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:	Poppy Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Announced
Date of inspection:	03 August 2021
Centre ID:	OSV-0004472
Fieldwork ID:	MON-0026981

About the designated centre

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

Poppy Services is run by the Brothers of Charity Services, Ireland. The centre provides a service for up to six male and female adults. The centre comprises three houses which are located in Co. Roscommon. The premises supports three residents in one house, two residents in another and one resident in the third. The centre can provide care to for up to six male and female adults who have a moderate to severe intellectual disability and autism. One of the houses operates as shared care arrangement with family for part of the week. The centre is managed by a qualified nurse and social care staff are available at all times to support the residents. The residents avail of a wrap-around day service which is operated from the individual houses. At present one house is awaiting significant remedial works required in the premises. Staff are on duty at night on a sleepover basis and during the day to cater for the needs of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 3 August 2021	9:00 am to 5:00 pm	Catherine Glynn	Lead

What residents told us and what inspectors observed

This was a centre that very much ensured residents were provided with the care and support that they require. All efforts were made by staff to ensure residents had multiple opportunities to engage in activities of interest to them, in accordance with their capacities and assessed needs. Overall, this was a centre that prioritises the needs of residents in all aspects of the service delivered to them.

Through observations and review of residents' information, the inspector found that residents were receiving appropriate care and support. Residents were supported to engage in activities of their choosing and the centre's staff team were supporting residents in a way that promoted their views and rights.

The inspector had the opportunity to meet with two of the residents who were receiving their day service programme from their home. Due to their assessed needs, they were unable to communicate directly with the inspector about the care and support they received. One resident was relaxing in the living area while watching television. Another resident was being supported by staff to do their art activity in another sitting room. The inspector met briefly with a number of staff who were on duty that morning who advised the inspector that the residents' living arrangements worked very well.

The residents appeared comfortable and to enjoy the activities they were engaging in. One of the residents was watching the Olympics while another resident was listening to music videos. The inspector was supported to interact with both residents for a brief period. The staff members supporting the residents was aware of the resident's communication skills and helped the resident to inform the inspector about their engagement with special Olympics, and enjoying the sporting events on the television. The inspector observed warm and friendly interactions between the residents and staff members supporting them throughout the inspection. The inspector noted that residents observed appeared comfortable in the company of staff.

A review of residents' information demonstrated that they were receiving person-centred care that was developed in line with their needs. Weekly residents meetings were held that gave residents an opportunity to choose meals and activities they wished to engage in. There were also regular individual work sessions being carried out between residents and staff members. These sessions were linked to goals that had been identified during the development of their personal plans. Activities included arts and crafts, bowling, and cookery.

There was also clear evidence of the provider and staff team supporting residents to maintain relationships with their family members through assistive technology and physical visits when possible. There was evidence of the residents beginning to re-engage in community activities following the lifting of restrictions. Overall there were strong auditing practices regarding residents' information that ensured that the

changing needs of residents were being monitored and responded to. The inspection did, however, find that there were improvements required regarding other monitoring practices. The impact of this will be discussed in more detail in the following Capacity and Capability and Quality and Safety sections of the report.

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

Capacity and capability

Overall, the provider was able to demonstrate that they had good systems in place for the management and oversight of this service. However, some areas required improvement, including the quality of the environment and fire safety and these will be discussed later in the report.

The provider had ensured that there was a management structure in place that was led by a person in charge. There was a strong management presence, and in general, this led to effective delivery of care. The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre as per the regulations. Actions had been identified following these and the inspector found that actions remained outstanding at the time of inspection. In addition, there were actions identified on the day of inspection that were not identified in the most recent audit completed, for example, self-closing devices on all fire doors as required for effective containment of fire. Overall, the inspector found that the oversight of the service required improvement

A review of the staffs team training needs analysis record showed that the provider had ensured that staff had completed all mandatory training as required by the regulations, as well as bespoke training required for residents in the centre. These included basic life support, fire safety training, therapeutic crisis intervention training, medication management, first aid and autism care. Additional training in various aspects of infection control had also been provided to staff in response to the COVID-19 pandemic. There was also a range of policies to guide staff in the delivery of a safe and appropriate service to residents and a sample of policies viewed by the inspector were up-to-date and informative.

There were sufficient staff on duty on the day of inspection in order to meet and support the needs of the residents living in the centre. These staff were employed on a regular basis by the provider and this had developed good relationships with the residents. The inspector observed warm and engaging interactions between residents and staff and it was clear that the relationships were mutually respectful and beneficial to the residents and staff members supporting them. The provider had a clear roster in place, which ensured that there were sufficient staff on duty at all times. Where necessary, staff provided overnight cover on a sleeping over cover,

and was reviewed based on residents needs.

The provider was able to demonstrate good practice in relation to the recruitment of staff by ensuring that all required pre-employment clearances had been completed for staff working in the centre, including evidence of current Garda siochana (police vetting) clearances. Staff training records demonstrated that the provider had continued to ensure that staff were receiving regular training and refresher training, with an emphasis on mandatory training, due to the current COVID-19 restrictions.

