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:	The Elms
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	10 August 2021
Centre ID:	OSV-0004877
Fieldwork ID:	MON-0033186

About the designated centre

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

In this centre, a residential service is provided for a maximum of seven residents over the age of 18 years. The service provided responds to individual requirements with some residents availing of a less than full-time service. The centre is comprised of three separate premises, two of which are located in the suburbs of the main town and, one in a village approximately 15 kilometres from the main town. Two residents live in two of these houses. One house has an additional apartment attached where one resident resides and, two residents live in the main house. Each premises provides residents with access to their own bedroom, some en-suite facilities, shared bathrooms, sitting rooms, kitchen, dining areas, and, rear and front gardens. The model of care is social and staff are on duty both day and night to support the residents who live in this service. Management and oversight of the day to day operation of the service is undertaken by the person in charge supported by nominated social care leaders.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 10 August 2021	10:00hrs to 18:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to follow-up on the findings of the last HIQA (Health Information and Quality Authority) inspection undertaken in July 2020 and, to provide evidence to inform the decision making process further to the provider's application seeking renewal of the registration of this centre. The inspection findings were not satisfactory with much improvement needed in the governance and management arrangements of the centre, in the process for identifying and managing risks, in the use and oversight of restrictive practices, in providing a premises that was suited to the assessed needs of the residents and, ensuring there were safe and effective fire safety arrangements. While some improvement was noted in specific areas, these inspection findings did not reflect the transfer of learning or, improved effective oversight across the centre in its entirety. For example, the findings in relation to the use of restrictive practices and fire safety were recurring findings. It was evident that the provider aimed to provide residents with a good service and, to keep to them safe from harm. However, the failings in it's systems and, the failure to satisfactorily identify and address them, impacted negatively on the quality and safety of the service provided to residents.

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. The inspector was based in one house, the house where three residents resided and, was allocated the staff office for the day. This arrangement meant that the inspector could reconcile records with practice, meet at intervals with staff and management and, with the two residents in the house. As stated above when describing the designating centre, seven residents live in the centre, two residents were at home on holidays with family including one of the residents from this house.

One resident had just returned from home but was clearly very happy to be back in the centre. The resident smiled broadly throughout the day, confirmed that they were out in the morning with staff, went to the bank and, then had lunch outdoors. Newly recruited staff came on duty in the evening and, the inspector saw that the resident was very comfortable with the staff and, quite happy to be in their company. The staffing levels were as described and, it was evident that when planning the rota, consistency and familiarity of staff to residents was considered. However, weaknesses in the provider's risk management systems did not provide the required assurance that staffing levels and arrangements were always suited to the assessed needs of the residents. For example, there was a recommendation for one-to-one staff support as part of the falls prevention plan but this level of support was only partially in place. While there were controls (two alarms to alert staff), there was no risk assessment for the periods of time that the resident in the apartment was unsupervised. The weaknesses and inconsistencies in the process of risk management and, the impact on the quality and safety of the service is a recurring theme in this report.

The second resident did not interact directly with the inspector but facilitated and

tolerated the presence of the inspector in their apartment for a short period of time. Staff demonstrated to the inspector the communication application they used to offer the resident a choice of activities and routines. Staff said that the resident engaged with the process. The resident left shortly afterwards with staff to go to the local shop, an activity that was a very important part of their daily routine. The inspector noted that both the resident and staff were wearing a face mask as they left.

Over the course of both HIQA inspections the inspector has met with four of the seven residents living in this centre. The inspector saw that feedback from all seven residents was reflected in the providers' annual review of the service completed in early 2021. Overall, the feedback was very positive but residents did identify areas or particular things that they wanted, for example a request for a polytunnel and, for more space. However, how this feedback was integrated in to the overall findings of the review and action plan was not clear. In addition, the person in charge confirmed that the sheltered outdoor space requested by residents at the time of the last inspection was not yet in place.

There was a good response from representatives to the provider's request for feedback with six of seven representatives noted to have provided feedback. This feedback was also very positive with the service rated as excellent by five respondents and good by one. Representatives visited the house on the day of inspection. This was a planned visit and staff had described to the inspector how the visits could be challenging at times. The inspector discreetly observed that the visit in the garden was going well. The inspector made the decision not to interrupt the dynamic of the visit for the resident and their family.

