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:	Cois Dara
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	28 October 2021
Centre ID:	OSV-0007698
Fieldwork ID:	MON-0034634

About the designated centre

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

Cois Dara is a designated centre operated by Autism Initiatives Ireland Company Limited by Guarantee. It provides a community residential services to up to four adults with a disability. The centre comprises of a
main house which accommodates two residents and two attached individual apartments which each accommodate one resident. The main house consists of a kitchen, dining room, utility room, living room, two bedrooms, bathroom, staff bedroom and office. The first apartment contains a living room, bedroom, office, bathroom and kitchen. The second apartment comprises of a kitchen/living room and a bedroom with an en suite. The centre is situated close to a suburban area of County Wicklow. The centre is staffed by a team leader, two senior social care worker, social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 28 October 2021	10:00 am to 8:00 pm	Jacqueline Joynt	Lead
Thursday 28 October 2021	10:00 am to 8:00 pm	Michael Muldowney	Support

What residents told us and what inspectors observed

This was a risk based unannounced inspection. On arrival at the centre the inspectors asked the person in charge to inform the residents that they were visiting for the day and the purpose of their visit.

Four residents lived in the centre and during the course of the inspection, the inspectors met three residents. Conversations between the inspectors and the residents took place, as much as possible, from a two metre distance and wearing the appropriate personal protective equipment (PPE) in adherence with national guidance.

The centre comprised of a large two storey house with two adjoining single storey sole occupancy apartments. Two residents lived in the main house and the other two residents lived in the apartments.

In the main house, one resident was staying with family on the day of inspection so inspectors did not have the opportunity to meet them. The inspectors met and observed the other resident on numerous occasions throughout the day. The resident used non-verbal communication and was supported by staff when engaging with the inspectors. The inspectors observed throughout the day that the resident primarily lay on a bean-bag which was placed in the hall off the main entrance door. When inspectors, noted the continuous position of the resident and enquired about their choice of activities that day, staff and management advised that the resident enjoyed lying on the bean-bag and had been provided with a foot spa in the morning and went for a brief walk in the afternoon. Staff members also informed inspectors that the resident had not slept well the previous night.

The two other residents who lived in the apartments briefly engaged with the inspectors by showing them around their individual apartments. The residents seemed happy to show off their homes and appeared relaxed and comfortable in their environment. The inspectors observed that interactions between staff and residents were warm and respectful. The residents did not communicate their views of the service but did tell the inspectors about their plans for the day. One resident was going for a drink and ice-cream to the local petrol station and the other resident was going to the cinema that afternoon.

The person in charge accompanied the inspectors on a walk around of the centre. Overall, the inspectors found the centre to be in a poor state of cleanliness and repair and to have inadequate infection prevention and control systems and procedures in place.

There was a significant amount of signage and notes displayed throughout the centre. Some of the notices were frayed and worn. The inspectors found that the amount of notices was not conducive to a homely or person centred environment. The centre also implemented several restrictive practices including locked presses,

doors, and access to electronics. The high level of restrictions did not uphold the rights of residents to have free access to their home. During the inspection several loud alarms activated, these noises did not enable a relaxed atmosphere. Keys were observed to be hung off some door frames; this added to the institutional feel of the centre. All of these observations have been addressed in detail in the next two sections of the report.

In summary, the inspectors found that overall, due to the poor hygienic conditions and state of disrepair of the house, it could not be assured that the residents' well-being and welfare was maintained to a good standard at all times. While residents were supported to participate in community activities on the day, the report will demonstrate that due to staff shortages, choice of community activities was often limited for residents.

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

This risk-based inspection was completed following receipt of information of concern submitted to the Health Information and Quality Authority (HIQA) through solicited and unsolicited notifications. Some of the areas of concern related to governance and management systems, the use of restrictive practices, staffing levels and the overall impact of these on the quality of care and support provided to residents living in the centre.

The inspectors found that there had been communication challenges between the employer and employees of this designated centre which was impacting on its governance and management systems and directly impacting on the quality of care and support provided to the residents living in the centre.

Overall, the provider had not ensured that their own governance and oversight arrangements were being followed at all times. The inspectors found that management systems in place did not ensure that the service provided was safe, appropriate to the residents' needs, consistent or effectively monitored at all times. There was a significant increase of non-compliances found on this inspection compared to the last inspection in July 2020. In particular, the non-compliance found in Regulation 27, protection against infection, was of such concern that an urgent action plan was issued to the registered provider the morning after the inspection. The provider subsequently submitted a response and provided assurances that the risk was adequately addressed.

The provider had failed to ensure that there were adequate precautions in place to prevent and reduce the risk of the transmission of infection. For example, the

designated centre was observed to be unclean in numerous areas of the premises including dirty floors, unclean and stained furniture, bodily fluids on a bedroom wall and ineffective management of clinical waste. This impacted on the lived experience of residents in a negative way and increased the risk of the transmission of health associated infections in their home. Furthermore, the uncleanliness of high use areas and facilities was of concern as it was in contradiction to recommendations in the public health infection control guidelines for the management and prevention of COVID-19. This is addressed in greater detail in the quality and safety section of the report.

On review of the centre's auditing and review systems, to monitor the quality of care and support provided to residents, the inspectors found that they were not effective at all times. For example, the local health and safety weekly checks had not identified any of the infection control or premises issues that were identified on the day of the inspection. In addition, the provider's health and safety compliance review (carried out in April 2021) found issues such as mould on the ceiling of a resident's en-suite and a broken door handle on their bedroom door, however, there was no action plan or timeline to follow up on these issues and on the day of the inspection, neither of these issues had been satisfactory resolved. As a result, the lack of follow-up meant that there was a potential risk to a resident's health and safety for the last six months.

The provider had carried out a six monthly unannounced review of the quality of care and support provided in the centre in May 2021 however, the review had not identified any of the infection control issues found on the day of inspection nor had it identified issues that were found on the provider's health and safety audit one month previous. In addition the review did not identify any of the premise's maintenance issues found on the day of inspection.

