



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Carra Mor
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	16 September 2020
Centre ID:	OSV-0004887
Fieldwork ID:	MON-0030131

About the designated centre

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

Carra Mor centre provides full-time residential care and support to six older adults with an intellectual disability and additional health conditions. The care and support provided aims to meet residents' assessed needs while ensuring that they continue to enjoy a good quality of life. Carra Mor centre is located in a residential area of a large, busy town and within walking distance to local amenities such as shops and cafes and the providers main administration offices. Given the needs of residents, wheelchair accessible transport is provided. The premises is a purpose built bungalow-style house with its own well-maintained grounds. Six accessible bedrooms with attached en-suite facilities are provided; two residents share each en-suite facility. Residents also have access to a communal bathroom with a whirlpool type bath. Communal facilities include a kitchen/dining facility and sitting rooms. Residents also have access to garden facilities to the front and rear of the house. Given their assessed needs, residents are supported by a team of nursing, social care and support staff. At night-time, residents' care needs are supported by two staff, one on waking duty and one on sleepover duty.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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 16 September 2020	10:00hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID 19; residents given their age profile and assessed needs would be vulnerable to the impact of COVID 19. The inspector had the opportunity to meet with all of the six residents during the day and also had some opportunity to observe resident and staff interactions and the care and support that was provided. The use of a face mask by the inspector did not present as a barrier to engaging with residents who were all interested in and welcomed the inspector to their home. The individuality and holistic nature of the service was evident on arrival to the centre notwithstanding the relatively high physical and medical needs of the residents. The doors were open, the dog was watching attentively from the garden, some residents were enjoying a late breakfast while others were finished and were in their bedrooms getting ready for the day ahead. Nursing staff were attending to concerns arising from changing needs based on staff knowledge of residents and possible signs of ill-health. Residents were seen to be given independence and time to enjoy their breakfast but had support from staff as needed. Some residents were verbal communicators while others were not but all residents engaged and communicating effectively and seemed to enjoy having a visitor, albeit in the form of an inspector, to their home. Their interest, engagement and sense of humour was clearly communicated and reflected a group of residents that were well, comfortable and confident in their home.

After taking the dog for a short walk one resident invited the inspector to see their "mens' shed"; an outdoor recreational space where two residents supported by staff completed some furniture restoration and súgán chair making. One resident said that he found the work a little challenging now as his hand was not as flexible as it used to be. Both gentlemen left to enjoy an afternoon of fishing with a staff; the arrangements needed and preferences for the afternoon were heard to be discussed in an easy and equitable manner between residents and staff.

The remaining four and more dependent residents were seen to engage in a range of different plans supported by staff. Two residents visited the hairdresser; a resident went for a walk with staff; therapeutic foot spas and a range of table-top activities were provided. Staff described how a staff had applied transferable knowledge and skills to create puzzles suited to the needs and preferences of the residents. A resident discussed their enjoyment of a recent birthday and how they had been provided with their favoured chocolate cake. As the inspector left the centre residents supported by staff and joined by the dog were enjoying some refreshments and the late summer sunshine in the garden.

Capacity and capability

The observations described above, discussions with staff and records reviewed indicated that this was a good, person-centred service where residents received a good standard of care and support. However, this inspection also identified deficits in systems of management and oversight that had the potential to create risk and compromise the quality and safety of the service provided to residents. These deficits also raised some concern as to how the provider monitored and assured itself that the service provided was consistently appropriate to the number and assessed needs of the residents, was consistently safe and of the best possible quality. This finding is reflected in the level of non-compliance found with the relevant regulatory requirements.

For example while there was evidence of good staffing practices the evidence available to the inspector also indicated that staffing numbers were not always sufficient or reflective of the number and assessed needs of the residents. Good practice included a team of regular staff who were clearly familiar with and knowledgeable of each resident, their individuality, their needs and care. The staff skill-mix provided for nursing staff and while a full-time nursing presence was not maintained, staff spoken with were satisfied that the current allocated nurse complement was sufficient to meet residents needs. However, the review of staff rotas by the inspector demonstrated that while adequate staffing levels were generally provided for, day-time staffing numbers fluctuated and dropped at times, particularly at the weekend to two staff after 13:00hrs. Given the assessed and increasing needs of the residents this was minimal staffing given that 2:1 staff support was needed for at least two residents for all or some of their activities of daily living. This level of staffing meant that inevitably there were times when residents were unsupervised and did not have the choice to leave the centre if they wished as the staffing levels did not support this. There were other needs and risks that required adequate and appropriate supervision by staff to ensure that all residents were safe at all times such as a risk of falls, of accessing unsafe foods or leaving the centre without staff knowledge. This minimal level of staffing was compounded by the fact that weekend occupancy and dependency levels had actually increased due to circumstances arising from COVID 19. In addition records seen indicated that there had been times when staff had been required to leave the centre to provide assistance in another designated centre leaving one staff on duty in this centre. This was an incidental finding of the inspection and though it would appear to be an infrequent occurrence, it was inadequately monitored and not risk assessed.