The initial observations of the inspector were that this house did not promote accessibility and, the inspection findings would establish that it was not suited to the assessed mobility needs of one resident. There were steps at the main entrance and at the rear door to the garden and, steps internally where there were different floor levels. Access to the main stairwell was restricted by a recently introduced stair-gate as it was unsafe for a resident to use the stairs unsupervised; the resident's en-suite bedroom was on the first-floor. The provider was exploring plans to redevelop an area of the ground floor for the resident as, despite its unsuitability and its overall need for upgrade, the resident saw this house as home and, had expressed a wish to remain living in the house.

However, the inspector found that while some risks, such as this risk for falls were identified, others were not. There was also inconsistency when reviewing risks, when implementing controls to reduce the risk and, in the oversight of the effectiveness of these controls and their impact on residual risk ratings. For example, despite the assessed risk for falls and the risk of falls on the stairs, there was no restriction of the stairs at first floor level and, no device to alert staff to a possible fall in the first floor bedroom. Furthermore, while the provider has processes for identifying, sanctioning and reviewing the use of controls that had a restrictive dimension, no process or system of oversight including daily oversight, had identified the fact that, the single-occupancy apartment was a fully secured area at night. Staff confirmed that the door between the main house and the apartment

was latched and, the key removed at night.

In general, because of the deficits in risk management the rationale for practice such as this was inadequately justified and, while there clearly were risks that needed to be managed, proportionality, rationale and purposeful use of restrictions was poorly demonstrated. Restrictions (the locking of doors) increased at times, for example, if new staff were providing support as this was reported to increase the risk of the resident leaving the apartment quickly and spontaneously. Records seen by the inspector demonstrated that there had been a serious incident in the community in early 2021 that seriously challenged staff as they acted to keep the resident safe from imminent danger. The incident was reviewed and plans and protocols were revised, but the fundamental risk assessments were a confusing mix of risk and controls. Neither risk assessment (there were two one for the community and one for the apartment) set out the pivotal requirement for familiar and experienced staff support in the community, given that it had been identified by the provider that new staff acted as a trigger for this risk behaviour.

The apartment itself presented as quite a confined and restricted space. All rooms in the apartment (bedroom, bathroom and living space) led off the main kitchen-dining area, the living area with television and couch also served as an office for staff. The resident was seen to access and stand in the garden during the day but this was a shared space for all residents and, staff reported divergent resident needs. There was nothing of a sensory or therapeutic nature in the garden itself. Staff described how the resident liked to stand in the garden and listen to the sound of the glass breaking in a nearby bottle bank so clearly there was potential for sensory and purposeful development.

Again, despite internal systems of review, there was much scope for improvement in the providers' fire safety arrangements. A fire safety review had been completed in March 2020 and, an audit of the simulated drills undertaken in 2020 had also been completed. These reviews either did not identify the deficits identified by this HIQA inspection or, did not bring about the improvement needed where scope for improvement had been identified. For example, this HIQA inspection found that there was a significant number of final exits that had key-operated locks and each lock required a different key. This included the apartment where the bedroom was an inner bedroom though this had been considered by the provider and, an exit door was provided from the bedroom itself. Simulated drills did not satisfactorily demonstrate that all three residents could be safely and effectively evacuated by one staff on sleepover duty which was the usual night-time staffing level.

There were some similarities between these HIQA inspection findings and, the findings of the provider's own internal reviews of the service. For example, seven of the 17 actions that issued from the most recent internal review related to risk management and fire safety. However, the findings of internal reviews, of this and the previous HIQA inspection, did not reflect a service that was governed and overseen in a way that achieved and sustained improvement. The inspection findings did not reflect governance and management that ensured, assured and, maximised the consistency, quality, safety and, evidence base of the support and

service provided to residents.

The next two sections of the report will expand on 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.

