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:	Unannounced
Date of inspection:	04 April 2022
Centre ID:	OSV-0004573
Fieldwork ID:	MON-0036566

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 4 April 2022	09:20hrs to 16:45hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed for No.4 Seaholly to monitor compliance with the Health Act 2007. The inspector was greeted by the social care leader on arrival at the centre. A brief conversation was held with the social care leader and the person in charge in relation to the current status of the centre. This included the well being of the five residents currently residing in the centre.

The inspector had the opportunity to meet and interact with members of the governance team appointed to the centre. The person in charge had a good awareness of the support needs of the residents in the centre and of their regulatory responsibilities. There was evidence of clear communication with the governance team to ensure areas requiring improvements were addressed. Some improvements were required in the monitoring of systems. This included in such areas as medication management.

The inspection was completed during the COVID pandemic with the inspector adhering to infection prevention and control measures such as social distancing, hand sanitisation and the use of face masks throughout the inspection. Staff were observed adhering to local and national guidance including donning and doffing of personal protective equipment (PPE) and hand sanitising. Residents were observed to be encouraged to participate in hand hygiene throughout the day.

The centre was a hive of activity throughout the day with residents coming and going in their activities. Resident's activities were built around their likes and interests with one resident planning their overnight trip away. Some residents were supported to attend their day service. One resident told the inspector on their return that they had a good day and were happy.

Interactions between staff and residents were observed to respectful and jovial in nature. Residents appeared comfortable in the company of the staff team and the members of the governance team present. When staff spoke of residents they did so in a respectful manner being mindful of the resident's dignity.

The governance team allocated to the centre had a keen awareness to the needs of the residents in the centre and were aware of a number of non-compliances which were required to be addressed. This included the premises. Some work had been completed to date with the shared area of the centre being warm and homely with photographs of the residents participating in activities on display. One self-contained living area did require attention. This had been identified by the provider and an improvement plan was in place to ensure all work required was completed. This area was decorated in a minimalistic manner in accordance with the residents assessed needs.

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 designated centre. This will include areas requiring improvement including the management of medicinal products.

Capacity and capability

The inspector reviewed the capacity and capability of the service provided to residents within No. 4 Seaholly. Overall, a good level of compliance was evidenced. Some areas of improvement were required in the areas of medication management and restrictive practices to ensure residents were supported to lead a meaningful and safe life.

The registered provider had appointed a clear governance structure to the centre and with clear lines of accountability and responsibilities. The person in charge was suitably qualified and experienced to fulfil their governance role. They held responsibility in a number of centres under the remit of the register provider. The person in charge was supported in their role within this centre by an appointed social care leader whom held a number of delegated duties.

A number of regulatory required duties were completed and overseen by the person in charge and social care leader, including the supervision of the staff team in accordance with the organisational policy. This was completed through formal supervisory meetings, annual appraisals and regular staff meetings. The registered provider had ensured a suitably qualified and experienced staff team was allocated to the centre. Staff spoken with were very aware of the support needs of the residents currently residing in the centre.

The provider had in place a complaints policy and all complaints were well documented in a complaints log, which was up-to-date. How to make a complaint was displayed, in an easy to read format, in the designated centre. Details on how to contact a confidential recipient were also on display. The information was clear on how an appeals process could be accessed. It was evidence through review of closed completed complaints that the staff team advocated for residents and submitted complaints on their behalf.

A number of centre specific monitoring systems were also implemented. These included infection control, personal plan audits and health and safety audits. Some improvements were required to ensure all monitoring systems were utilised to identify and address areas requiring improvement. For example, the use of restrictive practices and safe practices relating to medical products.

Six monthly unannounced visits to the centre and the annual review of the service provision were undertaken by a delegated person and areas for improvement were identified. The most recent six monthly audit had been completed in October 2021.

The annual review had been undertaken in February 2022 with the report available for review following this. Overall a comprehensive review of the quality and safety of care and support in the designated centre was demonstrated. As part of the annual review, residents and families were communicated with to address any concerns or areas which they felt required improvement. Overall, the feedback received from families was positive.