Furthermore, the inspectors found that other local governance and management monitoring systems in place, such as the cleaning schedule and checklists, the food safety checklists and monthly audits of residents' personal plans were also ineffective at times. This was primarily due to the lack of oversight of these systems which meant that gaps were not addressed and required quality improvements were not implemented.

To support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the service that they were delivering, the provider had put in place a staff performance management system. One to one meetings between management and staff were due to take place from 31st October 2020 to the 30th of September 2021 on five separate occasions. However, on review of a sample of staff files, the inspectors found that a large number of these meetings had not taken place and in particular, the annual final performance meeting in September 2021 had not taken place for most staff.

Previous to July 2021, there appeared to be adequate systems to ensure there were effective arrangements in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. However, the inspectors

found that many of the arrangements in place, such as team meetings, (albeit of low attendance), and as mentioned above one to one performance management meetings, were no longer occurring in line with policy and procedures and that currently the primary form of communication between management and staff was through a communication book. The inspectors found that the use of the communication book, was not an effective communication pathway. For example, inspectors were advised that not all learning from behavioural incidents were shared with the team or used to update residents' personal plan.

The centre was managed by a full time person in charge who reported to an area manager and was supported by two deputy managers. The person in charge supervised a team of social care workers and support workers. The person in charge was maintaining a planned and actual staff roster showing the staff on duty. A minor amendment was required to the rota to ensure that the hours worked by all staff were clear.

The inspectors found that the centre was not currently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose or was appropriate to the assessed needs of residents. Despite the use of regular relief staff and redeploying staff from other centres to work in the centre, as well as on-going recruitment efforts by the provider, there was currently three whole-time equivalent vacancies in the centre. The deficit in staffing resulted in negative outcomes for the residents and impacted on their ability to access a meaningful day and have choice and control in their daily lives. For example, there were times when residents missed out on their planned community activities and other times where the choice of a community activity was not available to them. In addition, due to staffing shortages, the management team were, at times, covering front-line shifts. This in turn had the potential to impact on their ability to carry out the effective governance, operational management and administration of the designated centre at all times.

The inspectors observed that the complaints procedures and protocols were evident and appropriately displayed and available in the designated centre to residents and families. There was easy-to-read information on making complaints so that residents could better understand the procedure. Staff and management advocated on behalf of the residents and had submitted a number of complaints on their behalf. For example, complaints were made when residents missed out on community activities due to staff shortage, or when residents felt anxious or upset due to the impact of behavioural incidents taking place in their home. However, on review of the complaint log, the inspectors found that there was a number of gaps in the documentation. Although, there was evidence of follow up and work in progress to some of the complaints, the log did not always include a record of the follow up, or if the resident was satisfied with the outcome.

Regulation 15: Staffing

Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of the resident.

The actual and planned roster was maintained by the person in charge, however, an amendments was required to clearly reflect all shift times of all staff.

The provider has not ensured that the number of staff was appropriate to the number and needs of the residents. There were staff vacancies which were at times impacting on the residents access and right to a meaningful day and in particular in accessing activities in the community.

The provider was actively trying to recruit staff to fill vacancies, and using regular relief and redeployed staff from other centres to cover shifts. The person in charge was also, at times, covering shifts which had to potential to impact on the time available to them to fulfil their management duties.

Judgment: Not compliant

Regulation 23: Governance and management

Communication challenges between the employer and employees of the designated centre were impacting on its governance and management systems and directly impacting on the quality of care and support provided to the residents living in the centre.

Overall, the provider had failed to ensure that their own governance and oversight arrangements were being followed at all times. The inspectors found that the management systems in place did not ensure that the service provided was safe, appropriate to the residents' needs, consistent or effectively monitored at all times.

The inspectors found that a number of the provider's monitoring and auditing systems were not always effective in identifying and addressing improvements required to ensure a safe and good quality service was being provided to the residents living in the designated centre.

Performance management meetings were not occurring in line with the centre's policy and procedures and there had been no team meeting between the person in charge and staff since August 2021.

The inspectors found that the centre was not currently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors found that the information governance arrangements in place to ensure that the designated centre complied with notification requirements was not effective at all times. For example, a number of restrictive practices observed on the day of the inspection, had not been notified to HIQA as per the regulatory requirement.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints procedures and protocols were evident and appropriately displayed and available in the designated centre to residents and families.

However, the inspectors found that improvements were required to the complaints recording system as a number of gaps were found in the centre's complaint log relating to follow up actions and satisfaction levels of the complainant.

Judgment: Substantially compliant

Quality and safety

Overall the inspectors found that there was a significant failure by the provider to ensure the designated centre was achieving the basic quality and safety standards required by the regulations in relation to protection against infection. This meant there was a significant risk to the safety of the residents in the event of an outbreak of infection. In addition, other areas, relating to the quality of care and support provided to residents, and in particular restrictive practices and protection required action to ensure that residents were living in a safe and supportive environment that met their needs and empowered them to live life as independently has they were capable of.

There were significant infection control risks posed to residents due to poor levels of cleaning and maintenance in the designated centre. The environment required considerable attention and upkeep. The inspectors observed floors, walls, windows, ceilings, furniture, equipment, and soft furnishings to be unclean. In addition to the cleanliness factors, the provider had not adopted measures to protect residents from the risk of infection. Damaged and compromised fixtures, fittings, and furniture posed as risk for the spreading of bacteria and infections.

The inspectors observed the floor in the main sitting room to be unclean and there was visible dust and cobwebs throughout. Equipment in the room was not being adequately cleaned or maintained which in turn posed the risk for bacteria or other infections to colonise and to potentially be transferred to residents. For example, a specialised chair used by a resident was unclean with spilled liquid and food debris on it. Another office type chair in the room was stained with areas of the material in deterioration.

The dining area had recently been renovated and was a bright and inviting space with recently purchased new furniture. However, further improvements were needed to the room to ensure it provided a clean and safe environment for residents to enjoy. For example, some of the floor tiles and wooden window frames were chipped and there were thick cobwebs and dead insects hanging from the ceiling.

The inspectors observed areas of the hallway to be dusty with a thick layer of dust on fire extinguisher boxes and on a small heated bean bag used by a resident. The carpet on the stairs and in two staff rooms was not hovered and there was unidentified debris on it.

