Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	No 4 Brooklime
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	09 February 2022
Centre ID:	OSV-0005147
Fieldwork ID:	MON-0031556

About the designated centre

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

No 4 Brooklime is located on the outskirts of a large town in Cork. The centre provides residential support for up to three adults with severe levels of intellectual disability including those with autism. The individuals have multiple/complex support needs including behaviours that challenge. The service is based on a social care model. To meet the needs of the residents the house has been refurbished and redesigned to incorporate two self-contained apartments. It is a ground floor premises with large garden spaces and a patio area in a tranquil setting. Access to local amenities and shops requires the use of transport. One apartment can support two residents, each with their own bedroom. There is also a shared bathroom, separate toilet area, kitchen-dining area, utility room and two sitting rooms. The second apartment supports one resident who has their own bedroom, sitting room, kitchen-dining area, bathroom and shower room, staff office/bedroom with en-suite and a store room. The centre's focus is on providing a consistent and predictable supported environment including a total communication approach by staff. The individual needs of the residents are supported in a homely environment and they are supported to reach their fullest potential by participating in leisure, social and household activities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 9 February 2022	09:30hrs to 18:15hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The residents living in this centre received a very good, individualised service and appeared to enjoy a good quality of life. They were supported by a committed staff team and had opportunities to participate in activities that were meaningful to them. Improvements were required in the recognition of the restrictive practices in use and in the centre's fire safety measures.

The centre was a bungalow located in a rural area on the outskirts of a town in county Cork. The premises had been divided into two separate living areas. Although registered for three residents, at the time of this inspection there were two residents, one in each living area. Each resident had their own bedroom and exclusive use of a kitchen, sitting room and bathroom facilities. Previously two residents had shared one of the living areas. When speaking with the inspector, staff and a relative of the resident who had previously shared were very positive about the move to a single-occupancy model of service. This approach was reported to have made a significant improvement in the quality of life enjoyed by the residents.

This was an unannounced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection. The inspector arrived at the centre as one resident was leaving to attend their day service. The other resident had already left for the day. Both residents of the centre attended day services five days a week. The person in charge advised that their attendance had been prioritised by the provider during the COVID-19 pandemic, given the importance of a regular routine to their overall wellbeing.

There was one staff team in the centre who supported both residents at different times. A small group of regular relief staff had also been identified to work in the centre, as required. The importance of a consistent staff team was highlighted in conversations with the inspector and in documentation reviewed. This had been a challenge at different stages during the pandemic and management were conscious of the need to establish and maintain a consistent staff team. There were at least two staff working in the centre when both residents were present. There was a third staff in the afternoon or evening every day. In addition, a fourth staff was also rostered on occasion to further support activities and outings. At night, there was one sleepover and one waking staff. In the course of the inspection the inspector met with several members of the staff team, including one who was working in the centre for the first time. Staff were very knowledgeable about the residents, their preferences and support needs. They also displayed an enthusiasm for the opportunities available to the residents to further enhance their quality of life.

On arrival, a staff member greeted the inspector, spoke about the residents living there and showed them both living areas. The centre was observed to be clean and decorated in a homely manner. Staff informed the inspector that a 'deep clean' was

completed in one area of the centre on an alternate basis every six months. The two living areas in the centre were separated by a locked door at the end of a corridor. Staff moved between the two areas via the kitchen / dining room. However residents did not move throughout the centre and each side of the building had at least one external door that they used to access their own living area. One resident had moved into the larger bedroom in their living area in October 2021. Input was provided by a speech and language therapist to support this move. The bedroom was recently repainted and decorated with canvas prints. The room beside this had also been recently redecorated and equipped with sensory-focused equipment. Staff told the inspector that the resident found spending time in this room relaxing. There was also a laundry room, a living room and a well equipped kitchen in this area. Some fruit and vegetables were stored in the refrigerator but the majority of foods were stored elsewhere. This will be discussed later in this report.

The second living area contained a small living room, a kitchen / dining room, a resident's bedroom, and a staff office / bedroom with an ensuite bathroom. Both bedrooms in this part of the centre were inner rooms. This means that access to these rooms was through another room. This arrangement increased the risks to both staff and the resident should evacuation be required in the event of a fire. The risk was further increased as it had been assessed that this resident may sleep through a fire alarm at night and required staff support to safely evacuate at all times. This and other identified issues regarding the fire safety precautions in the centre will be outlined later in this report.

