refresher training in manual handling practice. A number of training opportunities were scheduled for staff before the end of the year.

Given the inconsistency in the staff team however, a system for the provider to review the training completed by agency and day service staff was required.

The provider also identified that review of their medicines policy was required following the August 2024 inspection to review specifically the training needs for staff to allow them to administer rescue or emergency medicines. Minimum training requirements were now identified for staff in this instance.

Judgment: Substantially compliant

Regulation 23: Governance and management

As previously mentioned the last inspection of this centre in August 2024 found non-compliance with all regulations reviewed. Due to the seriousness of these findings and the submission of notifications of concern by the provider to the Chief Inspector of Social Services via the notifications process, two regulatory actions were taken. A notice to cancel the registration of this centre and a notice to refuse to renew the registration of this centre were issued to the registered provider.

The provider submitted 17 specific actions in their written representation to improve their services. For the most part these actions were completed which was acknowledged as being positive. However, improvement was still required in the quality of information available within the centre such as the staff roster as stated, staff team meeting minutes or consistent minutes that identified communication of, decisions made or actions in place by the management team.

One critical action remained outstanding however, a review of the support needs of all individuals, the outcome of which, it was stated, would guide the provider in the provision of services based on their assessed need. The implementation of this action in particular was essential in ensuring compliance could be potentially achieved and maintained in this centre.

A review of incidents that had occurred since the previous inspection highlighted that longstanding issues of peer to peer behaviours of concern continued to impact on the lived experience of residents in the home. These included incidents whereby one resident struck another on at least two occasions, another resident was punched in the eye, residents engaged in verbally aggressive behaviours that had an impact on others. As assessments of needs were not completed no definitive decisions could be made on solutions to manage the incompatibility present.

Judgment: Not compliant

Quality and safety

The provider had made a number of improvements within this centre to the physical premises and in the quality of information available to guide staff in areas such as risk management and medicines management. These improvements and the clear evidence of the provider's targeted actions are acknowledged as providing an improvement in the quality of care and support.

Regulation 26: Risk management procedures

The provider had completed a comprehensive audit and review of the risk assessments in place in the designated centre following the last inspection in August. This had been completed by a manager from another of the provider's services and had provided a comprehensive action plan for the provider in reviewing the risk assessment and management practices in this centre.

The centre risk register now had 41 risk assessments in place that considered all potential areas of concern. These included, risk of missing persons, lone working, COVID-19, maintaining the safety of residents, falling, accidental injury, transport. In addition, each area had associated risk management plans that contained clear control measures that were to be in place. The registered provider had improved systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies.

Improvements were found in the recording of and learning from incidents in the centre. An incident review system was being put in place that allowed for the development of trends and could guide staff resources when these were more consistently in place.

The challenge found with risk management in this centre was directly associated with staff knowledge of risk. With such a high amount of risk on the centre register (41 risks) and detailed control measures, it is important that staff know and understand this risk. However the provider had conducted a thorough and full review of this area since the previous inspection and had a system in place.

Judgment: Compliant

Regulation 8: Protection

There were seven safeguarding plans within this house as part of the designated centre. These related to the primary matters of resident incompatibility and the inconsistency in staff knowledge and familiarity in support.

Overall while residents were being kept reasonably safe there remained a series of interlinked safeguarding concerns related to residents in this centre. The fact remained that resident's assessed needs meant they did get along and two residents in particular were involved in more of the incident reports involving their peers. This ranged from verbal, physical safeguarding incidents and entering other residents bedrooms. One resident told inspectors that this still happened and he did not like it. Staff were observed managing this on the day of inspection but this was clearly a challenge. For example, an elderly resident was asleep in bed when inspectors arrived and his bedroom door was wedged open. Other residents were moving

freely up and down the hall (not always directly supervised) and could easily have entered this residents bedroom (as had occurred previously). Staff were doing other tasks i.e. personal care, handover, getting transport ready, medication and monies ready and at these times residents were 'opportunistic' in their peer to peer behavioural/interactions. Hence it was very important that staff knew residents behaviours, presentation and triggers.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Although there remained concerns around the impact of residents' rights within the service due to the diverse mix of residents' needs, the staff present on the day of inspection were supportive of the residents' rights and clearly knew them well and cared for them. The staff demonstrated in their practice, the value of respecting the individual needs of residents. How by recognising and responding to communication cues and the triggers for potential behaviours of concern the potential for incidents could be reduced.

