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:	Announced
Date of inspection:	14 August 2024 and 15 August 2024
Centre ID:	OSV-0005082
Fieldwork ID:	MON-0036274

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
Wednesday 14 August 2024	11:00hrs to 17:30hrs	Tanya Brady	Lead
Thursday 15 August 2024	09:00hrs to 14:00hrs	Tanya Brady	Lead
Wednesday 14 August 2024	11:00hrs to 17:30hrs	Sarah Mockler	Support
Thursday 15 August 2024	09:00hrs to 14:00hrs	Sarah Mockler	Support

What residents told us and what inspectors observed

This was an announced inspection completed to inform a decision regarding the renewal of registration for this designated centre. The inspection took place over two days and was completed by two inspectors.This inspection was completed as part of a group inspection whereby inspectors were present simultaneously in three centres operated by the provider and in the provider's offices over a two day period.

This inspection found that the governance and management arrangements in place did not ensure a quality and safe service was provided in this centre. There was a deterioration with levels of compliance found since the previous inspection in June 2023. Given the very poor findings in this centre, on the second day of inspection, two inspectors focused their time in the larger house and a third inspector gathered required documentation in the second house for the inspectors to review. In addition, as stated above, core documents were reviewed by additional members of the inspectorate team in an office space.

Although, residents appeared comfortable in their homes on the days of inspection, some residents expressed that they were not happy living in the centre. They had expressed this to the staff and local management team over the preceding months and again to inspectors on the days of inspection. This is discussed in further detail below.

Inspectors found poor practices with the oversight and management of safeguarding, risk management and management of medicines. This negatively impacted aspects of the lived experience of residents in particular in one of the houses although there was poor management of risk found in both locations. The governance and management systems had failed to identify the majority of issues as found on this inspection.

There had been some incidents which had occurred in the centre between peers since the last inspection. These incidents negatively impacted on residents' rights in a number of ways, including residents' right to privacy, due to residents entering others personal rooms and taking each others possessions. There had been some safeguarding incidents which also negatively impacted on the quality of life in the centre. Inspectors found that the provider was not consistently identifying all potential safeguarding incidents, therefore no systems were in place to mitigate against associated risks. This is discussed in more detail under Regulation 26 and 8.

This centre comprised of two separate homes that are located approximately 10 minutes from each other on the outskirts of Waterford city. Five residents availed of full-time residential care and there were no vacancies on the day of inspection. There had been a change in residents since the last inspection of this centre as one resident had sadly passed away and a new resident had moved in to one house earlier in 2024. Inspectors acknowledge the loss of a resident was difficult for the staff team and the residents who had been together for a number of years. Four residents lived in one home and the second home provided an individualised service to one resident. Inspectors visited both homes on each day of the inspection.

On arrival at the first home the inspectors knocked at the door and had to wait approximately five minutes until it was answered by a resident. There was one staff member present with two residents and they were very busy with the residents' morning routine. The staff member and resident welcomed the inspectors into the home and the inspectors completed the sign in procedure. As the staff member was busy supporting residents, the inspectors met briefly with the residents present and completed a walk around of the premises. Two residents had left the centre with another staff member. One was going to their active retirement group and the other had gone in the vehicle with them for a drive and to stop and get a coffee which was part of their daily routine. They returned later in the morning accompanied with the second staff member. The two residents who were present in the centre were up and about preparing for their day.

The first home visited by the inspectors comprises a detached bungalow building in a housing estate. There was parking to the front of the home and to the rear of the home was a patio and garden area. Flower pots had recently been planted outside the home. Both inspectors completed a walk through of all aspects of the house. All residents had their own bedroom, two bedrooms had en-suite facilities. Residents had access to two other larger bathrooms and a smaller bathroom with a toilet and sink, a kitchen-dining room and a separate sitting room. There was also a utility room and a staff office and store room. These last two rooms could only be accessed by entering a code into a key pad lock. The home had significant wear and tear present, all areas of the home required painting. Some bedrooms in particular needed upgrading as fixtures and furnishing present was worn and damaged. The condition of aspects of the premises posed an infection prevention control risk as it could not be cleaned in an effective manner despite best efforts of staff.