The kitchen was observed to be clean and bright. However, improvements were required to insure the room provided a safe and hygienic environment to cook in. For example, there was no lid on the general waste or recycling bin. The freezer required defrosting and the fridge contained unlabelled open foods. In addition, the kitchen blinds were stained and deteriorating. This had been self-identified by the person in charge and the inspectors were advised that that new blinds had been ordered.

Improvements were required to the cleanliness and upkeep of the medication room to ensure residents' medications were prepared in a hygienic environment. For example, the inspectors observed the floor and table in the medication room to have spillage of what appeared to be liquid medication on it. The room included a large portable fan which had a layer of dust on it. There was an empty medication storage box, supplied by the residents' pharmacy to transport medication, being used as a bin which contained used gloves, wipes, and medication packaging.

The main bathroom in the house was found to be unclean and in disrepair. A number of tiles were broken and the shower tray had mould on its surrounds.

The inspectors observed two of the bedrooms in the main house to be unclean and in poor state of repair including the furnishings. For example, in one of the bedrooms the fabric on the bed-frame and mattress was torn. The floors in both rooms were clinical in nature and neither room presented as homely. In one room there were thick dark cobwebs hanging from the ceiling, windows, radiator and walls. The en-suite toilet was unclean and bodily fluids were observed on the floor and wall behind the sink. In another bedroom the floor was sticky with bodily fluids on one of the walls beside the resident's bed.

Overall, the two single occupancy apartments attached to the premise required improvements to ensure the residents were living in an environment that was clean and free from risk of infection. In one apartment the living area required cleaning.

For example, the room was observed to be dusty and the in the kitchen section of the room, the fridge and cutlery drawer were found to be unclean. The inspector found a strong malodour in the bedroom and bathroom and there was mould observed on the bathroom ceiling and around the shower tray. In addition, there was damage to the walls and the radiator was rusty.

There was a large sensory room separate to the main building in a purpose built building. The sensory room was spacious and contained a variety of sensory equipment. However, the room and some of the equipment such as the water-bed was unclean. The room was also found to be cluttered and primarily due to an unused kitchen table being stored in the centre of the room. Subsequent to the inspection, the provider informed the inspectors that the table was not usually stored in the sensory room. However, as the table was there for four working days, it meant that it impinged on the space available to the residents during their use of the room and took away from the relaxed environment and sensory feel to the room including posing a risk of infection.

There was a detached building external to the main premises which was used as a maintenance shed. To the front of the shed, there was a separate room which contained a washing machine that was solely used for soiled laundry. However, due to poor storage there was a significant risk of contamination and poor infection control practices in this area. For example, items such as books and bicycle helmets were stored beside the washing machine. Furthermore, a resident's pillow was stored on top of a clinical bin that was currently in use.

The inspectors found that overall, the precautions against the risk of infection in the designated centre were poor. In addition to the cleanliness issues, the centre had demonstrated that it's precautions were insufficient. While there was residents had individual COVID-19 plans; the centre had no centre specific COVID-19 contingency plan. A service wide contingency required updating as it contained information that was not in line with public guidance. Of serious concern was that, staff were not consistently monitored for COVID-19 symptoms when commencing duty. COVID-19 symptom checks had not been completed for three staff on duty during the inspection. The centre had undertaken COVID-19 related risk assessments, however, some required review to ensure that they were in line with public health guidance.

As noted in the capacity and capability section of the report, the provider was required to submit an urgent compliance plan to address the urgent infection control risks found on the day of inspection.

Overall, there was adequate provision for food to be stored in satisfactory conditions however, to ensure that residents' food was safely stored at all times, improvements were required to ensure that opened food packages in the fridges in the designated centre were appropriately labelled and dated.

The inspectors reviewed the food safety checklists where temperatures of cooked food, refrigerated and frozen food were recorded and found that the procedure for completing these was not being followed and that there were gaps in the checklists.

This meant that basic daily checks were not being completed and the provider could not be assured that the service was being adequately reviewed for food safety, on a daily basis, as required by their own procedures.

Additionally, there was no evidence that these documents were subject to review. For example, where there were gaps in the documents, there was no evidence that improvements were being made to the overall quality of the completion of these records, as the same practice was noted on the checklists a number of weeks in a row.

The inspectors found that arrangements in place to ensure that medication was stored appropriately required improvements. For example, the inspectors observed that where a number of residents' liquid medications had been opened, they had not been labelled to demonstrate the date of opening. The fridge in the medication room had no temperature checking system in place and containers which carried medication to and from the pharmacist was currently being used as a rubbish bin. In addition, the medication room was unclean with stains on the counter and on spillages on the floor. The entrance door to the room included a number of notices including procedures in place when entering the room. Some of the notices were duplicated, frayed and stained from usage.

There had been a significant increase in the number of therapeutic interventions used in the designated centre from the first quarter to the second quarter of 2021 which were primarily related to behavioural incidents. Where appropriate, residents had been provided with a positive behavioural support plan and had been referred to the appropriate healthcare professional. However, on review of a sample of residents' behavioural support plans, the inspectors found that not all plans had been reviewed in accordance with the planned review dates. In addition, where there had been a safeguarding incident, follow-up actions from an interim safeguarding plan to update a resident's positive behaviour support plan, had not occurred. Furthermore, the provider could not be assured that staff were familiar with residents' positive behavioural support plans as not all signatory sheets, to confirm that staff had read and understood the plans, had been signed by staff.

The environment of the centre was highly restrictive for some residents and particularly in the main house. However, not all restrictions were in accordance with national policy and evidence based practice. For example, the locking of the dining room area had no risk assessment completed in advance of its use. The practice had been recorded in a resident's personal plan for a two week period to accommodate a change in the use of the room during an infectious outbreak in January 2021. However, on the day of the inspection, the inspectors found that the restrictive practice had remained in place. There were other examples of restrictive practices that were found not to be in accordance with the centre's or national policy and procedures. For example, restrictions relating to access to music, restrictions on kitchen cupboards, the location of mobile audio monitoring receivers and the logging of restrictions each time they were used.