Improvements plans were in place to ensure areas of non compliance identified were addressed. This included such areas as premises works which highlighted the need for this to be addressed in a timely manner.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured sufficient staffing was allocated to the centre. A core staff team was in place to promote continuity in supports.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure had been appointed to the centre. The registered provider had ensured the implementation of the annual review of service provision and a six monthly unannounced visit to the centre. Where actions had been identified these were not always addressed in a timely manner given the time between the review and the report.

Centre specific monitoring tools and checklists were completed to maintain daily oversight of operations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensured the development review of the statement of purpose including the information required under Schedule 1. However, some minor requirements were required in areas to ensure this document reflected the current function of the centre including the age range of residents and the governance structure in place.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had ensured an effective complaints procedure was in place, including accessible information for residents and an organisational policy.

Judgment: Compliant

Quality and safety

No. 4 Seaholly presented as a warm and homely centre based on a large campus on the outskirts of a city. Residents' were supported to have their bedrooms decorated in an individualised manner. Two buildings consisted of two self-contained living areas and the communal areas currently shared by three residents. The registered provider had self-identified the need to complete building work within the centre. This included new flooring in some areas and repair to damaged fittings. A plan of works was in place to address this. Completion of this work was required to ensure the area was in a good state of repair both internally and externally.

It was evidenced during this inspection that the service provided to residents currently residing in No. 4 Seaholly was person centred in nature. Residents were consulted in the day to day operation of the centre and in all areas of their daily life. Residents were observed interacting with staff in a positive and jovial manner. Residents were observed to be supported in the area of activation and meaningful activities within the house, on campus and within the wider community. On the day of the inspection one resident was planning an overnight trip away. From review of documentation it was evident that community socialisation was promoted for each resident.

Each resident had been supported to develop and review an individualised personal plan. These plans were found to be comprehensive and incorporated a range of support needs of residents including the areas of health care and social supports.

These plans incorporated a holistic approach to support needs and incorporated guidance from relevant members of the multi-disciplinary team.

The person in charge had not ensured effective and safe measures were in place for the ordering, receipt, storage, disposal and administration of medications. Where a resident's medication was reviewed the date of the review was not consistently clear on the kardex with some dated over 12 months, and required (PRN) emergency medications guidance did not consistently correspond to PRN plans in place. Where guidance was in place relating to the side effects this did not correspond to the medications in use. This required review.

The registered provider ensured that each resident was assisted and supported to develop knowledge and self-awareness required for keeping safe. Where a concern arose the registered provider ensured effective measures were in place to investigate and address this including consultation with residents and external agencies. Staff spoken with were aware of the procedures to adhere to should a concern arise.

The registered provider had ensured measures were in place to promote the safety of residents. This included the ongoing identification and review of risks within the centre and a planned response for emergencies. Each resident had relevant individual risk assessments in place to identify personal risk and ensure effective control measures were in place to minimise the impact of the risk. Some risks identified for individuals required to be documented and reviewed as such. This included one resident being afforded time alone in their living space.

The registered provider had ensured that effective fire safety management systems were in place. All residents spoken with could clearly articulate the evacuation procedures which corresponded to the fire evacuation plan and personal emergency evacuation plan in place. Fire evacuation drills were completed on a regular basis. However, documentation of these drills did not record the scenario of the drill and if additional supports set out in personal emergency evacuation drills were utilised and effective.

Regulation 13: General welfare and development

Residents were observed interacting with staff in a positive and jovial manner. Residents were observed to be supported in the area of activation and meaningful activities within the house, on campus and within the wider community.

Judgment: Compliant

Regulation 17: Premises

The centre presented as warm and homely with the residents observed to comfortable in their environment. Internal building works were ongoing and being completed to ensure the property was in a state of good repair both internally and externally. Completion of this work was required to ensure the area was in a good state of repair both internally and externally.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider ensured that there was a risk management policy in place. Effective systems were in place for the assessment, management and ongoing review of centre specific risk, including a system for responding to emergencies.