Resident meetings and consultation with residents had been more consistently in place. Staff acknowledged residents who had concerns and recorded and reported same. Overall while there were some rights infringements observed - these primarily related to peer to peer issues which the staff and provider were trying their best to manage.

Judgment: Substantially 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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Comeragh High Support Residential Services OSV-0005082

Inspection ID: MON-0044699

Date of inspection: 09/12/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A Social care worker has been appointed to cover the vacant post due to long term sick leave and to ensure consistency of staffing in the designated center. • The reliance on the use of agency staff is being minimised by the establishment of a pool of relief staff who have been fully inducted and are in place covering shifts. Agencies will only be used in cases of emergency. • An online roster has been developed with access for all relevant stakeholders to ensure an up-to-date planned and actual roster is available to the designated centre. The newly developed online roster clearly outlines any changes to the staff team due to annual leave or sick leave. • A discussion around roster hours and morning and evening routines was conducted at staff meeting on 12/01/2025. Roster hours are currently under review with the service manager and interim team leader to ensure adequate staffing is in place at all times which meets the assessed needs of all individuals at the center.	
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 learning needs analysis for 2025 has been completed and staff identified with training requirements have been booked to relevant training. This is reflected on the	

Training matrix that is available in the designated center.

• SIF training will be completed for all staff by 18/02/2025.

• Manual handling is now completed for all staff.

• SAMS refresher training has been completed for staff who required it.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An online roster has been developed with access for all relevant stakeholders to ensure an up-to-date planned and actual roster is available to the designated center. The newly developed online roster clearly outlines any changes to the staff team due to annual leave or sick leave.

• A discussion around roster hours and morning and evening routines was conducted at staff meeting on 12/01/2025. Roster hours are currently under review with the service manager and interim team leader to ensure adequate staffing is in place at all times which meets the assessed needs of all individuals at the center.

• A full schedule of monthly team meetings has been agreed for the year.

• All Multi-disciplinary and safeguarding meeting minutes will be available for all staff in the designated center in a timely manner.

• A full assessment of needs of all individuals in the designated center is currently being completed by the interim team leader and the service manager to ensure appropriate support is being provided to individuals' in line with their assessed needs. Three of these assessments have already been completed and the final one will be completed by the 31/01/2025.

• This completed assessment of needs will guide local management and the provider in ensuring adequate support is in place to minimise any potential impacts residents may have on each other.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • The current safeguarding plans in the designated center are a standing agenda at every monthly team meeting to ensure awareness around same. • A full assessment of needs of all individuals in the designated center is currently being completed by the interim team leader and the service manager to ensure appropriate support is being provided to individuals' in line with their assessed needs. Three of these assessments have already been completed and the final one will be completed by the 31/01/2025. • This completed assessment of needs will guide local management and the provider in ensuring adequate support is in place to minimise any potential impacts residents may have on each other. • Sign sheets have been implemented in the centre to ensure all staff are aware of the most up to date behaviour support plans in place for all residents.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • A review of the template for residents meetings is to be completed by the team leader so that meetings reflect issues and experiences of the residents in the designated centre. This will include a discussion piece around residents respecting each other's rights within the home as a standing agenda. • The current safeguarding plans in the designated center are a standing agenda at every monthly team meeting to ensure awareness around same.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	04/02/2025
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	14/01/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	03/03/2025

	as part of a continuous professional development programme.			
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	31/01/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	07/02/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	28/02/2025