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:	No 4 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	02 December 2020
Centre ID:	OSV-0004573
Fieldwork ID:	MON-0031299

About the designated centre

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

This centre is located in Cork City suburbs. It is within access to shops, transport and amenities. It comprises of two self contained apartments and an adjoining house catering for four residents. A maximum of six adults can be supported to reside in this centre. It has been adapted to meet residents' needs and is a ground floor premises. This centre was set up to provide a specialist service for persons with an intellectual disability including autism. It has an integrated day service. The centre's focus is on understanding and meeting the individual needs of each resident, by creating as homely an environment as possible. Residents are encouraged to live a meaningful everyday life by participating in household, social and leisure activities. Each resident's needs are assessed and a plan put in place to meet their needs. As residents' needs change, their individual plan of care is adapted and appropriate supports provided by staff. The ethos in this centre is to build a better world for every human being. The organisation works to develop supports and services based on the needs and choices of each individual. Residents are supported by a staff team with a skill mix of nursing and social care both by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Wednesday 2 December 2020	10:50hrs to 15:30hrs	Elaine McKeown	Lead

What residents told us and what inspectors observed

On the day of the inspection, the inspector had the opportunity to meet with two of the residents who lived in the designated centre. In an effort to minimise movement as a result of the COVID 19 pandemic, the inspector was located in the staff office during the inspection.

The inspector was introduced to the residents on their return to the designated centre around lunchtime on the day of the inspection. The staff team had outlined at the beginning of the inspection that some residents communicated without words or with limited words. The residents were curious about the presence of the inspector. The staff team had developed a social story in the days prior to the inspection to help assist residents understanding of why the inspector was in the centre. Both residents came into the staff office and acknowledged the inspector. The staff team outlined how both residents had enjoyed a drive to a local scenic area where they were able to walk around enjoying in the bright sunshine as the area was not too busy. One resident was observed to have put on their slippers on return to the centre, which was their usual routine. Both residents were supported to have their lunch by staff who were familiar with their assessed needs and preferences. The inspector did not get to meet the third resident on their return to the centre as they chose to go straight to their own apartment to have their lunch and continue with their routine with staff support.

The inspector was informed that two other residents had gone for a long drive to west Cork on the day of the inspection and had plans to dine out for their lunch following the recent lifting of the government restrictions. While the inspector did not get to meet these residents on the day staff outlined how the availability of an additional transport vehicle for the designated centre facilitated the residents being supported to engage in activities more frequently away from the centre. One staff informed the inspector that the residents were supported to go out twice daily with transport if they chose to.

The inspector observed a number of interactions between staff members and the residents which were respectful in nature. It was evident residents were familiar with the staff supporting them. Staff were also aware of the individual preferences and routines of each of the residents.

Capacity and capability

This risk based inspection was undertaken to provide assurance that actions

identified during the last inspection in September 2018 had been completed. Overall, there was evidence of a competent service and workforce that responded to the identified needs of the residents. Effective leadership arrangements were in place to ensure good management and oversight so that residents were in receipt of a person-centred and meaningful service. In addition, there was evidence of good auditing which included an external financial audit of residents' personal finances, the provider had contracted an external agency to complete this. Issues identified during the audit in this designated centre had been rectified.

The inspector was aware prior to this inspection, that the remit of the person in charge had increased since the last inspection. At the time of this inspection, the person in charge, who worked full time had a remit over six designated centres. However, the inspector was informed during the inspection that the provider had advanced plans to reduce that remit by one designated centre with the appointment of additional roles within the organisation. The person in charge had ensured they maintained effective governance and administration over this designated centre. They were supported in their role by a social care team leader. This person was responsible for ensuring among other responsibilities that there was an accurate staff rota in place and had completed the supervision of all the staff team for 2020 apart from one person who was scheduled to complete their supervision in the weeks after this inspection.

Following a review of the staff rota there was evidence that the skill mix and number of staff supported the assessed needs of the residents. The staff team were flexible in responding to the changing needs of residents. In addition, the provider had supported the staff and residents with additional staffing resources during recent months when one resident required palliative care in the designated centre. Also, there were no staff vacancies on the day of inspection and the continued low staff turnover supported the continuity of care provided to the residents.