In the majority of documentation reviewed, the inspector noted that there was generally good provider oversight in place. For example, the health and safety documentation in the centre was being kept up-to-date and were relevant and clear. The inspector reviewed both the annual review and the most recent twice per year unannounced visit report and found that these were clear and balanced and had identified some areas where action was required to ensure a good quality of service was being offered. Where required, there was evidence of an action plan being developed and that actions were being taken forward and resolved in accordance with the agreed time frames. However, the inspector noted that the actions did not sufficiently detail the actions required to ensure that they would be suitably identifiable to the reader. For example, while one action required improvement to the completion of applications for funding in relation to required renovation works, it did not clearly state who was responsible and what practices needed attention. Therefore, there was a risk that the actions may not be completed.

The provider maintained records of all incidents that occurred in the centre; these were detailed and provided sufficient evidence that where required actions were being put in place to reduce the likelihood of the incident reoccurring. In addition, the inspector noted that the all incidents that required notification to the Chief Inspector of Social Services were being notified.

Overall, there were improvements required to the monitoring practices in a number of areas. The service being provided to residents was, effectively monitored and was leading to positive outcomes for residents.

Regulation 14: Persons in charge

The person in charge had overall responsibility for this centre and she was regularly present to meet with staff and residents. She had strong knowledge pf residents' needs and of the operational needs of the service delivered to them. She was responsible for two other centres operated by this provider and current support arrangements gave her capacity to effectively manage this service.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the required number of staff on shift each day was sufficient to meet the needs of all residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff development was prioritised and that staff had access to appropriate training.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had ensured that the directory of residents was maintained and contained information as required by the regulation.

Judgment: Compliant

Regulation 23: Governance and management

The inspector was not assured that the existing management structures and monitoring practices were appropriate. There were improvements required to ensure all aspects of the service were effectively monitored.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There were required improvements to ensure the statement of purpose contained the most up-to-date information.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had ensured that adverse incidents as listed in the regulations were reported within the prescribed period.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure that was accessible to residents.

Judgment: Compliant

Quality and safety

Overall, residents living in the centre received care and support which was of a good quality, person-centred and which promoted their wellbeing. There were some improvements necessary however, on the systems for risk management, and fire safety. This included fire doors in one house, self-closing devices in another house, and appropriate self-closing devices based on the assessed needs of residents in that house.

As discussed in the earlier sections, improvements to the risk management documentation in the centre were required. The inspector found that the provider had not risk rated identified risks appropriately to ensure they were under regular review, and were responded to in a timely manner. For example, the renovations required to a bathroom based on the assessed needs of a resident, which was identified in April 2021, remained outstanding and no work had commenced at the time of inspection.

Prior to the inspection the provider had consulted with the Health Information and

Quality Authority HIQA regarding one house in the centre and at the time of the inspection this house did not have any residents living there. The inspector viewed all three houses on the day of inspection and found that the building which was vacant was not fit for purpose as outlined in the statement of purpose until satisfactory remedial works were completed.

Residents were supported to exercise choice and control in their daily lives and the staff on duty were observed to be actively supporting them to do the things they wished. The residents appeared relaxed in the company of staff and enjoyed doing these activities with staff. There were examples of positive risk taking being practiced within the service, with residents being supported to explore goals such as financial independence, personal development skills and garden activities.

The inspector observed posters of the organisations human rights charter, an easy-to-read guide on making a complaint and information on the national advocacy service. Residents were engaged in weekly meetings. The person in charge had developed a schedule of topics to be reviewed at each meeting. The meetings aimed to promote information sharing and learning for the residents and where possible residents were encouraged to choose activities of their choosing, There were also a number of goals developed for the residents that focused on community and social inclusion along with engaging the residents in their preferred activities.

There were arrangements that ensured that each resident was receiving or had access to appropriate healthcare. Where residents presented with complex health needs, there was evidence of input being provided by a range of health and social care professionals and therapeutic services. Residents were facilitated to attend a range of medical appointments. There was evidence of the staff team acting as advocates at times regarding treatment plans and following up with prescribers to ensure that the plans were the most appropriate options.

There were systems in place to manage and mitigate risks and keep residents and staff members safe. However, the inspector noted that the risk assessments required review, as the risk rating did not clearly reflect the outstanding controls that were required to mitigate or remove possible risks in the centre for residents. Adverse incidents were discussed as part of team meetings, and learning from incidents was promoted.

On review of a second house, the inspector noted that the premises also required review. This included painting throughout the accommodation, due to marks, plaster peeling away and possible water damage. It was noted that the cupboards were also in a state of disrepair in the kitchen and utility areas.