On the morning of the first inspection day the inspectors spent time with three residents that were present. One resident spoke to the inspectors about a recent hospital admission and subsequent move into the centre. This had been a life-changing event and the resident spoke about how they found it a challenge to settle into their new home. They proudly spoke about a recent healthy life-style change that would have a positive impact on their health. This resident was later heading to their day service and staff were seen to support them to get ready and to prepare a packed lunch. They had new clothes on and the staff member was helping style their hair in a particular way. On their return in the afternoon the resident was observed relaxing in the kitchen and completing some knitting.

The second resident present was also supported to sit in the kitchen and have their breakfast. They were eagerly awaiting a family visit and did not engage directly with the the inspectors. They were observed supported by the staff to complete personal care and to move freely through their home. They left the centre later in the day.

In the kitchen-dining room area of the home, there were a number of A4 size laminated sheets on the cupboard doors, with the house rules displayed. This included visual signs stating 'no mocking' ,'no lighting things on fire' and 'no fighting'. When a resident was asked about these posters they did not seem to know what they were for and and read out what was said on each one. From speaking with staff, they stated they were the house rules and that it was the residents' preference to have them displayed. This approach required review to ensure it met best practice in relation to promoting a rights based approach to care and support for adults.

The third resident met by the inspectors in the morning was sitting in the living room with their take-away coffee listening to music. The resident spoke to the inspectors about collecting cards and recent clothes they had purchased. They were eager to talk to the inspectors about these aspects of their life and their conversations were centered around these topics. They moved around their home freely and were seen to call out to staff if they wanted help and support.

Later in the day the fourth resident returned and was supported to relax on their bed and selected a film they wished to watch on television. They stated that they had enjoyed their day and looked forward to speaking with inspectors on the second day.

In the afternoon the inspectors visited the second home. The premises comprised a terraced bungalow home on the same site as offices operated by the provider. The other homes in the terrace, form part of another designated centre also operated by the provider. The resident present was eager to tell the inspectors about a recent minor injury and their subsequent visit to their General Practioner (GP). The resident, used complex communication strategies to communicate which included word approximations, a form of personally adapted sign and gesture based system and used pictures/symbols. The resident was very effective with using their communication and staff readily understood and helped the resident communicate with the inspectors. They had a visual board present in their kitchen which displayed the staff working with the resident and their daily routine which was represented using familiar visual symbols. The resident readily used this visual support to help them communicate.

The resident had an individualised service and was supported by a consistent staff team. Their home was overall well presented with the resident having access to an open plan kitchen/dining/living area, their own bedroom and separate bathroom. There was a room allocated to a staff office/sleepover room. The resident showed the inspectors around their house, pointed out items that were important or that they had engaged with recently such as an air-fryer on the counter and then sat to relax in their armchair in front of the television.

On the second day of inspection the inspectors spent time in the larger premises that was the home of four residents. As stated above a third inspector participating in the group inspections briefly attended the second house to gather requested documentation and met with the resident and their support staff there. The resident communicated to the inspector that they had visited the doctor with a sore toe which they had told the other inspectors about. The resident again used their visual picture board to support their communication with the inspector. It was evident that this staff member was also very familiar with the resident, their needs and their communication style. The staff member explained to the inspector that they were preparing to leave the centre to visit a day service and later complete some shopping. Overall the resident appeared comfortable in their home and in the presence of staff across both days of the inspection.

On arrival at the larger house all four residents were present with two staff members available to support them. Residents were up and about, getting ready for their day. Two residents who were in the kitchen/living room spoke with the inspectors. They showed inspectors pictures they had coloured and talked about their love of art. A third resident joined the discussion in the kitchen and gave inspectors cards they had written for them. One resident expressed how they were not happy living in the centre and mentioned behaviours in the house that made them worried. Another resident stated that a peer resident engaged in behaviour that sometimes they 'did not like', these statements of concerns were passed on to the provider by inspectors.