Records of staff meetings demonstrated that staff were raising their concerns since at least early March 2020 in relation to both this practice and the inadequate staffing levels in the context of increased occupancy and increasing needs that needed more support from staff. The internal review of the quality and safety of the service completed in July 2020 on behalf of the provider noted that the increasing needs of residents were highlighted to the auditor as an ongoing challenge for staff as was an identified need for additional staff. The audit report referenced a business case submitted for additional staff support at weekends but the status of this business case was unclear, for example its internal and external escalation. There was no

evidence of the objective assessment of impact and risk of these low staffing levels in support of the business case. The timescale for completion was not timely (December 2020) given the assessed needs of the residents, the concerns noted by staff in March 2020 and a further clinical record seen which stated that a needs assessment completed in October 2019 had highlighted the need for additional staff.

The records of training completed by staff were somewhat difficult to review but the inspector concluded that deficits had arisen in the completion of refresher (mandatory and required) training by a significant number of staff. These deficits were, by the time of this inspection being addressed. In the context of COVID 19 and the cessation of practical training the provider had put alternative methods of training in place to prevent such deficits from happening. Staff had recently completed this on-line training and practical training dates were seen to be booked for a range of training such as manual handling, responding to behaviour that challenged and medicines management training. Again though there was inconsistency between records, a representative sample of records seen by the inspector provided assurance that staff had completed the training modules required to ensure they had the skills and knowledge to respond appropriately to COVID 19. This training included such hand-hygiene, breaking the chain of infection and the correct use of PPE (Personal Protective Equipment). In general the training recorded as completed reflected the work that staff did and the assessed needs of the residents, for example the provision of alternative forms of nutrition such a diets of a modified consistency and supplementary forms of nutrition. However, a further record seen stated that Sonas therapy (a therapeutic sensory programme that focuses on retaining resident skills and abilities, improved mood, enhanced well-being and communication) was no longer facilitated by staff. This had resulted as staff required refresher training rather than because of any lack of appropriateness, engagement or benefit to residents.

The inspector was advised that there were no open complaints; the internal provider review referred to above monitored the receipt and management of complaints and also reported that there were no open complaints. The internal auditor actively sought feedback from residents and also incorporated feedback provided by their representatives. The feedback received as noted by the auditor was sufficient to be representative (4 of six respondents had replied) and the feedback provided was positive. This inspector noted that residents were consulted with during this inspection and were effective in communicating their needs and preferences to the staff team.

Regulation 15: Staffing

The evidence available to the inspector indicated that staffing numbers were not always sufficient or reflective of the number and assessed needs of the residents. The review of staff rotas demonstrated that day-time staffing numbers fluctuated and dropped at times particularly at the weekend to two staff after 13:00hrs. Given the number, assessed and increasing needs of the residents this was minimal

staffing given that 2:1 staff support was needed for at least two residents for all or some of their activities of daily living. This level of staffing was compounded by the fact that weekend occupancy and dependency levels had actually increased due to circumstances arising from COVID 19. In addition records seen indicated that there had been times when staff had been required to leave the centre to provide assistance in another designated centre leaving one staff on duty in this centre. The internal review of the quality and safety of the service completed in July 2020 on behalf of the provider noted that the increasing needs of residents were highlighted to the auditor as an ongoing challenge for staff as was an identified need for additional staff. The audit report referenced a business case submitted for additional staff support at weekends but the status of this business case was unclear, for example its internal and external escalation. The timescale for completion of the business case was not timely given the length of time that staffing concerns had been raised for. There was no evidence of the objective assessment of the impact and risk of these staffing levels to both residents and staff in support of the business case.