In addition, the inspectors found that some of the existing environmental restriction required review. For example, there was an audio monitor in one resident's bedroom

which was in place at night-time to alert staff when the resident woke up. However, the level of risk to the resident, if they woke up during the night, did not appear to warrant this level of restriction. As such, assurances to demonstrate that it was the least restrictive for the shortest period were not afforded.

Another restrictive practice in use in the centre included the locking and alarming of a number of doors throughout the premises. During the inspection, a number of locked doors were opened throughout the day and on each occasion, a loud piercing alarm sounded. The loudness and involuntary characteristics of the alarmed doors had the potential to impact negatively on the lived experience of all residents living in the centre. A review of this restriction was needed as it impacted on the right of residents to live in a calm, relaxed and homely environment.

There was ongoing incompatibility issues between residents resulting in a high level of restrictive practices and incidents of a safeguarding concern. On the day of the inspection, management advised the inspectors that they had identified compatibility issues between some residents. There was a number of safeguarding plans in place to protect residents against the risk of abuse and to reduce the chance of adverse incidents re-occurring. However, some of the supports in place to protect residents and respond to compatibility issues, included additional environmental restrictions. For example, locking and alarming the centre's front door.

There was evidence to demonstrate that some of the behavioural incidents occurring in the centre impacted negatively on residents. For example, residents, supported by their staff, had raised complaints regarding the negative impact behavioural incidents had on their lived experience in the centre. One complaint logged noted that a resident felt anxious and needed to be reassured by their staff that they were safe.

On the day of the inspection, management advised the inspectors that, in line with a resident's safeguarding plan and in consultation with their family, the provider was actively exploring alternative premises and staffing arrangements to better meet the resident's assessed needs and in an effort to reduce the compatibility issues in the centre. However, these plans were at an early stage and a formal compatibility assessment had not yet been completed. As such, and as this situation remained ongoing, the inspectors found that not all residents were protected from all forms of abuse at all times.

Residents were provided with a personal plan which included an assessment of their needs and what supports were required to meet those needs. Residents' personal plans demonstrated that residents were supported to progress and achieve their chosen goals through one to one monthly meetings with their keyworker.

However, on review of a sample of plans a number of gaps were found. The recording of information to inform the plan was inconsistent and this impacted on the effectiveness of the assessment of the plan. For example, one of the resident's plan had not included sufficient detail of all of the specific interventions required to support a health-related need. In addition, where there had been changes in circumstances for one resident relating to restrictive practices their plan and not

recorded the proposed changes or provide a rationale for the changes.

Furthermore, the provider had put systems in place to ensure that all residents' personal plans were regularly monitored and kept up-to-date. There was a monthly auditing system in place which reviewed the different sections in each plan. For example, the support plans, the 'about me' section, risk assessments, restrictive practices and health action plans. However, on review of each resident's plan, the inspectors found the monthly audit had not taken place for the majority of residents' personal plans during the last three months.

Regulation 17: Premises

The premises was not kept in a good state of repair or suitably decorated.

Most of the rooms in the house required paintwork.

Flooring in two bedrooms in the main house was clinical in nature which took away from homeliness of the room.

Some furniture was damaged and required repair or replacement.

There were a lot of overgrown weeds outside the entrance and pathway to one of the apartments.

The handle on a bedroom door was broken.

A specialised bicycle belonging to one of the residents had two flat tyres and inspectors were advised that there was no equipment to fix it.

The environment did not meet the needs of all residents as restrictive practices in some areas of the house meant that it was not accessible to all residents.

Further issues relating to premises have been addressed in Regulation 7 and Regulation 27.

Judgment: Not compliant

Regulation 18: Food and nutrition

Improvements were required to ensure that opened food packages in the fridges in the designated centre were appropriately labelled and dated.

Food safety checklists, where temperatures of cooked food, refrigerated and frozen

food were recorded were not being completed at all times.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There precautions and measures to protect residents against infection were poor. The centre was not clean and lacked adequate procedures to guide staff on the cleaning and handling of infectious waste. Cleaning equipment was not stored appropriately. Specific measures in relation to the COVID-19 pandemic required immediate review. Risk assessments regarding the transmission of COVID-19 required update. The centres contingency plan was not specific to the centre and required update. Daily COVID-19 symptom checks for staff were not taking place. The inadequate measures to prevent and control infection posed a significant risk to the health and well-being of residents as well as staff and visitors.

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurances that the risk was adequately addressed.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Arrangements in place to ensure that medication was stored appropriately required reviewing so that they were in line with the centre's policies and procedures and with best practice.

The room which medication was prepared in was found to have unclean floors and surfaces and equipment and using storage boxes as bins.

Not all aspects of this regulation was reviewed on the day.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The recording of information to inform the plan was inconsistent and this impacted on how the effectiveness of the plan could be assessed.

Residents were provided with an individual personal plan however, some plans had

gaps in the documentation. For example, one of the resident's plan had not included sufficient detail of all of the specific interventions required to support a health-related need. In addition, where there had been changes in circumstances for one resident relating to restrictive practices, their plan and not recorded the proposed changes or provided a rationale for the changes.

Improvements were also required to ensure that plans were monitored in line with the centre's monitoring procedures.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The environment of the centre was highly restrictive for some residents and particularly in the main house.

Not all restrictions were in accordance with national policy and evidence based practice and it was not demonstrated for all restrictions that alternative measures had been considered before restrictions were used. For example, restrictions relating to the locking of the dining room, access to music, access to kitchen cupboards, the location of mobile audio monitoring receivers and the logging of restrictions each time they were used.

Some of the existing environmental restriction required review to ensure that it was the lease restrictive for the shortest period such as the audio monitor in a resident's bedroom and the noise from the alarmed locked doors in the house.

Not all positive behaviour support plans had been reviewed in accordance with the planned review dates or in-line with recommendations from other action plans.

The provider could not be assured that staff were familiar with residents' positive behavioural support plans as not all signatory sheets, to confirm that staff had read and understood the plans, had been signed by staff.