As this inspection was announced, questionnaires called "tell us what it is like to live in your home" were sent out in advance of the inspection and five questionnaires were completed and returned to the inspectors. Residents stated that they liked their houses with one stating "I moved bedroom a few months ago. I am getting new floors and the walls will be painted". One resident commented that they liked living on their own and were supported to 'visit family and to greet their neighbours'. Residents stated they liked the staff team that supported them with comments such as 'or "I know each [staff] member coming in - my schedule is on the board" or 'they listen, talk and help me make decisions" or "staff support me to go to concerts". However, residents also raised concerns that they do not always feel safe in their home and that there are some compatibility concerns. A resident stated "One of the lads annoys me" and one resident stated "its not a nice place to live because some of the other people shout and torment me". A resident stated they would prefer 'not to live with friends who pull hair and hit'.

In summary, from what residents told us and what inspectors observed, while residents were busy engaging in activities they enjoyed, improvements were required in relation to governance and management, medicines management, and safeguarding practices in particular. The next two sections of the report present the inspection findings in relation to the governance and management and how these arrangements affected the quality and safety of residents' care and support in the centre.

Capacity and capability

This announced inspection was completed to inform a decision on the renewal of the centre registration. Due to the poor levels of compliance found on this inspection the decision to renew the registration cannot be determined at this time.

The provider had management systems in place that were not consistently overseeing and monitoring residents care and support. Inspectors found that while provider audits were occurring as required, such as an annual review and six monthly unannounced visits, actions arising from these were not consistently completed within the timelines identified. In addition, local and centre based audits were not effective in identifying areas requiring improvement. The systems in place were neither robust or comprehensive and indicated that there were a lack of effective systems in place.

Regulation 15: Staffing

The provider had ensured that there was consistency of care and support provided to residents with a core staff team in place in both locations. One home had staff lone working over a 24 hour timeframe. The other home had two staff present by day and one staff at night. There was one vacancy which was for a 0.5 whole time equivalent position and this was advertised and currently filled by a consistent member of the provider's relief panel.

Inspectors reviewed a sample of the centre rosters and found them to be poorly maintained. A roster template that was partially completed with recurring core staff shifts was used with blank shifts on the roster filled in as required. The current roster for the week of inspection was available for review by inspectors. It had a number of blank spaces unfilled so it was not apparent who had worked for instance two days prior to inspection nor did it reflect the staff on duty on the days of inspection. Staff outlined that they filled it in retrospectively at the end of the week using handover sheets as guidance. Inspectors found that the rosters of the preceding two weeks had only first names and no surnames. On 06 August 2024 the centre roster had for example, a lone working shift staffing denoted as 'agency' and this was mirrored on the handover records. There was no record in the centre of who the agency staff was as there was no corresponding name on any documentation within the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors found that some improvement had been made in staff training since the last inspection. However, some staff still required refresher training in key trainings in line with the provider's policy. In addition a small number of staff required training in key areas. There was a core staff team of nine staff in this centre. Inspectors found for example, that three staff required fire safety refresher training, two staff did not have up -to -date safeguarding training, two staff were not trained in the safe administration of medication. In addition the provider had set out the requirement for this centre in it's procedures that there must be a first aid trained member of staff on each shift and there were no records available for eight of the nine staff members available for review.

All staff were in receipt of formal supervision in line with the provider's policy. Staff training, competencies and skills were discussed at these meetings.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had identified local management arrangements for this centre where lines of authority and accountability were in place. Inspectors found that these arrangements were not effective. The provider had appointed a person in charge who had responsibility for this and one other centre operated by the provider. The centre statement of purpose outlined that only eight hours a fortnight were allocated to this centre. These hours were confirmed by the centre management team. From a review of the visitors log, the person in charge visit reports and discussions with staff, it was clear that there was a very limited management presence in the centre. For example, the visitor log indicated that the person in charge had been present in the centre only 12 times in 2024, further formal visits to complete audits were noted on four occasions. Similar reviews for persons participating in management indicated five visits to the centre since the first of 2024 with three of those in the month of January when a resident had passed away.

The limited presence of the management team in the centre had resulted in poor oversight and management of day-to-day practices within the centre. Although it is acknowledged that the staff team were working very diligently to support the residents to the best of their ability. The lack of written updated guidance, presence of management and sufficient oversight resulted in the residents' lived experience being negatively impacted.