The provider had a system to ensure a comprehensive training programme was in place for staff working in the designated centre. Staff were supported to complete training on-line where possible such as infection prevention and control training. Training in relation to COVID-19 had been completed by all staff working in the designated centre. The provider was actively progressing with ways to implement the safe return of face–to–face training while adhering to public health guidelines. Refresher training had been scheduled in advance of expiry for some staff. While 18% of staff required refresher training in managing behaviours that challenge at the time of this inspection, the expiry of their previous training had only occurred during the pandemic restrictions and the person in charge had scheduled some of these staff to attend training in the weeks following this inspection.

The inspector reviewed the complaints log for the designated centre. Staff had advocated on behalf of residents for the provision of a second transport vehicle in October 2019. This matter had been escalated and actioned by the provider resulting in the documentation of the satisfaction of the complainants in March 2020 when the second vehicle became available. The inspector was informed of the many compliments that family representatives regularly submitted to the designated centre regarding the care and support their relatives consistently received. These

compliments had been stored away at the time of the inspection so were not available for review. However, one family representative did phone the centre during the inspection and spoke with the social care leader. They wished to express their heartfelt thanks to the entire staff team who had supported their relative and the family for many years and more recently during and after the expected death of their relative in the designated centre.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed and they held the necessary skills and qualification to carry out the role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the number, skill mix and qualifications of staff was appropriate to the number and assessed needs of the residents in the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had systems in place to ensure that the centre was adequately resourced, the quality and safety of care delivered to residents was regularly monitored.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It reflected the services and facilities provided at the centre and contained all the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that the Chief Inspector was notified in writing of adverse events as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were supported to make a complaint and the provider had ensured that all received complaints were recorded and investigated.

Judgment: Compliant

Quality and safety

The inspector reviewed the quality and safety of the care and supports provided to residents living in the designated centre and found improvements had been made since the last inspection. All actions from the previous inspection in September 2018 had been addressed. There was evidence of progress and ongoing review to ensure the assessed needs of residents were being met. The focus of care was person-centred and specific to the identified needs of the residents.

Personal care plans were in place and reflected clear information about residents. The plans reviewed by the inspector showed evidence that the goals identified were meaningful and had been developed with involvement of the resident and their family. There was evidence of regular multi-disciplinary reviews and regular updates

to reflect residents' changing needs and circumstances. Some goals could not be achieved due to the lockdown restrictions, such as going on holidays. However, there was documented evidence of goals being re-adjusted and reviewed in light of the current situation; for example, one resident was able to go to an adapted chalet for a mini break which supported them to achieve one of their readjusted goals while adhering to public health guidelines. The staff team ensured all measures were in place to support this resident including access to a transport vehicle to support their return to the designated centre at any time if they wished. Staff outlined the importance of maintaining this activity for the resident to assist in coping with anxieties around change in routines or planned activities.

The provider had also ensured residents participated in meaningful activities during the lockdown period. The designated centre had been given an activity resource pack from the occupational therapy department to assist with this. Five of the residents had been supported with an integrated day service in the designated centre prior to COVID-19 and this had continued during the government restrictions. In addition, staff focused on supporting residents to continue to engage in activities to promote their physical fitness and well being such as walks in non-crowded areas, for example, beaches and amenity areas. The provision of a second transport vehicle facilitated the staff team to be able to support regular activities away from the centre in small groups or to support individual interests of the residents.

Residents' healthcare needs were well met in the designated centre. Residents had regular access to a general practitioner, GP, who completed a scheduled visit during the inspection. Residents were supported to attend allied health care professionals and specialists as required. For example, one resident was being supported to attend hospital for a planned day procedure. They had been supported with information in easy to read documents regarding the requirement to take swabs for COVID 19 on the afternoon of the inspection. The GP had assisted the staff team to liaise with the consultant teams in the hospital to ensure the resident was supported as per their assessed needs during this hospital procedure scheduled for a few days after the inspection. The inspector was also informed of how the staff team facilitated residents to spend time with a very ill peer in recent months and supported them to deal with any issues that arose during that difficult time. Staff were of the opinion that this helped some of the residents to cope with the loss of their friend of many years. Also, the staff team supported the family to spend time in the designated centre while adhering to public health guidelines and ensuring the safety of the other residents. Staff created an area for the family to access and supported residents to go out on activities as much as possible. The environment was cleaned thoroughly after family members had left the area to reduce the possible risks to other residents in the designated centre.