Judgment: Not compliant

Regulation 16: Training and staff development

Sonas therapy (a therapeutic sensory programme that focuses on retaining resident skills and abilities, improved mood, enhanced well-being and communication) was no longer facilitated by staff. This had arisen as staff required refresher training rather than because of any lack of appropriateness, engagement or benefit to this particular cohort of residents individually and collectively.

Judgment: Substantially compliant

Regulation 23: Governance and management

Findings of this inspection indicated that this was a good, person-centred service where residents received a good standard of care and support. However, this inspection also identified deficits in systems of management and oversight that had the potential to create risk and compromise the quality and safety of the service provided to residents. These deficits also raised some concern as to how the provider monitored the service and assured itself that the service provided was consistently appropriate to the number and assessed needs of the residents, consistently safe and of the best possible quality. This finding is reflected in the level of non-compliance found with the relevant regulatory requirements.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector was advised that there were no open complaints; the internal provider review monitored the receipt and management of complaints and also reported that there were no open complaints. How to complain was prominently displayed. This inspector noted that residents were consulted with and were effective in communicating to staff their needs and preferences. There were procedures for actively seeking feedback from residents and their representatives; records seen indicated that the feedback received was positive.

Judgment: Compliant

Quality and safety

Fundamentally residents in this centre received a good, person-centred service. Staff were noted to be knowledgeable, attentive and prioritised the needs of residents and raised with management any concerns they had about the quality and safety of the service. However, as stated in the first section of this report there were governance related deficits that had the potential to create risk and did not provide adequate assurance as to how the provider monitored and assured itself of the consistent appropriateness, safety and quality of the support and service that residents received. For example, evidence of inadequate staffing levels has been discussed in the first section of this report. In this section deficits such as those found in fire safety and risk management systems will be discussed.

The care and support provided to residents was guided by the personal plan. The inspector reviewed one personal plan and saw that it reflected the needs, care and support described by staff. The plan was detailed and personalised to the resident with evidence of good consultation and input from multi-disciplinary supports (MDT). The plan was seen to be reviewed and updated as needs changed and increased. However, the inspector did note that some decisions in relation to the support provided were made at local staff team level. These decisions may have been good and sound, for example in relation to deteriorating mobility and the decision to use hoist transfers at all times, but would be better assured if made with the relevant MDT person. The requirement for monitoring and a process for such decision-making was discussed at verbal feedback of the inspection findings.

On inspection the inspector saw how staff monitored resident well-being, were attuned to possible signs of illness including atypical signs and took timely action to prevent deteriorating health. Such action was informed by clinical knowledge but also the sound knowledge that staff had of each resident and their assessed needs. Staff said that there were no obstacles to accessing the healthcare services that residents needed and that access as needed had continued throughout the COVID-

19 pandemic. Centre based nursing staff and external services worked collaboratively together to ensure that residents received the care that they needed to keep well and healthy. Records of reviews and recommendations were included in the personal plan as were healthcare specific care plans. As stated above the care interventions described by staff were as found in the personal plan and this provided assurance that the care provided was as recommended by the relevant clinicians.

There was some requirement for support so that residents coped with challenges and anxiety in a way that did not create risk for themselves or their peers. Records seen indicated that support was available from and provided by the behaviour support team. The positive behaviour support plan set out the supportive strategies to be implemented by staff. Staff were attuned to the impact of change and the importance of routine for residents, for example staff related changes and change as a consequence of COVID-19. There were some practices that had a restrictive dimension, but overall residents were observed to have minimal restrictions in their daily life. There was a rationale for the restrictions in place and the rationale was relevant to the particular diagnosis. These interventions were subject to review and the provider itself had recently identified a need for better evidencing of consultation with the resident and consideration of the possible impact of the restrictions on peers. This internal recommendation should be followed through on prior to the next internal review.

In general notwithstanding the age profile and associated healthcare needs of the residents the inspector saw that staff found a good balance between medical and social models in the care and support that was provided. While acknowledging increasing needs and declining function including cognitive function the plan of care clearly articulated the objective of ensuring that residents continued to enjoy as full and as meaningful a life as possible. Goals that were set by staff sought to maintain personhood, function, interests and activities that were enjoyed throughout life for as long as was possible. Residents were facilitated to have continued links with family, to cope with loss and bereavement and to have continued access to the general community. Staff confirmed that the transport provided had been recently upgraded and included wheelchair access for two residents at a time.