Centre based audits failed to identify areas where improvement was required or areas that potentially presented a risk to residents living in the centre. There was, for example, no system in place to capture incident trending by the local management team. The local management team had identified that staff needed to add more information and detail to incident reports. This was documented in staff meeting minutes reviewed by the inspectors. This had not brought about the required improvement based on the sample of incident reports reviewed by inspectors. Other examples of where audits were not proving fully effective were in relation to premises / infection prevention and control and medicines management and these will be discussed under Regulations 17 and 29.

The safeguarding culture and oversight of safeguarding incidents within the centre required significant review. When alleged safeguarding events were reported in incidents, these were not reported or investigated as required. The providers six monthly unannounced audit report stated that 'work on safeguarding recognition was required' however, no further oversight, actions nor review of safeguarding practices within the centre were found to have been implemented.

Judgment: Not compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to the Chief Inspector of Social Services under this Regulation were reviewed during this inspection. These included incident and accident records, resident daily notes and multidisciplinary team meeting minutes. Submitted notifications are important as they provide information on the running of a designated centre and matters which could negatively impact residents. Inspectors found that not all incidents were being submitted as required by the Regulation and when notifications were submitted they were not done so in line with the required timelines.

For example, on review of the provider's incident and accident reports, it was found that three incidents of an alleged safeguarding nature were not notified to the Chief Inspector. There was also an absence of accurately reporting restrictive practices as not all restrictive practices had been identified in the centre. This included for instance the storing of a selection of residents' clothes in a locked storage room.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider is required to develop, adopt, and implement policies in accordance with Schedule 5 and that are specific to the care needs and services provided. The inspectors reviewed the provider's polices and examined each policy individually, as outlined in Schedule 5.

From review of the providers policies, there was no policy in place covering 'The use of restrictive procedures and physical, chemical and environmental restraint'. Therefore this absence did not provide for written guidance for staff in the development of procedures or written guidance on the recognition, assessment, implementation and review of restrictive practices in any of the centres inspected. This was found in this centre where a number of restrictions such as those stated under Regulation 9 were not identified.

Judgment: Not compliant

Quality and safety

Residents were being supported to engage in activities that they enjoyed and were supported to maintain relationships with family and friends. Further action was required to ensure that improvements were completed in relation to care and support so that residents were in receipt of a safe and good-quality service.

Residents were not being protected by the policies, procedures and practices relating to risk management in this centre. In addition, there was a poor culture of safeguarding and practices relating to keeping residents safe required improvement. Safeguarding concerns by a number of residents were not recognised as such, nor were they being investigated or managed in line with the safeguarding policies, procedures and practices.

In line with findings of the previous inspection, inspectors found that the systems to ensure the safe administration of medicines was inadequate and required significant review. Medication was inappropriately stored, administered and records were not well maintained.

Regulation 17: Premises

Both inspectors completed a walk around of the two premises associated with the designated centre. As previously discussed five residents lived across two separate properties located a 10 minute drive from each other. Both homes were located in residential areas of Waterford city.

The first premises reviewed by the inspectors was home to four residents. On the walk around of the premises the inspectors noted areas of wear and tear in the majority of areas of the home. It is acknowledged that external painting work was to be completed prior to the inspection however, due to unforeseen circumstances this had to be rescheduled. Painting was only one aspect of maintenance required in the home, additional works were also required to ensure the centre was well maintained and presented in a homely manner. For example, in two residents' bedrooms, laminate was peeling from the wardrobe and cupboard doors.

One resident's en-suite bathroom had no door present, there was a build up of mould, rust and staining on the tiles around the shower area. In both en-suites skirting and door frames had water damage. In another resident's en-suite a large wooden chest of doors was present which contained their clothing and had a damaged surface. The store room and sitting room had a build up of condensation on both windows indicating that ventilation was poor in these areas.

The second home had also some wear and tear which required maintenance such as marking and scratches on flooring or damage to paintwork. These had been identified by the provider and were listed for review, however, the flooring was stated on an audit for replacement by May 2024.