Capacity and capability

As discussed in the previous section of this report, the findings of this HIQA inspection, did not reflect governance and management at a level that ensured, assured and maximised the provision of a consistently safe and, quality service. There was some improvement noted in that specific matters that arose on the last inspection had been addressed. However, it was not evidenced how the learning from this was used to inform further and continuous improvement. For example, the last HIQA inspection found that improvement was needed in the use and oversight of restrictive practices. While there was evidence that particular matter had been addressed, the learning from this was not evident in the use and oversight of restrictive practices in this house. Governance deficits and inconsistency impacted on and, limited the quality and safety of the service but also meant that the provider did not demonstrate an improved and satisfactory level of compliance with the regulations. Much improvement was needed in management and oversight, in risk identification and management, in the reasonable and proportionate use of restrictive practices, in the provision of an environment that was safe and suited to the needs of residents but, also promoted their quality of life. Improvement was needed in fire safety arrangements. In addition, assurance was needed that staffing levels and arrangements were suited to the assessed needs and associated risks of the residents, and, the design and layout of the house.

It was evident that there were systems of management and oversight. For example, the person in charge spoke of unannounced spot-checks of specific areas and, the inspector saw audits completed of medicines management systems and, the review of incidents that occurred individually and collectively. Risks that were identified as of high risk were escalated to senior management. In addition, the provider was completing both the annual review and the six-monthly unannounced reviews of the service required by the regulations. However, these reviews, their findings and, the corrective actions taken did not, based on these HIQA inspection findings, result in a service where resident safety and quality of life was robustly assured by robust risk management and, consistent and effective oversight. Internal reviews and systems of oversight including day to day practical oversight, did not identify many of the failings and deficits identified by this HIQA inspection. The many examples of this have been discussed in the opening section of this report and will be discussed again in the next section of this report when the impact on quality and safety is explored.

Because of the deficits in risk identification and management and, in fire safety, assurance was needed that staffing levels and arrangements were suited to the assessed needs of the residents, the associated risks, the number of residents and, the overall design and layout of the house. The occupancy of the house fluctuated as two of the three residents availed of a less than full-time service. However, there were periods each week when all three residents were present and, there was only one staff on duty to provide support and supervision in both the main house and, the apartment. There was a recommendation based on clinical review that one to one staff was needed as part of the falls prevention programme, but this was only partially in place. The safety and suitability of the night-time sleepover staff arrangement needed to be risk assessed as did the proposed move of the staff sleepover room to the first floor, an arrangement that would remove it further from the annexed apartment. The staff support needed to ensure safe community access required a robust re-assessment of risk to ensure that if it was deemed safe for one staff member to do this, it was an experienced and familiar staff member.

The staff rota did demonstrate that the allocation of staff sought to promote consistency for residents. There was a period of induction for newly recruited staff. The inspector was advised that staff supervisions were on schedule. The inspector reviewed the staff training records for this particular house and saw that all staff had completed their mandatory, required and desired training. Training for new staff was substantially complete and, what was outstanding was scheduled.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was appointed to the role in the weeks prior to this inspection. The person in charge had the required skills, qualifications and experience. The person in charge was aware of the need for improvement and, understood the failings identified by this inspection.

Judgment: Compliant

Regulation 15: Staffing

Because of the deficits in risk identification and management and, fire safety identified by this inspection, it was not adequately demonstrated that staffing levels and arrangements were suited at all times to the assessed needs of the residents, the associated risks, the number of residents and, the overall design and layout of the house.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Based on the inspector's review of staff training records, staff working in this house had completed mandatory, required and desired training.

Judgment: Compliant

Regulation 23: Governance and management

The findings of this and, the previous HIQA inspection, did not reflect governance and management at a level that ensured, assured and maximised the provision of a consistently safe and, quality service. Systems of review and oversight including day-to-day oversight, did not always identify deficits or where they did, the improvement made was partial and, learning was not expanded to improve and assure practice across all of the centre. This deficit and inconsistency in governance impacted on the quality and safety of the service provided but also meant that the provider did not achieve a satisfactory level of compliance with the regulations.

The inspector saw that feedback from all seven residents was reflected in the providers' annual review of the service completed in early 2021. Overall, the feedback was positive but residents did identify areas or particular things that they wanted to make life better. How, resident feedback was integrated in to the overall findings of the review and the action plan was not clear.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider submitted, with the application seeking renewal of registration, a statement of purpose that contained all of the information required. For example, details of the management arrangements and, how to make a complaint.

Judgment: Compliant

Regulation 31: Notification of incidents

The environmental restriction of the locked door between the main house and the apartment was not returned to HIQA in the written report provided each quarter. There were inconsistencies in the returns in relation to the parameters of use that would reflect the inconsistency noted on inspection.