The provider's fire safety arrangements required review and amendment. The provider did not adequately demonstrate that it had effective arrangements for the evacuation of all persons from the centre if this was necessary, for example in the event of fire. The premises was purpose built and was equipped with a fire detection and alarm system, emergency lighting and fire fighting equipment; records seen confirmed that these systems were inspected and tested at the required intervals. The inspector also noted that fire resisting doors with self-closing devices to contain fire and its products were provided. However, the inspector noted that the staff sleepover room was an inner room (accessed through another room); inner rooms are permitted to be used under certain criteria, one of which is that they should not be used as bedrooms. On discussion in the centre it was not evident that this arrangement and associated risk was recognised. The inspector did see that the centre specific evacuation plan stated that the window in the staff bedroom was an escape route though it was not explicitly indicated as such. The floor-plans

submitted to HIQA for the purposes of registration in November 2018 did not indicate the use of this room as a bedroom. This room, the safety and suitability of its use as a bedroom required inclusion in the providers review of its overall fire safety and evacuation arrangements and procedures. In conducting this review the provider was advised that advice should be sought from a competent person to advise in terms of the appropriate use of this room. Given the floor plans submitted it was likely that the room was approved as a therapeutic space for residents and not as a bedroom.

Regular simulated evacuation drills were completed in which both staff and residents participated. However, the record of a drill completed in late August 2020 to simulate the night-time scenario had a recorded completion time of over 13 minutes as one resident was reluctant to evacuate for staff. The resident required the physical assistance of two staff to evacuate and in the context of the residents assessed needs it is reasonable to conclude that the resident may not have fully comprehended the impact of their reluctance to evacuate. Corrective action to be taken following this delayed evacuation was to alter the assistance to be provided by staff; it was agreed that staff were to hoist transfer the resident to a wheelchair so as to evacuate, and to update the resident's PEEP (Personal Emergency Evacuation Plan) accordingly. However, the inspector found that the PEEP had not been updated and therefore did not provide guidance on the altered evacuation procedure though one staff spoken with did know that a hoist transfer was now recommended. In general the inspector found that there was a lack of clarity and consistency between the PEEPS and practice that had the potential for risk and did not provide assurance as to the adequacy and effectiveness of the providers evacuation procedures. This is of note given the number and dependency levels of residents in this centre. For example, the original PEEP for the resident above advised that a favoured drink should be offered as an incentive to evacuate but it was not evident if this was attempted. There was a lack of clarity as to the use or not of the evacuation mat that was provided in the centre. It was cited in a PEEP seen but staff said that it posed a manual handling risk and was not used. There was also some duplication of PEEPS and another seen stated that it was last reviewed in October 2018. Further to other evacuation concerns raised in late 2017 an independent review was completed and a recommendation was made that a door should replace the bedroom window and therefore support full bed evacuation. There was no documentary trail that evidenced the consideration of this recommendation (it had not been progressed) not only for that particular resident but in general given the dependency levels of residents, the manual handling required of staff and the recent prolonged evacuation time as cited above.

Following this inspection, HIQA initiated a process of engagement with the provider, including a meeting with HIQA Fire and Estates. This meeting was convened to discuss in detail with the provider, the risk identified on inspection to safe and effective evacuation of the centre, current applicable fire safety guidance, and the requirement for further assurances over and above that which was initially submitted by the provider, for example evidence that was submitted following the inspection to support consideration of the use of the inner room that had occurred in 2015. The provider engaged positively with this process and provided evidence that it had comprehensively reviewed and amended its evacuation procedures and

had reduced the time it took to evacuate all residents in the event of fire. The provider in its revised response to HIQA set out the short-term measures that it had taken and the longer-term plan to convert the night-time staffing levels to two waking staff; this would negate the need for the use of the inner-room as a bedroom. While some fire safety related records requested by HIQA were still awaited, the revised response to the inspection compliance plan was accepted.

Though there was a comprehensive suite of risk assessments seen on inspection, much of them directly related to the assessed needs of the residents, there were deficits in the identification, assessment and monitoring of risks and their control. Some risk assessments required updating, additional controls were not always followed through on and all risks were not identified and managed. For example, as discussed above in relation to fire safety while the relevant risk assessment (delayed fire evacuation) was reviewed the risk rating did not increase and the PEEP had not been updated following the recent delayed evacuation of residents. As discussed in the first section of this report the impact and potential risk to resident safety and quality of life created by inadequate staffing though subjectively expressed was not objectively assessed.