Premises audits were being completed and the premises condition had been highlighted by the provider during their six monthly unannounced visits. It was seen that premises actions listed on the visit report dated December 2023 were marked as not completed on the subsequent May 2024 audit. The outside area of one home had flagstones on the patio and these were found to be uneven and presenting a trip hazard, this had not been noted on the centre audits for example.

Inspectors acknowledge that the homes were clean and that staff were observed completing cleaning tasks over the two days of inspection. Processes were in place for the cleaning of individual equipment such as nebuliser machines and masks and shower chairs or mobility support equipment.

Judgment: Not compliant

Regulation 26: Risk management procedures

Overall the inspectors were not assured that appropriate practices were in place in relation to risk management. On the walk around of one of the premises the inspectors noted an epilepsy alarm panel in place in a resident's bedroom. The person in charge informed the inspectors that this equipment no longer worked. It was further explained that this had been reviewed by the multidisciplinary Team (MDT) and that there were systems in place around the management of this risk as the monitor was no longer in place. On review of the resident's individual risk assessments it was found that there was no specific epilepsy risk assessment in place. The practice of no longer using the alarm had no associated MDT notes where this had been discussed. In addition, as there was no written guidance or associated risk assessments, staff practices differed on how this resident was supported at night. For example, some staff stated that the resident's bedroom door was left open while other staff stated it was closed. This resident was regularly having seizures and had a seizure on the day of inspection. This risk was not being managed in line with the provider's policy or best practice and was putting the resident at risk

In addition, on review of other residents' individual risk assessments, some identified risks associated with their assessed needs had no corresponding risk assessment. For example, some residents had an assessed risk of choking and were prescribed modified diets. There were no risk assessments present in relation to this risk. Again these risks were not being managed in line with the providers own risk management policy.

Staff in both locations worked in lone working environments, there was no clear guidance for staff on who they could check in with or how to specifically manage presenting risks other than to call on-call management out of hours. No centre specific risk assessments were in place for the centre in relation to lone working arrangements.

As previously discussed trending and learning from incidents required significant improvements. It was unclear on how incidents were trended or informing risk assessments. If learning was identified from incidents this was not clearly documented in incident reports, risk assessments, staff meetings or other documentation. The systems in place to ensure incidents were escalated and used to inform future practice were not in place.

Judgment: Not compliant

Regulation 28: Fire precautions

Both premises associated with the designated centre were provided with fire safety equipment which included a fire alarm, emergency lighting and fire containment measures. On the walk around of the premises, it was found that one bedroom door had a significant gap between the door and the door frame which compromised the integrity of the containment measures. This was immediately brought to the attention of the person in charge and was rectified by the provider's maintenance department. However, the door required review from a suitably qualified fire expert to ensure it's effectiveness. In particular due to the installation of a specific hinge fitted for the door to open in both directions and the removal of the self closing mechanisms (required for the door to operate) the containment measures and risk associated with this required review. Staff reported leaving this door open at night for instance to perform epilepsy safety observations.

Containment between the attic space and the house in one location also required review as pipework and metal ducts had been passed through the ceiling in a number of locations including residents' bedrooms. These had not been sealed and posed a fire containment risk. These were shown to the person in charge on the day of inspections.

Improvement was also required regarding fire drills carried out in the centre. While multiple fire drills had been carried out in 2024, from records reviewed, these all reflected a day time scenario when staffing levels were higher. The last recorded fire drill that occurred with the least number of staff and maximum amount of residents was dated 2022. There had been a new admission to the centre in this time and this scenario had not been practiced.

The centre specific fire evacuation plan was reviewed by the inspections. This had not been updated to reflect the change in resident's. Therefore there was a lack of up-to-date information to guide staff practice.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors were not assured that practices in relation to medicine management were in line with the provider's policy. The providers audits were not picking up on the errors and omissions found by inspectors.

On arrival at the centre in the main office, inspectors found a locked box sitting on a chair. This locked box contained specific medicines that were to be used in an emergency. The box was to be brought in the car with the residents when they left the centre. At this time, one of the residents who this medicine was prescribed for was not in the centre and this medicine was not with them. This was not in line with the associated risk assessments or practices relating to this medication. In addition the administration guidance for staff relating to these medicines was poor and required review. For instance, on one residents plan it stated that if the resident did not recover following one administration of the medication then this could be repeated. No time lines were given, no maximum dosage was noted and no second dose was available for use. Another resident had been prescribed a second medicine to be administered as required, no staff had received training on the use of this medicine as it was newly prescribed however, it was available for use. Written guidance stated it could be given as a second line of defence however, no timelines or other direction was available for staff.