Judgment: Not compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The provider gave notice to HIQA and, submitted the required supporting documentation when changes were made to the role of person in charge.

Judgment: Compliant

Quality and safety

There was clearly an objective to keep residents safe and well, connected to life in general, their community and, to family and friends. However, as discussed so far in this report deficits in management and oversight, in risk management, in fire safety, in the suitability of the premises, and, in the use and oversight of restrictive practices impacted negatively on the safety and quality of the service and, did not provide robust assurance that residents and staff were safe at all times.

For example, the provider itself had identified that the premises was not suited to the assessed needs of a resident who was at risk of falls including a risk for fall on the stairs. The resident's en-suite bedroom was on the first floor. The person in charge discussed the provider's plan that was at an initial stage to provide ground-floor accommodation for the resident. However, in general, the premises did not promote accessibility with steps at the main entrance and rear exit and, steps internally due to different floor levels. The inspector noted that grab-rails were provided. By day, staff said and, the inspector noted the resident had access to a very compact ground floor toilet. There was a step down to the toilet, general access was limited by items stored in the area and, its size was not conducive to staff assistance in the event of a fall. The annexed apartment presented as a compact and somewhat confined space in the context of the age and needs of the resident living in the apartment. For example, the living space also operated as an

office for staff. Residents in the main house and in the apartment had divergent needs but shared the rear garden space. There was nothing of a sensory or therapeutic nature provided in the garden.

The inspector saw that the premises was fitted with emergency lighting, a fire detection and alarm system, and, doors with self-closing devices designed to contain fire and its products. However, oversight of fire safety either did not identify deficits in the provider's fire safety arrangements, or, did not ensure timely resolution where deficits had been identified so as to improve fire safety. For example, on the day of inspection, three self-closing devices were not fully closing three fire doors. In addition, two doors with self-closing devices were manually held open with wedges. This practice was risk assessed but, it was unclear why the specific type of self-closing device was still in use given the stated preference of the resident for the doors to be open. There was a high level of residual manual locks operated by keys. The keys were hanging loosely rather than in a key-box and, a different key was required for each door. This created an additional risk particularly at night if staff had to access the apartment from the outside. An internal review completed in March 2020 had identified that works were required to protect the stairs which was the escape route from the first floor. This work was not complete and, on the day of inspection there was some storage of combustible materials underneath the stairs.

In addition, an internal review of the simulated drills completed in 2020 had identified that only two staff had participated in those drills with only one staff participating in a night-time drill. Drills completed to date in 2021 indicated that this was partially addressed. It was evident that therapeutic advice had been sought to ensure that all residents would evacuate. Staff described the prompts used and, they were also referenced in the individual evacuation plan. However, the records of simulated drills seen by the inspector did not provide assurance that the drills adequately tested the evacuation procedures. For example, there was no drill that accurately and adequately simulated the night time scenario of maximum occupancy, with residents upstairs and in the apartment, and one sleepover staff on duty. One record seen indicated that staff assisted a resident from the first floor to the ground floor living room and, then commenced and timed the evacuation. Despite the deficits identified internally and, by this HIQA inspection, the centre specific risk assessment for fire safety how a very low risk rating.

The person in charge was requested to arrange a review of the location of the gas storage tank in the garden to ensure it was sufficiently distanced from the annexed apartment and, from a possible rear evacuation route.

As previously referred to, high risks in the centre included a risk for falls. The personal plan included a mobility plan, a falls prevention plan and, staff utilised a post-falls assessment. In general, the personal plan reviewed reflected the assessed and changing needs of the resident and, the support and care to be provided in response. The plan was devised and reviewed in consultation with the resident, the resident's representatives who were an important part of their life, and, relevant healthcare professionals. For example, there was evidence that the care and support provided to residents was informed by clinical input from speech and language therapy, occupational therapy, psychiatry and, the general practitioner. The personal

plan reflected the impact on COVID-19 on residents' lives and the measures taken to mitigate the impact such as the facilitation of outdoor visits and, the use of technology to connect with peers. The plan included the plan for responding to behaviour of concern and risk. The plan was current and devised in consultation with the behaviour support team.