The provider had responded to manage and protect residents and staff from the risk posed by COVID-19. As discussed in the first section of this report staff were required to complete relevant infection prevention and control training. There was a suite of COVID-19 specific policies, procedures and risk assessments guided and informed by national guidance. Infection and prevention control measures observed included the monitoring of staff, resident and visitor well-being and enhanced environmental cleaning. Staff confirmed that they had adequate access to PPE and were seen to use face masks when unable to maintain the recommended physical distance. The inspector enquired as to how adherence to infection prevention and control measures was monitored and was advised that audits were planned and an audit tool had been devised. The inspector was prompted to enquire as while the overall evidence was of good practice that has protected residents in this centre from COVID-19, there was some evidence of practice that was not in line with best practice in relation to the use of face masks specifically in relation to their correct sessional use and disposal between each period of use.

There was a strong awareness of the impact on residents of the restrictions imposed in response to COVID-19 and staff sought to safely support residents to re-engage with family and community whilst protecting them from the ongoing risk of COVID-19. During the period of highest restrictions contact with family had continued by phone or managed visits outdoors. Managed visits to the centre both outdoors and indoors had recommenced as had visits to family; controls such as temperature checks and the use of face masks were required and implemented; representatives were reported to be satisfied with the arrangements in place.

Regulation 11: Visits

Visits to the centre were managed to prevent the accidental introduction of COVID-19. There were risk assessments and reasonable controls to reduce the risk of the accidental introduction and onward transmission of COVID-19.

Judgment: Compliant

Regulation 13: General welfare and development

There was a strong awareness of the impact on residents of the restrictions imposed in response to COVID-19 and staff sought to safely support residents to re-engage with family and community whilst protecting them from the ongoing risk of COVID-19. In general notwithstanding the age profile and associated healthcare needs of the residents the inspector saw that staff found a good balance between medical and social models in the care and support that was provided. While acknowledging increasing needs and declining function including cognitive function the plan of care clearly articulated the objective of ensuring that residents continued to enjoy as full and as meaningful a life as possible.

Judgment: Compliant

Regulation 17: Premises

The premises was purpose built and its design and layout was therefore suited to the assessed needs of the residents, for example ceiling hoists were provided in the bedrooms to assist residents with higher physical needs. The inspector saw that residents were provided with the facilities and equipment they needed for their care and comfort and there were procedures for ensuring that such equipment was inspected and kept in good working order. The premises was however welcoming, homely and personalised to reflect the individuality and interests of each resident; their artwork and personal photographs were displayed; there was a cuckoo clock as requested by one resident. The grounds were well maintained, used and enjoyed by residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There were deficits in the identification, assessment and monitoring of risks and their controls. Some risk assessments required updating, additional controls were