Some risks identified for individuals required to be documented and reviewed as such.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had ensured that procedures consistent with those set out by guidance issued by the Health Protection and Surveillance Centre were in place. The centre presented as clean and with a cleaning schedule in place to maintain this level of cleanliness at all times.

Staff were observed adhering to national and organisational guidance with respect to COVID 19 including the use of facemasks and social distancing. Audits in the areas of infection prevention and control were completed.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems were in place. All residents spoken with could clearly articulate the evacuation procedures which corresponded to the fire evacuation plan and personal emergency evacuation plan in place. Documentation of fire evacuation drills did not record the scenario of the drill and if additional supports set out in personal emergency evacuation drills were utilised and effective.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured effective and safe measures were in place for the ordering, receipt, storage, disposal and administration of medications. For example:

- Guidance on the administration of emergency medication did not correspondence PRN protocols in place.
- PRN protocols did not correctly identify what to do should a medication not work effectively.
- Review date of daily medications not clear on medication kardex.
- Guidance of side effects of medications was not clear and consistent.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were assessed and support plans were in place with each resident being supported to have a comprehensive personal plan in place. All reviews of each residents personal plan incorporated guidance and recommendations from members fo the multi disciplinary team.

Individual personal preferences were taken into account and respected in the development and review of personal plans.

Judgment: Compliant

Regulation 8: Protection

The inspector observed on the day of inspection that there were systems in place to ensure residents were protected from harm. All staff spoken with were clear on the process to follow and the governance team were actively addressing any areas of concern.

Following an incident staff and management had implemented measures to promote the safety of residents, this included multi disciplinary input, staff training and resident awareness.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to make choices and decisions in their home which were listened to with regard to activities and personal goals. The registered provider ensured that each resident's privacy and dignity was respected at all times.

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 (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 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No 4 Seaholly OSV-0004573

Inspection ID: MON-0036566

Date of inspection: 04/04/2022

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: The Provider will ensure that all actions arising from internal monitoring systems, including Provider 6 monthly visits and Annual Review of the Centre, are actioned on a timely basis The Provider will ensure that the restrictive practice log will be reviewed and updated to ensure all restrictions are recorded and reviewed to support residents to lead meaningful and safe lives. [01/07/2022]. A medication audit will be carried out to review practices to ensure compliance with Providers system. [30/06/2022]	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The registered provider will review the age range in the statement of purpose at the next scheduled review of the statement of purpose [30/06/2022]	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider has an improvement plan in place for the Centre, these planned works are reviewed and updated on a six monthly basis. Works commenced on painting in the Centre [14/05/2022] and were completed on 28/05/2022. The main bathroom was upgraded and competed on [17/06/2022].	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Provider will ensure that the Risk Register in the Centre identifies all risks including those identified for individuals. A review of all risk in the Centre will be carried out by the Person in Charge with the staff Team and all risk assessments underpinning the risk register will be reviewed and updated [31/07/2022]	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider will ensure that the documentation for all fire drills identifies the scenario assumed for the fire outbreak, the additional supports called upon and the effectiveness of the drill that may require update of the Personal Emergency Evacuation Plans for the residents in the Centre.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Person in Charge will ensure that the 1. PRN protocols are reviewed to ensure they are in line with the Kardex [04/04/2022]. 2. All PRN protocols will be reviewed to ensure there is guidance on what to do should a treatment not work [15/07/2022] 3. There is a system in place to ensure that recent reviews of the Kardex is readily available in line	

with the start date of the medication [11/04/2022]. 3. An up to date booklet is in place that identifies medication and its side effects will be available in the centre [30/06/2022]

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)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	17/06/2022
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	17/06/2022
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	Substantially Compliant	Yellow	01/07/2022

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/07/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/07/2022
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	Not Compliant	Orange	15/07/2022

	medicine that is kept in the designated centre is stored securely.			
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	30/06/2022