However, deficits in the process for managing risk limited the efficacy of the plan and the support provided and, did not provide sufficient assurance that risk was adequately managed so that the safety of residents and staff was maximised. There were many examples to support this finding. For example, as already discussed in relation to staffing and, in relation to the oversight of fire safety arrangements. In addition, in relation to preventing falls, there was a requirement for staff supervision on the stairs. There was reference to this, but no explicit evidence based risk assessed procedure, advised by an appropriate professional, that protected and maximised the safety of both the resident and staff on the stairs. This was of concern given the risk posed to resident and staff by an incident that occurred on the stairs in April 2021. The inspection findings also raised the issue of timeliness of response to risk. For example, records seen stated that access to the stairs was only restricted in June 2021. Access to the bottom of the stairs was restricted but not the top; the resident's bedroom was in close proximity to the top of the stairs. There was no falls prevention or movement device at first floor level to alert staff in particular sleepover staff to a possible fall. There was a recorded fall in the bedroom in July 2021.

There was an assessed high risk for a resident leaving the apartment without staff and, for leaving the company of staff while in the community. A reported identified trigger for this risk was new staff. However, the risk assessments in place were a confusion of risk and controls and, did not prioritise the fundamental requirement for support in the community from suitably experienced staff and, how this experience was defined by the provider. This should have been a fundamental finding and requirement in managing this risk and, in the learning from incidents. This was of concern given a very serious incident that had occurred in April 2021 particularly given that it was reported to the inspector that a new staff had been allocated to support the resident that day, a factor that was a known risk. There were two alarms in use in the apartment to alert staff at night but no risk assessment that assured the safety of the resident in the apartment at night in the context of it being a fully secured and unsupervised unit.

A further consequence of the deficits in risk management was a concerning inconsistency noted in recognising, using, rationalising the use or not, and reviewing the use of restrictive interventions. For example, as discussed above access to the bottom but not the top of the stairs was restricted. There was no device at first floor level to alert staff to a possible fall. The possibility of a therapeutic programme around laundry had not been considered as an alternative to locking the utility door. Day to day oversight of the service had not identified the securing and impact of the secured door between the main house and the apartment at night. Staff demonstrated to the inspector how the key was removed and the latch activated at night. This practice was not specified in any record pertaining to the use of

restrictive practices in the centre.

Regulation 10: Communication

Residents present with a diverse range of communication styles. In this house the inspector saw that staff were using a range of tools to support effective communication with and for residents. For example, staff used visual supports and a communication application to communicate the daily routines and choices. Residents had access to a range of media and, staff had supported residents to use these to counteract the impact of COVID-19 restrictions. The person in charge spoke of the interactive roles of communication and behaviour and, this is a theme that should continue to develop.

Judgment: Compliant

Regulation 11: Visits

Controls were implemented so that visits to the centre and to home could be safely facilitated in the context of COVID-19. The controls took account of developments such as the impact of vaccination.

Judgment: Compliant

Regulation 17: Premises

The provider itself had identified that the premises was not suited to the assessed needs of a resident who was at risk of falls including risk of a fall on the stairs. The resident's en-suite bedroom was on the first floor. In general, the premises did not promote accessibility with steps at the main entrance and rear exit and, steps internally due to different floor levels.The annexed apartment presented as a compact and somewhat confined space in the context of the age and needs of the resident living in the apartment. For example, the living space also operated as an office for staff. Residents in the main house and, in the apartment had divergent needs but shared the rear garden space. There was nothing of a sensory or therapeutic nature provided in the garden.

The request made by residents at the time of the last HIQA inspection for an outdoor recreational space was still outstanding.

Judgment: Not compliant

Regulation 26: Risk management procedures

Deficits in the process for managing risk limited the efficacy of the support provided and, did not provide sufficient assurance that risk was adequately managed so that the safety of residents and staff was robustly assured. There were many examples to support this finding. For example, as discussed in relation to staffing, the oversight of fire safety arrangements, falls prevention and, ensuring resident safety when accessing the community. The inspection findings also raised the issue of timeliness of response to risk.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had procedures that reduced the risk of the accidental introduction and, controlled the onward transmission of COVID-19. These procedures, plans and risk assessments were the subject of review and discussion, for example at team meetings.

Judgment: Compliant

Regulation 28: Fire precautions

Oversight of fire safety either did not identify deficits in the provider's fire safety arrangements, or, did not ensure timely resolution where deficits had been identified so as to improve fire safety. For example, there was a high level of residual manual locks operated by keys. The keys were hanging loosely rather than in a key-box and, a different key was required for each door. This created an additional risk particularly at night if staff had to access the apartment from the outside.