Judgment: Not compliant

Regulation 8: Protection

There was ongoing incompatibility issues between residents resulting in a high level of restrictive practices and incidents of a safeguarding concern.

There was evidence in the complaint logs to demonstrate that some of the behavioural incidents occurring in the centre impacted negatively on residents.

Plans to reduce the compatibility issues in the house had commenced however, were at an early stage and a formal compatibility assessment had not yet been completed. As such, the inspectors found that not all residents were protected from all forms of abuse at all times.

Judgment: Not compliant

Regulation 9: Residents' rights

The residents rights to privacy was impinged as personal information such as, medication administration sheets, were observed to be in the kitchen area of the main house.

Residents were not afforded the right to live in a clean home that was in good state of repair.

Residents' right to have the freedom to exercise choice and control in their daily lives was not always afforded due to staff shortages (for example, lack of daily access to community activities).

Residents' right to make decisions about, and participate in their care and support, were impinged when restrictive practices that were not in line with national policies and procedures were put in place in the centre.

Where residents had been supported to make complaints, their satisfaction level of the outcome of the complaint or how it was dealt with was not sought.

Some of the restrictive practices in the centre did not promote resident's autonomy, independence and choice at all times.

The above issues have been addressed further in Regulation 7, 15, 17 & 27.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Cois Dara OSV-0007698

Inspection ID: MON-0034634

Date of inspection: 28/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Staffing:

The Organisation have engaged with TTM and Excel recruitment agencies who specialize in recruiting for the health and social care sector, both agencies have been contacted for both temporary and permanent appointments in the designated centre, interviews will take place on 29.11.21 and where successful candidates are identified core skills induction training will take place prior to commencement.

AII Day service staff members have been and will continue to be redeployed to the designated centre to support the three vacant positions and any additional staff shortage due to unplanned leave, to date the following staff have been redeployed:
• Two senior facilitators
• Two facilitators
All day service staff redeployed have received Autism Initiatives Core skills training
All day service staff members' redeployment to Cois Dara has been supported with service specific inductions and redeployed staff member will receive person specific training where applicable.

AII are supporting the transition of one resident from the designated centre to a nearby AII service, once complete this transition will reduce the number of staff vacancies required in the designated centre, this transition will commence in December 2021.

AII will continue to Liaise with local colleges to support recruitment, online recruitment sessions have taken place with NCI and Carlow IT on 15.11.21 and 16.11.21, further appointments will continue to be scheduled to support recruitment for the designated centre.

The organisation will continue to Liaise with overseas recruitment agencies, online recruitment days/sessions took place on the 23rd, 24th and 25th November, two successful candidates have been offered positions and AII are currently awaiting

acceptance.

The organisation are liaising with the HSE and alternative service providers to discuss a potential transition for one of the residents who currently resides in the Cois Dara designated centre, a transition to an alternative service provider is being explored to ascertain if there is a service that may be better equipped to support the clients medical needs, if a suitable alternative provider is identified this transition will further reduce the staffing vacancies in the Cois Dara designated centre, Contact has been made with the HSE on 22.11.21 and the 24.11.21 to request a meeting to discuss this further, AII are currently awaiting a response from the HSE.

Actual and Planned Roster

The typo on the actual and planned roster omitting the pm from the 11pm finish was amended on the day of inspection 28.10.21, ensuring that the rota clearly reflects am or pm will continue to be checked during the provider unannounced 6 monthly inspections.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Infection Control as outlined under regulation 27

The organisation has established an Internal Infection control committee, this committee was established on the 05.10.21 , since appointment the committee have updated the organisations Infection control policy to reflect the new HIQA guidance (Guide and framework to Regulation 27 – Protection against Infection (DCD) published on 24.09.21), this policy update was completed and circulated on the 29.11.21.
Infection Control committee members and the service manager of the designated centre attended the Infection Prevention & Control and Auditing Procedures with NB Training Services on the 03.11.21, receipt of this training will support and influence the infection control auditing throughout the organisation,

Internal Infection control audits are taking place throughout the organisation, these will be scheduled 6 monthly and will be carried out by the Health and Safety Officer, Organisational level Infection control audits began taking place throughout the organisation in October 2021, an internal infection control audit is scheduled to take place in the Designated Centre on 29.11.21.

A service level infection control audit is currently being designed and due implementation from December 2021 at present the service level infection control requirements have been added to the weekly health and Safety checklist, this includes ensuring that health screening is taking place, cleaning schedules are completed in full and the PPE stock check has been completed.

A Deep clean of the designated was arranged as part of the provider assurance plan submitted on 01.11.21 This was carried out by M and M Cleanex cleaning services in Cois Dara service on 05.11.21.

Cleaning checklists have been updated to include areas of non-compliance found i.e. sluice room, laundry room and bins, specific cleaning checklists have been developed for all individual rooms in the main house and both apartments within the designated centre, these checklists will be checked to ensure satisfactory completion during the manager weekly check.

The Maintenance department attended the designated centre on 01.11.21 and completed all maintenance works identified during inspection, the maintenance log is being updated to reflect a priority rating and a timeline for completion, a draft template has been created and is currently under review, this was circulated to members of the HIQA steering committee on the 19.10.21 and due for circulation on the week beginning the 29.11.21.

A Purchase list has been compiled for the designated centre by the service manager and purchasing for all identified fixtures and furnishings is underway, Items requiring immediate replacement and purchase such as pedal bins and mop storage have been purchased and were put in place on the week beginning the 01.11.21. remaining items have been ordered and are awaiting delivery,

AII Health Screening policy was reviewed, updated and recirculated by the operational team on the 05.11.21.

The Designated Centre Covid 19 contingency plan has been updated to ensure it reflects service specific needs and the measures to support same with specific emphasis on staffing shortages.

An infection control risk assessment in relation to soiled laundry was completed for the designated centre by the service manager on the 05.11.21 and sent to the health and safety officer for review and input prior to implementation.

Weekly Spot checks are being carried out by members of the Service management team i.e. Service manager and senior social care workers to ensure that all infection control measures are being adhered to, this will be recorded on the manager weekly checklist.