The inspector was informed all safeguarding plans had been reviewed and closed as per the provider's procedures. Proactive and response based protocols were in place to support the residents' behavioural profiles, such as seating arrangements on transport vehicles. These were regularly reviewed through individual and centre specific risk registers. The staff team had successfully reduced the level and number of restrictive practices in use in the designated centre since the previous inspection, with evidence of ongoing review to continue to reduce or eliminate practices where

possible. Risk assessments had been completed to facilitate home visits for individuals who were assessed as requiring them to support their assessed needs during the pandemic.

The provider had measures in place to ensure that all residents were protected from potential sources of infection. The designated centre had a regular routine and record log of additional cleaning applied to regularly touched areas. During the inspection, the inspector reviewed the template used in the designated centre for staff to complete when cleaning regularly touched areas and equipment. It was discussed with the person in charge and social care leader that the thermometer used daily by staff reporting for duty at the start of their shift and all persons entering the building was not on this checklist at the time of the inspection. Cleaning checklists had documented evidence of being completed by staff but the consistency of this being done as documented was not evident in the records reviewed. Staff had undertaken training in areas of hand hygiene and the use of personal protective equipment, PPE. A COVID-19 folder was available in the designated centre with updated information and guidance. In addition, all staff were supported to raise any concerns through a dedicated email address set up by the provider and monitored by the COVID -19 oversight committee.

The provider had fire systems in place in the designated centre including a fire alarm system, emergency lighting and fire extinguishers; with such equipment being serviced at regular intervals. Fire exits were observed to be unobstructed on the day of the inspection, while fire evacuation procedures were also on display in easy-to-read format. Personal emergency egress plans, PEEPs were in place for all residents which were subject to regular review. The PEEPs also included details of actions required to be taken by staff to support evacuation of residents without causing anxiety. Regular fire drills were completed, including a minimal staffing drill with details of issues arising discussed at staff meetings. Centre specific risks relating to fire were under regular review with fire assessments being completed. The role of fire warden was identified as the responsibility of one staff member who ensured that fire training was completed by all staff and conducted the weekly fire checks. However, when this person was not on duty or on annual leave the weekly checks had not been completed. This was discussed with the social care leader and person in charge during the inspection.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to maintain regular contact with family members during the pandemic restrictions in line with public health guidelines.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had policies and procedures in place relating to risk management which included COVID-19 and a process for escalating risk where required. Detailed individual and centre wide risk assessments were in place with evidence of regular review.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had ensured that residents who may be at risk of a healthcare infection (including COVID-19), were protected by adopting procedures consistent with those set out by guidance issued by the health protection and surveillance centre. However, not all checks had been completed as per the frequency outlined on documents reviewed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured arrangements were in place for the detection, containment and extinguishing of fires. However, weekly fire safety checks were not always completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment by an appropriate health care professional of the health, personal and social care needs of residents was carried out.

Judgment: Compliant

Regulation 6: Health care

The health and well-being of the residents was promoted in the designated centre. Staff demonstrated a good knowledge of the residents' health care needs and how to support them.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had positive behaviour support plans to guide staff practice and to promote positive behaviour amongst residents. This ensured consistency in the care and support given to residents.

Judgment: Compliant

Regulation 8: Protection

Residents were protected from the risk of abuse, all staff had received up-to-date training on the safeguarding of residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider ensured residents personal rights were supported.

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 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially 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 No 4 Seaholly OSV-0004573

Inspection ID: MON-0031299

Date of inspection: 02/12/2020

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 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The PIC has ensured that the Team leader will review the recording of infection control measures in the Centre in accordance with Provider guidance and that these will reviewed by the Person in Charge on a weekly basis.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: In addition to the existing fire training for staff and the role of the fire Warden, to comply with the Provider systems, the Person in Charge has ensured that weekly fire checks are now carried out on a specific day in the week by the senior staff on duty on that day. This will ensure that there are no gaps in the monitoring of safety measures and fire risks in the Centre.	

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 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	09/12/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	09/12/2020