The records of simulated drills seen by the inspector did not provide assurance that these drills adequately tested the evacuation procedures. For example, there was no drill that accurately and adequately simulated the night time scenario of maximum occupancy, with residents upstairs and in the apartment and, one sleepover staff on duty.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plan was informed by the assessment of resident needs. The plan was the subject of review. The resident and their representatives had input into the support and care that was provided. Multi-disciplinary advice was sought and reflected in the plan. The provider did not however, have all of the arrangements needed to meet these assessed needs; this is addressed in the respective regulation such as the premises and, staffing.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being and ensured that residents had access to the care, services and, clinicians that they needed for their continued health and well-being.

Judgment: Compliant

Regulation 7: Positive behavioural support

Concerning inconsistency was noted in recognising, using, rationalising the use or not, and, reviewing the use of restrictive interventions. For example, as discussed above access to the bottom but not the top of the stairs was restricted. There was no device at first floor level to alert staff to a possible fall despite the fact there was a recent fall. The possibility of a therapeutic programme around laundry had not been considered as an alternative to locking the utility door. Day to day oversight of the service and of restrictive practices had not identified the securing of the door between the main house and the apartment as a restrictive practice that resulted in the apartment becoming a fully secure unit at night.

Judgment: Not compliant

Regulation 8: Protection

The provider had safeguarding policy and procedure. All staff including staff on induction had completed safeguarding training. Residents, in the internal questionnaires completed, had named specific staff and members of the management team that they would speak to if they had a concern or worry.

However, the inspector saw from the internal review of resident feedback, that four of the seven residents had not replied to the question as they whether they felt safe or not in the centre. While this was noted internally, it was not evident if the reason for this had been explored further. This was highlighted to the recently appointed person in charge who assured the inspector that there were no safeguarding concerns.

Judgment: Compliant

Regulation 9: Residents' rights

The feedback provided by residents to inform the annual review indicated that they were happy with the choice and control that they had in their daily lives. The provider's plan to modify the premises sought to facilitate the resident's request to continue living in this house which they saw as home. The inspector noted that residents had access to family and home, to their local community and community groups. The inspector saw that some restrictive practices were discussed with residents including residents impacted by their use but who did not need them, for example, the use of the stair-gate. However, the rights of residents with less capacity to participate and consent to decisions about their care, needed to be integral to the required review of all restrictive interventions in the centre.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not 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	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Elms OSV-0004877

Inspection ID: MON-0033186

Date of inspection: 10/08/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider will ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre by: • Staffing levels have been risk assessed in terms of the assessed needs of residents, the no. of residents, associated risks relating to the residents' and the design/ layout of the house. [Complete] Action Plan is in progress, as outlined below (under Regulation 26: Risk Management) relating to one residents' proposed move to another service area, to ensure his own, assessed needs are appropriately met and his safety and quality of life is supported and promoted with sufficient staffing levels. • Based on said residents' move, staffing levels in this service area would remain in place for the other 2 residents solely. [Complete]	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Failings in the governance and management systems within the designated centre will be addressed and remedied as follows: • A full, comprehensive risk register review is in progress in the first instance, to adequately identify the risks relating to the system failures to date; and to address them sufficiently (See below under Risk Management for further plan in relation to this action). [30/09/2021] • PIC will review residents' feedback from the 2020 annual review of the quality and safety of care and support in the designated centre; and review identified items requested to ensure these are followed up on and actioned in each respective service area. [30/09/2021] • Residents' meetings in each service area will focus on Safeguarding & Personal Safety, to ensure all residents understand the concept of feeling safe in their own home, and	