A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that actions detailed on health and safety checklists, PPE stock checks, cleaning checklists, medication audits are being captured and followed up, this document will also capture any gaps in HACCP recording, health screening and will form part of the weekly infection control spot checks,

The Designated Centre Covid Specific risk assessments were reviewed and updated by Service managers in consultation with staff team on the week beginning the 01.11.21.

Contract cleaners have carried out weekly cleaning services in the designated centre for

the month of November starting on the 03.11.21 and these will continue until a review takes place in January 2022.

Identified resident new bed has been purchased and the organisation is currently awaiting delivery, the existing bed has been repaired to ensure it meets all infection control standards in the interim period,

Cleaning checks within the service have been updated to ensure they are specific to individual rooms and in line with new infection control guidance,

The Provider 6 monthly unannounced inspection template is currently being updated to reflect infection control measures, this updated template will be implemented from December 2021.

Communication with staff team
Communication with the staff team through team meetings will continue to take place, as discussed on the day of inspection a staff team meeting was scheduled to take place on the 29.10.21, this meeting took place as scheduled and the meeting minutes were circulated on the 08.11.21 to ensure communication of matters discussed to all staff members not in attendance.

Performance review training was provided to the two new deputy managers on the 15.11.21 and Performance reviews have been rescheduled to take place in December 2021.

The organisation have engaged and will continue to engage with Forsa union officials and the percentage of the Cois Dara staff whom they represent in an attempt to resolve the situation leading to union members working under protest, this percentage of the team represented by Forsa have communicated that as advised by their union they are working under protest due to an essential service roster change. Since the roster change was first discussed in July the organisation have continued to schedule staff meetings in the designated centre, the organisation will continue to communicate service developments to staff members and seek staff team input on matters relating to the service. Despite union officials advising their members not to engage in any dialogue about roster changes, team meetings have taken place and been scheduled to take place in the designated centre on:
01.07.21
23.07.21
22.08.21
27.09.21 (canceled on day due to low attendance)
29.10.21
13.12.21

The management team will continue to encourage staff members to engage with the organisation via its internal grievance procedure.

Team meeting minutes will continue to be reviewed as part of the provider 6 monthly unannounced inspections, this inspection tool has been updated to reflect that team

meetings are required to take place every 6 weeks and an action will be given where a team meeting has not taken place within the 6 week timeframe.

Resources:
The Organisation have engaged with TTM and Excel recruitment agencies who specialize in recruiting for the health and social care sector, both agencies have been contacted for both temporary and permanent appointments in the designated centre, interviews will take place on 29.11.21 and where successful candidates are identified bespoke core skills induction training will take place.

AII Day service staff members have been and will continue to be redeployed to support the three vacant positions and any additional unplanned leave in the designated centre, to date the following staff have been redeployed:
• Two senior facilitators
• Two facilitators
All day service staff redeployed have received Autism Initiatives Core skills training
All day service staff members' redeployment to Cois Dara has been supported with service specific inductions and redeployed staff member will receive person specific training where applicable.

AII are supporting the transition of one resident from the designated centre to a nearby AII service, once complete this transition will reduce the number of staff vacancies required in the designated centre, this transition will commence in December 2021.

AII will continue to Liaise with local colleges to support recruitment, online recruitment sessions have taken place with NCI and Carlow IT on 15.11.21 and 16.11.21, further appointments will continue to be scheduled to support recruitment for the designated centre.

The organisation will continue to Liaise with overseas recruitment agencies, online recruitment days/sessions took place on the 23rd, 24th and 25th November, two successful candidates have been offered positions and AII are currently awaiting acceptance,

The organisation are liaising with the HSE and alternative service providers to discuss the potential transition of one of the residents from the Cois Dara designated centre to an alternative service provider who may better support the clients medical needs, if a suitable alternative provider is sought this transition will further reduce the staffing vacancies in the Cois Dara designated centre, Contact has been made with the HSE on 22.11.21 and the 24.11.21 to request a meeting to discuss this further, AII are currently awaiting a response from the HSE.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notification of Outstanding Restrictive Practices

All restrictions in situ in the Designated Centre were reviewed the week beginning 01.11.21 and added to the updated service specific restrictive practice register and monthly managers report to ensure that triangulation is in place to support accurate notification of restraint on the HIQA quarterly returns NF39A.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Complaints:
The organisations complaint form has been updated to request more detail on how the outcome of a complaint is being communicated to the complainant, the complaint form further requests that this communication is to be completed in a manner that is meaningful to the service user, a weekly review of submitted complaint forms has been added to the designated centre weekly manager checklist to ensure complaints are responded to within the agreed timeframe and that the complainant is informed of the outcome. The manager weekly checklists has been devised and implemented on 22.11.21.

The 6 monthly provider unannounced inspections has been updated to reflect a more in-depth review of the individual service complaints folder, this updated inspection template now requires the nominated person to check:
• How the complaint was processed,
• How the complaint was responded to,
• If the complaint was responded to within the agreed timeframe
• That the complaint was correctly recorded on the complaints log
• That the complainant was satisfied with the outcome,
• How the outcome was communicated in a meaningful manner

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Provider unannounced 6 monthly inspection template was updated on 26.11.21 to reflect any cosmetic damage to furnishings and fittings that could potentially harbour infection, This inspection tool has been updated to reflect a review of the whole premises that includes outside areas i.e. garages, garden, sheds, during this review of the premises homeliness, state of repair and safety will be a primary focus, action plans will reflect

furniture requiring replacement and repairs needed.

The Maintenance department attended the designated centre on 01.11.21 and completed all maintenance works identified during inspection, the maintenance log is being updated to reflect a priority rating and a timeline for completion, a draft template has been created and is currently under review, this was circulated to members of the HIQA steering committee on the 19.10.21 and due for circulation on the week beginning the 29.11.21.

A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that actions detailed on health and safety checklists, PPE stock checks, cleaning checklists, medication audits are being captured and followed up, this document will also capture any gaps in HACCP recording, health screening and will form part of the weekly infection control spot checks.