Effective fire safety precautions were in place, including fire detection, fire safety checks, emergency lighting arrangements and multiple exits were also available throughout the centre. Fire drills were occurring on a regular basis and records demonstrated that staff could effectively support residents to safely evacuate the centre. A personal emergency evacuation plan (peep) was in place for each resident which ensured the staff guidance on how to support each resident required to evacuate. However, while the inspector noted that there were illuminated

evacuation signs in the house, there were no self-closing devices installed on any fire door in this house to ensure effective containment of fire. The provider was asked to review all houses following the inspection and ensure self-closing devices were installed, based on the assessed needs of residents in all houses of the centre.

Infection control arrangements at the centre were robust and reflected current public health guidance associated with managing a possible outbreak of COVID-19. The person in charge had developed a COVID-19 response plan for the centre, which informed staff of actions to be taken in all eventualities, including an outbreak amongst residents staff members, or staff shortages. The COVID-19 risk assessments developed for residents, the staff team and visitors were detailed and developed according to the Health Protection Surveillance Centre (HPSC) guidelines.

Regulation 10: Communication

The staff team supporting residents were aware of their communication needs.

Judgment: Compliant

Regulation 17: Premises

The centre comprised of three buildings located across a local community. During the walk around of these centres, the inspector noted that there were areas in two houses that required review. One house was currently vacant due to significant remedial works required. The provider had notified the inspector of the vacancies, and the necessary work required. In the second house, while some actions required had been identified by the person in charge and the provider, however, these remained outstanding at the time of inspection. This included: painting walls internally and externally, ceiling and architrave doors were partially painted and this was very noticeable on several doors, crumbling plasterwork in two areas in hallways beside the kitchen. The inspector also noted that five kitchen presses were missing laminate covering and several doors required repair as they were not hanging correctly. In the main bathroom, the bath panel was worn and discoloured.

Judgment: Not compliant

Regulation 20: Information for residents

Information was provided to residents. This included information, in user friendly format, about staff on duty each day, residents rights, how to make complaints, COVID-19 information and personal planning.There was also a written guide to the

service that met the requirements of the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

There were policies and procedures for the management, review and evaluation of adverse events and incidents. Improvements were required to the risk register in the centre. This included appropriate risk rating for risks identified which were not addressed or completed, at the time of the inspection. For example, required modifications to a bathroom based on the assessed needs of a residents which was identified in April 2021 remained outstanding at the time of inspection and was not correctly risk rated.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the HIQA.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety management systems were in place and appropriate fire drills were held with the residents. However, the inspector noted that the provider did not have effective fire containment measures in place in the centre. The inspector noted during the walk around, that the fire doors in one house had no self-closing devices installed as required to ensure effective containment in the event of fire in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Robust systems were in place to ensure residents' needs were subject to regular

review and re-assessment and that personal plans were put in place to guide staff on the specific supports that residents required.

Judgment: Compliant

Regulation 6: Health care

Overall, the inspector found that residents' healthcare needs were well monitored, with evidence of regular review by the general practitioner (GP).

Judgment: Compliant

Regulation 7: Positive behavioural support

Effective systems were in place to ensure residents received the care and support they required in response to their behavioural needs. Clear behaviour support plans were in place to guide staff on how best to respond to specific residents' behaviours and this centre was suitably supported by a behavioural support therapist in the review and monitoring of all care interventions. There were some restrictions in use at the time of this inspection and the provider had ensured that these were under regular review.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured that there were systems in place for the reporting and investigation of any safeguarding concerns. Staff had received safeguarding training and were provided with refresher training on a regular basis. At the time of the inspection there were no active ongoing safeguarding concern investigations.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Poppy Services OSV-0004472

Inspection ID: MON-0026981

Date of inspection: 03/08/2021

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Internal Audits are being reviewed to ensure all regulations are robustly reviewed to support monitoring practices. This will include communication with internal auditors and a review of audit tool. One Action outstanding from a recent internal audit is actively being followed on by the Manager of the Service.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose has been reviewed to contain the most up to date information in relation to the service.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
17 (1)(b) Investigation works have concluded in one house and the cause of issues arising within the property have been assessed. A timeline has now been set with facilities manager, builder and area manager for all remedial works to be carried out. The timeline for conclusion of these works is within six months.
Repairs works are being completed in the second house in this Designated Centre.

17 (1)(C) One house is currently being redecorated.
17 (6) Plans are in place for one house within the Designated Centre to have works carried out to ensure accessibility for all people supported who live here. Funding is being sought to ensure that works can be completed to support accessibility issues for all people.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk ratings on the risk register have been reviewed.
Risk Management procedures and ratings will continue to be reviewed at team meetings.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Door closures have been installed on the doors in one premise.

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 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.	Not Compliant	Orange	30/04/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	30/11/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of	Not Compliant	Orange	30/11/2021

	purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
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.	Substantially Compliant	Yellow	30/11/2021
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	04/08/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and	Substantially Compliant	Yellow	30/09/2021

	extinguishing fires.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	04/08/2021