what this entails/ feels like, to ensure they can adequately communicate what they need to feel safe within their home. [30/11/2021]
• To ensure transfer of learning across the locations in the designated centre, the findings of all HIQA inspections, will be discussed with the SCW team leads from each service location within the designated centre in a SCW team meeting chaired by the PIC; and support teams (where relevant) at their next team meetings. This will ensure effective oversight and prevent recurring findings in future.
[30/09/2021]
• Recruitment is in progress to hire a new PIC, who will take on the role as PIC for the Elms once recruited, and appropriately inducted/ mentored into the role. The person recruited will be suitably skilled, experienced and qualified to fulfil the role.
In the interim, the current PIC will remain in the role and ensure the actions outlined in this compliance plan are completed as per the timelines advised. The PIC will ensure effective governance and oversight across the DC and will endeavour to improve the service provision to ensure best quality care and support for all residents.
[30/11/2021]
• The overall structure of the designated centre is under review; with the aim of re-structuring the designated centre into 2 separate designated centres due to the varying needs of residents in each service area and the geographic locations of the 3 services currently within the designated centre. An application to vary will be submitted to HIQA with respect to this change. [31/10/2021]
• The provider will at all times going forward, 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. The governance system will clearly identify the lines of authority and accountability, will specify the roles and detail the responsibilities for all areas of service provision.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The PIC will ensure that all restrictive interventions in use in the Elms, including physical, chemical or environmental restraint; will be notified to HIQA quarterly, as per regulatory requirements.
• The PIC will ensure that any adverse incident which would be within the parameter for a three-day notification will be reported to HIQA within the required time-frames.
• [31/10/2021]

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The registered provider will 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. This will be ensured as follows:
• Renovations to both the main house, and apartment in Mountain View are in progress:
• Scope of works for upgrading main house has been completed; this includes upgrade of 2 x bathrooms, re-flooring of first floor, painting, and fire safety measures including installation of cladding on stairs and replacement of 3 x regular doors upstairs to fire doors and one downstairs (hot press/ service doors/ utility room doors).

o E-tender process to commence 02/09/2021; to be completed by 16/09/2021.
o Plans in progress for alternative accommodation for residents in main house while works are carried out.
o Works expected to take 3 weeks.
[Completion Date: 30/11/2021]
• OT re-assessment has been carried out for the resident residing in the apartment in Mountain View. [Completed] Recommendations are in progress.
• Plans have been drawn up and approved for creating a sensory space for one resident in the back patio area. [31/10/2021]
This space has been discussed with the residents of the main house; whose needs and wishes are also being incorporated into the plans.
• In addition, the upgrade of bathroom in apt is being progressed, this upgrade will be staggered with above works being carried out to prevent disruption to residents.
• Residents have been consulted and have selected the chosen outdoor space. Sheltered outdoor space has been ordered and approved.
[28/02/2022]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
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. This will be ensured as follows:
A full, comprehensive risk register review for the service area inspected is in progress in the first instance, to adequately identify the risks relating to the system failures to date; and to address them sufficiently, as follows:
• Open, higher risks have been fully reviewed and comprehensively assessed, including: staffing levels, falls risk for one resident, absconding risk for one resident, outbreak of fire, risk of reduced supervision at night for one resident, living environment/ premises, level of restriction in one residents living environment, manual handling & people moving and governance & management of The Elms. The aforementioned risks have been actioned; and escalated where relevant and remain under regular review. [Complete]
• This review will include ensuring all hazards/ risks are appropriately identified and assessed, well managed/ controlled, and any additional controls required are identified and actioned in a timely manner. Risk ratings will reflect the actual level of risk identified.
• Monitoring/ Closed (lower) risks, will be fully reviewed and comprehensively assessed in the coming weeks to ensure existing controls are robust, and reduce the risk to residents/ staff within the centre.
[Overall completion date for this service areas' risk register review: 30/09/2021]

• Following the above risk register review which is noted by the provider to be a priority; the other two services within the DC will be subject to a full, comprehensive risk register review in turn.
[Completion Date: 31/10/2021]

One residents' falls risk and associated assessed need for 1:1 support will be actioned as follows:

• An alternative service location has been identified as a suitable home for this resident by the provider, which would provide said resident with the required 1:1 support as per his need/ level of risk. Said service location is fully accessible.
• Current discussions taking place with resident, family members, PIC & support team of alternative location to discuss suitability of resident transferring there.
• Compatibility assessments for residents are in progress.
• If deemed appropriate, and best suited to resident's needs, and wishes, and all parties are agreeable; this move will be guided by a transition plan taking into account the residents' needs and wishes.
• Variance of registration will be submitted to HIQA in advance of this proposed move to seek authorization to proceed.
[Completion Date: 30/03/2022]
Interim Measures put in place:
• Falls detection alarm system installed. [Completed – 25/08/2021]
• Stair-gate to be installed at top of stairs. [03/09/2021]
• Manual handling assessment to take place, to provide a specific procedure on how staff should support said resident on the stairs. This procedure will be included in the residents' falls management care plan thereafter. [30/09/2021]