not always followed through on and all risks were not identified and managed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While the overall evidence was of good practice that has protected residents in this centre from COVID 19 there was some evidence of practice that was not in line with best practice in relation to the use of face masks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider did not adequately demonstrate that it had effective arrangements for the evacuation of all persons from the centre if this was necessary for example in the event of fire. The record of a drill recently completed to simulate the night-time scenario had a recorded completion time of over 13 minutes as one resident was reluctant to evacuate for staff. Corrective actions to be taken following this delayed evacuation was to alter the assistance to be provided by staff and the residents PEEP (Personal Emergency Evacuation Plan) was to be updated accordingly. However, the inspector found that the PEEP had not been updated and therefore did not provide guidance on the altered evacuation procedure for staff though one staff spoken with did know that a hoist transfer was now recommended. In general the inspector found that there was a lack of clarity and consistency between the PEEPS and practice. This created a potential for risk and did not provide assurance as to the adequacy and effectiveness of the providers evacuation procedures. This was of note given the number of and dependency levels of residents in this centre. Further to concerns raised in late 2017 an independent review was completed and a recommendation was made that a door should replace the bedroom window and therefore support full bed evacuation. There was no documentary trail that evidenced the consideration of this recommendation (it had not been progressed) not only for that particular resident but in general given resident dependency levels, the manual handling required of staff and the recent prolonged evacuation time. In addition the inspector noted that the staff sleepover room was an inner room. The floor-plans submitted for the purposes of registration in November 2018 did not indicate the use of this room as a bedroom. This room and the safety and suitability of its use as a bedroom must be included in the providers review of its fire safety and evacuation arrangements and procedures; advice from a competent person should be sought in this regard.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The care and support provided to residents was guided by the personal plan. The plan reviewed by the inspector was detailed and personalised to the resident with evidence of good consultation and input from multi-disciplinary supports (MDT). The plan was seen to be reviewed and updated as needs changed and increased. The support and care interventions described by staff were as found in the personal plan and this provided assurance that the care provided was as recommended by the relevant clinicians.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being, were attuned to possible signs of illness including atypical signs and took timely action to prevent deteriorating health; such action was informed by clinical knowledge but also the sound knowledge that staff had of each resident and their assessed needs. Staff said that there were no obstacles to accessing the healthcare services that residents needed and that access as needed had continued throughout the COVID-19 pandemic. Centre based nursing staff and other services worked collaboratively together to ensure that residents received the care that they needed to keep well and healthy. The records of these reviews and recommendations were included in the personal plan as were healthcare specific care plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Though practical refresher training was needed and scheduled, staff had baseline training and had completed refresher on-line training in the interim. Staff also had access to the behaviour therapy team and positive behaviour support plans to guide their practice and responses. While the evidence was of minimal and proportionate restrictive interventions the provider itself had identified the need for better evidencing of consultation with the resident and consideration of the possible impact of restrictions on peers. This internal recommendation should be followed through on at the next scheduled review.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policy and procedures and exercised as necessary its responsibility to ensure that residents were protected from all forms of abuse and harm. The recent provider internal audit reviewed the providers' own protective measures to ensure that they were adequate to protect residents; for example the auditor evaluated staff knowledge of safeguarding and reporting procedures. There were plans to ensure that personal care was provided to residents in a dignified manner.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carra Mor OSV-0004887

Inspection ID: MON-0030131

Date of inspection: 16/09/2020

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 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: 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.</p> <ul style="list-style-type: none"> • The PIC and PPIM will ensure that the current roster is reviewed to ensure staffing levels are appropriate throughout the week, particularly on weekends as capacity has increased at weekends due to circumstances arising from COVID-19 pandemic. • A business case is in progress for submission to the HSE alongside changing needs report for the provision of additional funding for one resident currently funded for part-time residential service; who now requires full-time residential supports. • Risk assessments in place for staffing levels at weekends and for changing needs of one resident by the PIC and escalated to senior management; accepted by SMT. • The registered provider shall ensure to maintain current staffing levels at all times and a detailed risk assessment for maintaining staffing levels be escalated to senior management for immediate review. <p>30/11/2020 - timescale for completion.</p>	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.</p> <p>The PIC shall ensure that the staff member who has attended Sonas Therapy training</p>	

previously will be booked on a refresher programme which can be completed via e-module on line.
 Upon successful completion of the Sonas eModule users will have their Sonas Programme Licensed Practitioners (SPLP) license renewed and receive a Sonas Programme License certificate and badge. The Sonas Programme License is valid for 2 years; and will be refreshed 2-yearly thereafter.

31/10/2020 - timescale for completion

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

The registered provider shall ensure (23(1)(c) 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 registered provider will confirm this is in place by ensuring the following actions are completed:

The PIC is now ensuring that they are on-site regularly ensuring appropriate levels of governance and management to ensure safe and effective supports at all times; while also adhering to Covid-19 public health guidelines.

The PIC will ensure that the files and record keeping review system is implemented to ensure ongoing review and monitoring of systems within the centre in a timely and well evidenced manner.

In addition, the following measures are in place to ensure good governance and management systems are in place: Provider-led 6-monthly audits, annual review carried out by PIC, regular medication audits, introduction of IPC audits & PPE spot-checks, Organisational policies and procedures to outline best practice for supporting people within our services.

The PIC will complete a detailed risk assessment outlining the minimum requirement staffing levels appropriate to the number and assessed needs of the residents, ensuring the service provided is at all times safe and of a good quality. If deemed necessary, the PIC will escalate this risk assessment to the SMT.

31/10/2020 - timescale for completion

Regulation 26: Risk management procedures	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The registered provider shall ensure that (26(2) 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, includes the following:

- A Risk Management Policy is in place in the organisation and the PIC and SCWs are knowledgeable of this policy and adhere to it within the service.