Restriction compliance plan outlined under regulation 7 Positive Behaviour support

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that actions detailed on health and safety checklists, PPE stock checks, cleaning checklists, medication audits are being captured and followed up, this document will also capture any gaps in HACCP recording, health screening and will form part of the weekly infection control spot checks.

The HACCP temperature check checklists was updated to reflect the number of fridges within the service to ensure temperature is checked and recorded for all fridges, the service specific HACCP risk assessment was updated on the 29.11.21 to make reference to the number of fridges in the designated centre.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Infection Control
The organisation has established an Internal Infection control committee, this committee was established on the 05.10.21 , since appointment the committee have updated the organisations Infection control policy to reflect the new HIQA guidance (Guide and

framework to Regulation 27 – Protection against Infection (DCD) published on 24.09.21), this policy update was completed and circulated on the 29.11.21.
The organisations Infection Control committee members and the service manager of the designated centre attended the Infection Prevention & Control and Auditing Procedures with NB Training Services on the 03.11.21, receipt of this training will support and influence the infection control auditing throughout the organisation.

Internal Infection control audits are taking place throughout the organisation, these will be scheduled 6 monthly and will be carried out by the Health and Safety Officer. Organisational level Infection control audits began taking place throughout the organisation in October 2021, an internal infection control audit is scheduled to take place in the Designated Centre on 29.11.21.

A service level infection control audit is currently being designed and due implementation from December 2021 at present the service level infection control requirements have been added to the weekly health and Safety checklist, this includes ensuring that health screening is taking place, cleaning schedules are completed in full and the PPE stock check has been completed.

A Deep clean of the designated was arranged as part of the provider assurance plan submitted on 01.11.21 This was carried out by M and M Cleanex cleaning services in Cois Dara service on 05.11.21.

Cleaning checklists have been updated to include areas of non-compliance found i.e. sluice room, laundry room and bins, specific cleaning checklists have been developed for all individual rooms in the main house and both apartments within the designated centre, these checklists will be checked to ensure satisfactory completion during the manager weekly check.

The Maintenance department attended the designated centre on 01.11.21 and completed all maintenance works identified during inspection, the maintenance log is being updated to reflect a priority rating and a timeline for completion, a draft template has been created and is currently under review, this was circulated to members of the HIQA steering committee on the 19.10.21 and due for circulation on the week beginning the 29.11.21.

A Purchase list has been compiled for the designated centre by the service manager and purchasing for all identified fixtures and furnishings is underway, Items requiring immediate replacement and purchase such as pedal bins and mop storage have been purchased and were put in place on the week beginning the 01.11.21. remaining items have been ordered and are awaiting delivery,

The organisations Health Screening policy was reviewed, updated and recirculated by the operational team on the 05.11.21.

The Designated Centre Covid contingency plan has been updated to ensure it reflects service specific needs and the measures to support same with specific emphasis on staffing shortages.

An infection control risk assessment in relation to soiled laundry was completed for the designated centre by the service manager on the 05.11.21 and sent to the health and safety officer for review and input prior to implementation.

Weekly Spot checks are being carried out by members of the Service management team i.e. Service manager and senior social care workers to ensure that all infection control measures are being adhered to, this will be recorded on the manager weekly checklist.

A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that actions detailed on health and safety checklists, PPE stock checks, cleaning checklists, medication audits are being captured and followed up, this document will also capture any gaps in HACCP recording, health screening and will form part of the weekly infection control spot checks.

The Designated Centre Covid Specific risk assessments were reviewed and updated by Service managers in consultation with staff team on the week beginning the 01.11.21.

Contract cleaners have carried out weekly cleaning services in the designated centre for the month of November starting on the 03.11.21 and these will continue until a review takes place in January 2022.

Identified resident new bed has been purchased and the organisation is currently awaiting delivery, the existing bed has been repaired to ensure it meets all infection control standards in the interim period.

Cleaning checks within the service have been updated to ensure they are specific to individual rooms and in line with new infection control guidance.

The Provider 6 monthly unannounced inspection template is currently being updated to reflect infection control measures, this updated template will be implemented from December 2021.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
HACCP
The HACCP temperature check checklists was updated to reflect the number of fridges within the service to ensure temperature is checked and recorded for all fridges, the service specific HACCP risk assessment was updated on the 29.11.21 to make reference to the number of fridges in the designated centre.

Infection Control

Cleaning checks within the designated centre have been updated to ensure they are specific to individual rooms and in line with new infection control guidance.

Blitz cleaning Contract cleaners have carried out weekly cleaning services in the designated centre for the month of November starting on the 03.11.21, these services will continue until a review takes place in January 2022.

A service level infection control audit is currently being designed and due implementation from December 2021 at present the service level infection control requirements have been added to the weekly health and Safety checklist, this includes ensuring that health screening is taking place, cleaning schedules are completed in full and the PPE stock check has been completed.

A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that actions detailed on health and safety checklists, PPE stock checks, cleaning checklists, medication audits are being captured and followed up, this document will also capture any gaps in HACCP recording, health screening and will form part of weekly infection control spot checks.

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:
See compliance plan outlined in relation to staffing regulation 15

See compliance plan outlined in relation to Positive Behaviour Support (Restrictions) regulation 7

Reviewing the working file (care plan) audits was added to the service manager checklist to ensure that all outstanding working file documentation is identified and followed up, the service manager checklist was devised and implemented on the 22.11.21

The organisation are liaising with the HSE and alternative service providers to discuss a potential transition for one of the residents who currently resides in the Cois Dara designated centre, a transition to an alternative service provider is being explored to ascertain if there is a service that may be better equipped to support the clients medical needs, if a suitable alternative provider is identified this transition will further reduce the staffing vacancies in the Cois Dara designated centre, Contact has been made with the HSE on 22.11.21 and the 24.11.21 to request a meeting to discuss this further, AII are currently awaiting a response from the HSE.