One residents' risk of absconding will be actioned as follows:
• Risk assessment has been re-completed, incorporating a review of residents' BSP, and a full review of incidents from 2016-Present to assess triggers for incidents, and ensure all relevant controls are included in the risk assessment. [Complete]
• BSP and related crisis management plan will be reviewed and updated based on this review [30/09/2021]
• Residents' overall care and support needs will be assessed in full to assess if current living situation/ staffing levels are sufficient to not only meet his basic needs, but to ensure he is supported to have a great quality of life. [31/10/2021]

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
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. This will be ensured by:
• 3 x night-time fire drills have been carried out with minimum staffing and maximum residency; since the inspection. On all occasions, 1 staff member successfully evacuated 3 residents from their respective bedrooms/ apt. within a safe evacuation time.
• All remaining staff on the team who work sleepover shifts, will carry out a night-time fire drill in the coming weeks. [10/09/2021]
• PIC has reviewed fire drill records and provided guidance and advice to staff on appropriate reporting of fire drills, to ensure sufficient detail is recorded; and learning can be extracted and reviewed at team meetings. [Complete]
• All locks in the apartment have been risk assessed; and works are in progress as outlined below under 'Positive Behavioural Support'.
• All keys have been removed and safely stored in a key-box in the staff office. [Complete]
• Items stored beneath the stairs on the day of inspection have been removed. [Complete]

• 2 x automatic fire door closers in place on day of inspection (on doors which were manually wedged open) have been replaced with wired acoustic door closers. [Complete]
• 3 x fire doors & attached fire door closers, which were not closing fully on the day of inspection have been serviced and repaired by a competent professional [Complete].
• Cladding of stairs is currently being tendered, along with renovation works outlined under 'Premises'. [30/11/2021]
• Fire safety officer inspected the location of the gas storage tank, and has advised that the gas tank is sufficiently distanced from the annexed apartment. [Complete]
• The overall fire risk will remain under regular review until all above actions have been taken. It will then be further reviewed and re-assessed if resident proposed to transfer to another service does indeed transfer out of this designated centre, as risk relating to safe evacuation of residents would then significantly reduce. [30/11/2021]

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
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. The provider will also ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort will be made to identify and alleviate the cause of the resident's challenging behaviour. This will be ensured by:
• Immediate action taken following the HIQA inspection: Lock on door between kitchen and utility room is no longer in use; and is not locked at any point; as per risk assessment regarding level of restriction this resident is subject to. [Complete]
• All locks in the apartment have been risk assessed; and works are in progress to:
o replace the 2 x external door locks for entering the patio with thumb-turn locks to allow the resident free access of the patio area where he likes to spend time daily
o Replace the 2 x external door locks for entering the estate (kitchen and residents' bedroom), the front door entrance of the main house, and the padlock on the rear garden gate with one universal master key, which staff will carry on their person for ease of access in the event of an emergency evacuation being required.
o Replacement locks as outlined above have been ordered, and will be installed as soon as stock is available to lock-smith. [30/09/2021]

• A complete review of restrictive practices in place in the Elms has been carried out with multi-disciplinary input; taking into account the respective risk assessments in place to ensure an effective system of oversight and to ensure that restrictive practices in place are proportionate, purposeful and rationale for their use is clearly evidenced. This review has ensured restrictive practice protocols clearly outline the exact nature of use for each restrictive practice and take into consideration residents' rights. Restrictive practice protocols have been reviewed with the staff team at the last team meeting. [Complete]
• Replacement door between the kitchen and utility room of the main house has been ordered and is due installation as part of overall renovations works outlined under

'Premises'. [30/11/2021]

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.	Substantially Compliant	Yellow	06/09/2021
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.	Not Compliant	Orange	28/02/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	30/11/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/11/2021
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/10/2021
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.	Not Compliant	Orange	30/03/2022

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/11/2021
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.	Not Compliant	Orange	30/09/2021
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 procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/10/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures	Not Compliant	Orange	30/09/2021

	including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/09/2021