- The PIC will review and update current risk assessments in the centre to ensure all control measures have been outlined in each respective risk assessment and they are proportional to the risks identified.
- The PIC will review overall all risks in the designated centre, and where appropriate identify where risks currently managed within the centre have not been included in the current risk register; and will ensure all monitoring of risk is evident in the assessments.
- The PIC will update all risk assessments to the new Organisational risk assessment template with additional controls clearly identified and actioned within timelines outlined.
- The PIC will use the files and record keeping review system in place to ensure ongoing review of risk, which is timely and effectively documented.

31/10/2020 - timescale for completion.

Regulation 27: Protection against infection	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:

The registered provider shall ensure that (27) the 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. The PIC will ensure this is in place by ensuring the following actions are completed:

PIC discussed the issue of appropriate use of face masks at team meeting on 29.09.2020 and requested that all staff familiarize themselves with COVID 19 – PPE guidance and resources as per HSE/ HPSC guidance and Organisational policies and procedures. SMT have completed 2 PPE spot-checks since inspection was carried out within the DC. Evidence of spot-checks retained on file within the DC and actions arising have been completed.

[Completed]

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider shall make (28(3)(d) adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations by ensuring the following actions are completed:

The following are the short term measures which have been taken by the Provider and the PIC to mitigate the current risk to residents:

- Risk Assessment for the use of the inner sleepover room further reviewed following meeting with HIQA on the 24/11/2020. The sleepover location will temporarily relocate at night time to the Recreational room to eliminate the risk of staff sleeping in an inner room. This risk is now completely mitigated as a result of the sleepover room no longer being an inner room. Risk Assessment submitted to HIQA for review.
- Revised floor plans obtained to reflect the temporary change in sleepover location.

Submitted to HIQA for review.

- Original Fire Certificate and associated floor plans/drawings requested as were completed when the original floor plans and application to the County Council to issue the Fire Safety Certificate in line with the Building Control Act 1990. Both documents will be submitted to HIQA for review.
- Fire Drill repeated on 25/11/2020 and evacuation mats utilized rather than hoists, to assess the time difference for evacuation. Full report of the drill submitted to HIQA for review.
- PIC has liaised with the external Fire Safety Training Officer, used for training and Fire Safety purposes by the organization, and a detailed assessment of the centers fire management safety arrangements and evacuation procedures is scheduled for the 27/11/2020.
- PIC has sought professional advices and a Fire Inspection was carried out on the building on the 26/11/2020. A report will be provided on the inspection.
- The Fire Alarm system will be connected to a monitoring company, and reviewed on an annual basis going forward. This is scheduled to commence on 27/11/2020. In the event of a fire, the PIC has liaised and confirmed with the monitoring company in relation to their remit to assist with contacting the emergency services as an additional control measure. The response from the monitoring company is extremely prompt and the staff can request assistance from the monitoring company once the alarm goes off to notify the fire services, so they can focus solely on the evacuation of residents.
- CEEP and PEEPs will be further reviewed and updated based on the fire drill carried out on 25/11/2020. CEEP submitted for review.

[All short-term measures will be completed by: 30/11/2020 – reports based on the inspections/ reviews carried out by the external professionals outlined above have been requested in a timely manner for return to HIQA, but this is out of the PIC/ providers control and will be submitted as soon as received]

The medium term measures being taken to mitigate the evacuation risk:

- The recommendations in the Fire Safety Training Officers report as well as the Fire Inspection report will be reviewed and implemented by the service on completion and receipt of both reports.

[Timeline is dependent on works recommended – service provider anticipates this will be completed by 31/05/2021 at the latest]

The long term measures to mitigate the evacuation risk:

- The staffing levels in Carra Mor will increase to 2-night awake staff, replacing the sleepover staff at night.

[This measure is likely to take some time as it will involve seeking funding to cover the additional cost of the additional resources required; and then will require recruitment and selection procedures to be carried out to seek appropriate competent persons to provide safe and effective care and support to residents.

31/12/2021 – timescale for completion]

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/11/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	31/10/2020

	place in the designated centre to ensure that the service provided is 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	31/10/2020
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	09/10/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Not Compliant	Orange	31/12/2021

	event of fire, all persons in the designated centre and bringing them to safe locations.			
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