The provider's policy gave guidance related to the use of over-the-counter medicines which stated these could be prescribed or for the residents' medicines management system to be shown to the relevant health and social care professional when purchasing an item. In the office (and not stored in line with the provider's policy) there were two packets of over the counter throat lozenges with a resident's name written on the packet. One packet contained a sugar-free version and and second packet contained lozenges with sugar. The resident that had consumed these items had a diagnosis of diabetes.They had consumed 17 sugar lozenges before it had been identified that these were not suitable. The staff had not followed the policy in relation to the purchasing, storage, and administration of these products in line with the policy. A second over the counter topical medicine had been used for all residents living on the home recently and on review of the residents' medicines management system, for three out of the four residents, the policy had not been followed on the recording of it's use. The use of over-the-counter medication required review to ensure it posed no risks to the residents living in the centre.

Inspectors reviewed a sample of residents' administration records and found a number of errors and omissions which were not identified. These related for example to medicines that were only taken on certain days of the week not everyday. It was unclear what days these had been administered and some areas had been removed using correction fluid and rewritten.

Judgment: Not compliant

Regulation 8: Protection

The provider had failed to protect all residents in this centre from all forms of abuse. Overall the approach to safeguarding and the culture in relation to safeguarding was not in line with National Policy or the requirements of the Regulations.

In one of the homes visited by inspectors some residents expressed that they did not feel safe in their home, these statements by residents made previously to others were also written in documents reviewed by inspectors. For example, one resident has met with the Person Participating in Management and Person in Charge and the meeting notes were provided to the inspectors for review. This meeting occurred on the 9 August 2024. In these notes the resident stated they were "not good" and that another resident "was always tormenting" them. The resident also directly told inspectors this information on the day of inspection.

Following a number of significant incidents between some residents that related to physical interactions the provider and management team had investigated and reported these as required. A safeguarding plan has been developed and is in place with engagement between the Health Service Executive safeguarding and protection team and the centre. This was reviewed by inspectors and a number of control measures and supports are in place. This level of awareness and reporting has not however been applied equally to all residents.

The inspectors reviewed a sample of incidents that were recorded on the incident and accident registers, reviewed multidisciplinary team meeting minutes and reviewed daily notes. These demonstrated poor awareness of and oversight of potential abusive engagements between residents. There was a lack of management systems or guidance for staff in place to protect residents.

Of particular concern was an allegation that one resident had been touched on the breast by a peer. Inspectors reviewed multidisciplinary team meeting minutes where this incident had been discussed although it had not been formally reported on the centre incident system and no corresponding records were available. The minutes noted that the resident who was touched "was upset by the actions of .....". There was no recorded follow-up to this meeting. Subsequently another incident relating to the same resident being touched and causing concern to them was recorded on the incident reporting system and discussed again by the multidisciplinary team. Minutes of this meeting on 17 June 2024 were also reviewed by inspectors. The minutes stated that the resident was "uncomfortable and concerned".

In addition there was an incident recorded on the provider's system relating to 11 July 2024 whereby one resident was reported to have thrown a cup of tea at another resident who was recorded to have been covered in tea. Again there was no evidence that the safeguarding policy had been followed in relation to this report.

From the samples reviewed, three recent incidents were documented in incident and accident reports that met the threshold of an alleged safeguarding incident. These incidents related to descriptions of peer to peer verbal altercations and physically threatening gestures made by one individual towards another. There was no evidence that these incidents had been reported or investigated. There had been no follow up, safeguarding plan, risk assessment or care plan developed. There was no evidence that these incidents had been reviewed from a safeguarding perspective.