In the interim period the organisation will continue to engage the services of a nutritionist to support with the residents dietary requirements to further support health needs, contact was made with a spectrum nutrition Dublin at the beginning of September

2021 and follow up contact was made on 29.11.21, the organisation are awaiting further response.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Restrictive Practices:
A review of all restrictive practices in situ in the designated centre took place on the week beginning 01.11.21, restrictions identified as not the least restrictive were removed or reduced i.e. audio monitor in place for one resident moved from bedroom to residents kitchen, where restrictive practices were still deemed necessary, further supporting documentation was completed for example where there is a restrictive practice in place a risk assessment is carried out to support the decision to implement the restriction, the review ensured that all restrictions are documented on both the service specific and organisational restrictive practice register, In addition on the week beginning the 22.11.21 all documentation relating to restrictive practice in The Cois Dara service has been sent to a member of the organisations practice support team not involved in the running of the designated centre.

Notification of Incidents:
All restrictions in situ in the Designated Centre were reviewed the week beginning 01.11.21 and added to the updated service specific restrictive practice register and monthly managers report to ensure that triangulation is in place to support accurate notification of restraint on the HIQA quarterly returns NF39A.

Positive Behaviour Support:
As outlined during the inspection AII will continue with their plan to transition the identified resident to the nearby designated centre, this plan was set in motion due to recently identified compatibility concerns and the impact of other residents restrictive practices on the identified resident , this transition had been agreed by key stakeholders on the 21.10.21.
Three transition meetings have taken place to date on the 21.10.21, 27.10.21 and the 22.11.21, A person centred transition plan has been completed and the transition is scheduled to begin on the 03.12.21, while the organisation has identified potential dates for key elements of the transition plan to occur, these dates will be subject to change as it is imperative that the transition is client lead, this will ensure that the transition happens at the clients own pace, with maximum client consultation, which will in enhance the prospects of a successful transition.

On the week beginning the 22.11.21 All PBSP's were sent for review to a member of the organisations practice support team and positive behaviour support trainer, upon review all staff members will sign updated documents and this will captured in the 6 monthly provider unannounced inspection report, where signatures are outstanding these will be

actioned.

The organisation are liaising with the HSE and alternative service providers to discuss a potential transition for one of the residents who currently resides in the Cois Dara designated centre, a transition to an alternative service provider is being explored after the completion of a reassessment of need to ascertain if there is a service that may be better equipped to support the clients medical needs, if a suitable alternative provider is identified this transition will further reduce the staffing vacancies in the Cois Dara designated centre, Contact has been made with the HSE on 22.11.21 and the 24.11.21 to request a meeting to discuss this further, AII are currently awaiting a response from the HSE.

A service specific managers checklist has been devised and was implemented on the 22.11.21, this document will be completed by the Service manager or the deputy service managers on a weekly basis to ensure that positive behaviour support plans and risk assessments requiring review as a result of Safeguarding plans are completed within the designated timeframe and signed by all staff members.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
See Staffing compliance plan outlined under regulation 15

Actual and Planned Roster
The typo on the actual and planned roster omitting the pm from the 11pm finish was amended on the day of inspection 28.10.21, ensuring that the rota clearly reflects am or pm will continue to be checked during the provider unannounced 6 monthly inspections

The organisation are liaising with the HSE and alternative service providers to discuss a potential transition for one of the residents who currently resides in the Cois Dara designated centre, a transition to an alternative service provider is being explored to ascertain if there is a service that may be better equipped to support the clients medical needs, if a suitable alternative provider is identified this transition will further reduce the staffing vacancies in the Cois Dara designated centre, Contact has been made with the HSE on 22.11.21 and the 24.11.21 to request a meeting to discuss this further, AII are currently awaiting a response from the HSE.

AII are supporting the transition of one resident from the designated centre to a nearby AII service, once complete this transition will reduce the number of staff vacancies required in the designated centre, this transition will commence in December 2021.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
See Notification of incidents compliance plan outlined under regulation 31

See Staffing compliance plan outlined under regulation 15

See Positive Behaviour Support compliance plan outlined under regulation 7

See Complaints compliance plan outlined under regulation 34

See Premises compliance plan outlined under regulation 17

See Infection Control compliance plan outlined under regulation 27

Right to Privacy:
Cara pharmacy medication administration record sheets (MARS) left on the kitchen counter of the designated centre were removed on the 28.10.21 day of inspection, the Organisations 6 monthly unannounced provider inspection template has been updated to ensure that no client information is displayed in public areas, this updated inspection tool will come in to effect in December 2021.

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	29/11/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	28/10/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet	Substantially Compliant	Yellow	05/11/2021

	the aims and objectives of the service and the number and needs of residents.			
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	15/01/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	05/11/2021
Regulation 17(2)	The registered provider shall ensure that where the designated centre accommodates adults and children, sleeping accommodation is provided separately and decorated in an age-appropriate manner.	Substantially Compliant	Yellow	15/01/2022
Regulation 18(1)(b)	The person in charge shall, so far as reasonable and practicable, ensure that there is adequate provision for residents to store food in hygienic conditions.	Substantially Compliant	Yellow	29/11/2021
Regulation 18(2)(a)	The person in charge shall	Substantially Compliant	Yellow	29/11/2021

	ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
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	29/11/2021
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	29/11/2021
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 months or more frequently as determined by the	Substantially Compliant	Yellow	15/12/2021

	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(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	22/12/2021
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	29/10/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a	Not Compliant	Orange	05/11/2021

	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.			
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.	Substantially Compliant	Yellow	01/11/2021
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	Substantially Compliant	Yellow	05/11/2021

	procedure including physical, chemical or environmental restraint was used.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	29/11/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	29/11/2021
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	29/11/2021
Regulation 05(6)(d)	The person in charge shall ensure that the	Substantially Compliant	Yellow	29/11/2021

	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.			
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include any proposed changes to the personal plan.	Substantially Compliant	Yellow	15/12/2021
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Substantially Compliant	Yellow	15/12/2021
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	15/12/2021
Regulation 07(1)	The person in	Substantially	Yellow	15/12/2021

	charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Compliant		
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	05/11/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	05/11/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive	Substantially Compliant	Yellow	05/11/2021

	procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	05/11/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	05/11/2021
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.	Not Compliant	Orange	05/11/2021
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,	Substantially Compliant	Yellow	28/10/2021

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