Overall the inspectors found that there was very poor practice in relation to safeguarding.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were supported to exercise choice and control in their daily lives within the context of their personal plans. However, as outlined at the beginning of the report, residents' rights were negatively impacted due to behaviours of concern occurring in one house. For example, freedom of movement was impacted upon a number of times due to residents being redirected when a peer was engaging in behaviours of concern. One incident report for example outlined how a resident had to be supported back into the house to wait while another resident presented with behaviours that challenged on the centre vehicle. This prevented the resident from leaving their home as planned. Residents' privacy was as stated previously, compromised by other residents entering their room and engaging in taking personal possessions. This was stated to inspectors by residents during the inspection.

The registered provider had also not ensured that the resident's privacy and dignity was respected in relation to written communication about aspects of the residents' care and support needs. In the office, on display on the notice board, was personal information in relation to residents' financial assessments and financial position. In addition specific medical needs were visually located on the desk and accessible to all. Any person who was in the office could readily read this information as they were not stored in an appropriate manner. Personal letters containing sensitive information for some residents were found by inspectors placed in daily files that went to day services or active retirement groups. This did not protect residents right to confidentiality and privacy.

Residents were not being consistently consulted with in relation to how their home was run. Residents meetings were not happening in line with the provider's policy and there was an absence of regular meeting minutes available within the centre for review. As outlined earlier in the report signage regarding house rules were displayed in the residents home in a manner that was not best practice and it was not apparent whether some of the rules still applied or had been reviewed following for instance a change in residents living in the centre.

Not all restrictive practices present in this centre had been recognised as being present. These included some that impacted on residents' rights such as the location of a residents clothing in a locked room as there was not space in their bedroom or the bedroom door and checks at night that were taking place. As practices had not been identified they were occurring with no regard to the impact on individuals' rights to privacy or to maintain control over their possessions.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Comeragh High Support Residential Services OSV-0005082

Inspection ID: MON-0036274

Date of inspection: 14/08/2024 and 15/08/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• A revised roster is now in place. This roster records the full names of staff members and also their relevant title.

• Agency staff members name and the name of agency is now being entered on the roster in advance.

• The PIC will issue the planned roster to the designated centre one week in advance. Any subsequent changes in staffing due to absences will be recorded as they arise

• The PIC will ensure that there is a staff trained in first aid rostered on each shift</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The Service Manager and PIC will liaise with training department to schedule outstanding refresher mandatory training for staff who require same.

• The PIC will oversee and monitor completion of training for all staff.

• All staff are have completed HSEland safeguarding training. A specific internal safeguarding training day was held for the staff of the centre on 25/09/2024. All staff have now completed BOCSI internal safeguarding training.</td></tr>
</table>

• Three staff are scheduled to attend fire training in October.

• Four staff are scheduled to attend First Aid training in October and November.

• Two staff who require safe administration of medication training will be facilitated to complete this in conjunction with the training department.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC will be based in the centre to provide oversight two days a week.

• A quality improvement plan has been developed for the centre which encompasses actions arising from all internal and external audits at the centre. A weekly meeting will take place with the PIC, PPIM's and Compliance Manager which will track the completion of these actions against the timeframe set out

• A PIC audit will be completed on a monthly basis and an action plan will be developed from this. The audit will be reviewed and signed off by the the Service Manager each month.

• A system for monitoring the trends around incidents has now been implemented at the centre.

• A schedule of visits over the coming months has been developed to include regular visits to the centre by the Service Manager, Regional Service Manager and the Compliance Manager with a view to improving oversight.

• A specific internal safeguarding training day was held for the staff of the centre on 25/09/2024. Eight staff from the designated centre were provided with refresher training from the Designated Officer on the recognition of safeguarding concerns, documentation and reporting of incidents in line with organisational policy.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of

incidents:
• All concerns or allegations of abuse will be addressed through the organisations safeguarding policy and the required notifications will be submitted via the HIQA Portal within required timeframes.

• A review of the provider's incident management system has been completed and any incidents requiring notification have been done retrospectively.

• A review of restrictive practices will be completed and the PIC will submit restrictions via the HIQA Portal.

• The lock on the storage room door has been removed and all residents have access to this area.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• While the Services Policy on Human Rights outlines the requirements for reporting of restrictions the provider. The provider is in the final stages of developing a more robust policy which will strengthen our procedures.

• A review of restrictive practices will be completed and the PIC will submit restrictions via the HIQA Portal.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Maintenance issued identified are scheduled to be addressed with some repairs currently is under way:

• Painting to the exterior of the centre has been completed

• Painting of interior of the centre is currently underway

• Wardrobe doors for both bedrooms have been ordered with completion scheduled by the end of October.

• The door of the en-suite has been ordered and is scheduled to be installed. • Tiles that have mould, rust and staining have been cleaned and new rails fitted. • Water damage to the door frames and skirting will be addressed and rectified. • A chest of drawers in one residents ensuite has been removed. • It has been identified that the windows in the store room and sitting room are stained due to broken seals within the window pane and these will be replaced. • New flooring has been ordered to replace the damage flooring identified in the audit. • Resurfacing is scheduled of the patio flag stones to ensure safety for all residents.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • A review of all risk assessments has been undertaken by an external auditor at the centre and actions identified will be addressed by the PIC. • A review has been completed of the epilepsy management plans for two residents. An electronic epilepsy monitoring system is currently being procured for each resident in line with their needs to assist with monitoring of seizures at night time. In the interim night checks, which are clearly documented, have been implemented on a temporary basis and a log of same is in place. • Risk Assessments have been completed for the following risks identified in the Audit - management of epilepsy, lone working and choking. • A system for monitoring the trends around incidents has now been implemented at the centre. • Shared learning of incidents will be disseminated through regular staff meetings, PIC/PPIM meetings.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A fire competent person has been sourced to carry out an inspection on fire doors and fire containment at the centre.

• A night time fire drill has been carried out since the time of this inspection with maximum occupancy four and minimum staffing of one. The full evacuation time for the drill was three minutes. This demonstrated that all residents could be evacuated safety and promptly within an appropriate timeframe.

• The seals surrounding the pipes going into the attic have been sealed and a fire competent person is scheduled to review same.

• The evacuation plan has been updated to reflect the current occupancy of the designated centre.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Protocols in relation to the carrying and administration of medication to manage seizure activity have been updated and this information has been shared with the staff team.

• All staff have been reminded of the importance of adhering to the organisations policy on safe administration of medication including the purchase, administration and storage of over the counter medication and recording of all medication administered and drug errors – this will be a standing agenda item at staff meetings.

• All epilepsy support plans have been reviewed to ensure that clear guidance is in place for the staff team in relation to supporting individuals with their epilepsy and emergency seizure medication.

• A medication audit will be completed to identify any areas of concern in relation to management of medication in the designated centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A review of the providers incident management system has be completed and any incidents requiring notification have be done so retrospectively.

• All concerns or allegations of abuse will be addressed through the organisations safeguarding policy and the required notifications will be submitted via the HIQA portal within required timeframes.

• Eight staff from the designated centre were provided with refresher training from the Designated Officer on the recognition of safeguarding concerns, documentation and reporting of incidents in line with organisational policy.

• Safeguarding will continue to be a standing agenda at team meetings

• A system for monitoring the trends around incidents has now been implemented at the centre.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Weekly residents’ meetings have commenced and notes of same are reviewed by PIC on weekly basis.

• All personal information has been removed from notice board in the office and no information will be shared in a communal space.

• All medical and personal correspondence being shared with the nurse in day service will be done in a confidential manner.

• A review of restrictive practices will be completed and the PIC will submit restrictions via the HIQA Portal.

• Staff will support the individuals to maintain their personal possessions safely this will be done in conjunction with the psychology and residential support team.

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(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	01/10/2024
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.	Not Compliant	Orange	30/11/2024
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	Not Compliant	Orange	30/11/2024

	internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/11/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	01/10/2024
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	01/10/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Not Compliant	Orange	30/11/2024

	responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/10/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	01/10/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	01/10/2024
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	Not Compliant	Orange	04/10/2024

	and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	04/10/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/10/2024
Regulation 04(1)	The registered provider shall	Not Compliant	Orange	31/10/2024

	prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/10/2024
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	30/09/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications,	Not Compliant	Orange	30/09/2024

	relationships, intimate and personal care, professional consultations and personal information.			