There was another room in this resident's living area that was not labelled on the floorplans or listed in the description of rooms in the centre's statement of purpose. Management told the inspector that this area was a corridor, however it did not match the usual description of a corridor and was the largest room available to this resident in the centre. This room had an island counter with some storage underneath but no other furniture. When the resident returned from day services they spent the remainder of the time where the inspector was in the centre standing in this area, leaning against the island, looking at their electronic tablet. Earlier staff had told the inspector that the resident loved spending time in this area as there was a large window with a view of fields and farm animals. This resident had a particular interest in agriculture and was involved in a social farming initiative. The layout of the centre, including how this impacted on the fire safety precautions in the centre, will be discussed later in this report in the 'Quality and safety' section.

When walking around the centre, some areas requiring maintenance were observed. These included areas on the ceilings in several rooms where mould was evident and walls that required either cleaning or repainting. Perspex coverings had been installed in front of televisions, some windows and some glass doors. These required cleaning or replacement. Later when the person in charge met with the inspector they showed them an extensive list of planned maintenance works in the centre. The areas highlighted by the inspector had been included on this list. A number of environmental restrictions were also observed in the centre. None of these had been recognised as restrictive practices or their use reported to HIQA (Health Information and Quality Authority), as is required by the regulations. These will be discussed in

more detail later in the report.

The inspector had an opportunity to spend some time with one of the residents later that afternoon when they returned from day service. Initially, the resident came into the room where the inspector was sitting. They appeared very much at ease in the centre and immediately knew where to find what they were looking for. They appeared content and staff who knew them well advised that their presentation and vocalisations indicated that they were enjoying themselves.

Although the inspector did not meet with the other resident of the centre, they did have an opportunity to speak with one of their family members. This relative had arranged to visit the centre on the day of the inspection. While there they spoke with the inspector about their, and their relative's, experiences of life in the centre. The person was very positive about the centre, saying that they always felt welcome. They also praised the support provided and the accessibility of staff and management. They told the inspector that as well as being involved in the annual review of their relative's personal plan and the development of goals, they also initiated regular meetings with the person in charge. They spoke with the inspector about how their relative responds when they return to the centre after any time away. They advised that this was a source of great comfort to them as they knew that their relative would not act that way if they weren't happy to be living in the centre and with the staff support provided. They specifically praised the staff, the individualised service and living arrangements provided, and the opportunities for a good quality of life available to their family member by virtue of living in the centre.

As well as spending time with one of the residents, speaking with a family member and various members of the staff team, the inspector also reviewed some documentation. Documents reviewed included the complaints log, the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The inspector also looked at both residents' individual files. These included residents' personal development plans, healthcare and other support plans. These were generally of a good standard. Areas for improvement were identified and will be outlined in more detail in the 'Quality and safety' section of this report.

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

Capacity and capability

Overall, good management practices were seen, the provider adequately resourced and staffed the service, and it collected information in order to improve the quality of life of residents. Management systems ensured that all audits and reviews as

required by the regulations were being conducted. Improvement was required in the understanding and recognition of the restrictive practices in use in the centre and in the oversight of fire safety precautions.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. At a time of this inspection the social care leader assigned to this centre was on extended leave. Another staff member had been fulfilling this position until the week prior to this unannounced inspection. The person in charge advised that recruitment was underway and there had been expressions of interest in the role. In the interim, the staff team were reporting directly to the person in charge who reported to the sector manager. On the day of the inspection the person in charge had arranged to attend a staff meeting in the centre. They told the inspector they visited this centre at least once a fortnight and that they were soon to be based in an office close to this centre.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. The annual review was completed in March 2021. The most recent unannounced visit had taken place in August 2021. There was evidence that a number of areas that needed to be addressed were identified through these audits. Actions had been developed as a result and there was evidence that these been progressed or completed. One notable exceptions to this was the identification of the use of restrictions in the centre. As was referenced previously and will be discussed in more detail in the next section of this report, there were a number of restrictive practices in use in the centre that had not been recognised as restraints. Although there was reference to issues with one resident evacuating the centre during fire drills, the other matters regarding fire safety highlighted in this inspection were not identified in any of the governance audits completed in the centre.

The inspector reviewed training records of the core staff team and relief staff who had recently worked in the centre. Some gaps were identified. Three staff required fire safety training. At the time of this inspection they had not been booked to attend this mandatory training. Records available indicated that one relief staff member had not completed training in the safeguarding of vulnerable adults. Four staff required training in management of behaviour that is challenging. One of these staff was booked to attend a refresher training however it was not clear from the records available that they had completed the full training at any stage. Training gaps were also identified in epilepsy management. The staff who required this training were booked to attend it in the week following this inspection. A review of the training records demonstrated that staff had been booked to attend various training sessions at various times in the previous two years but that due to public health restrictions at the time these had not been able to go ahead as planned.

The complaints log was also reviewed. Two complaints were made in 2021 and three in 2020. Some of these were made by staff advocating on a resident’s behalf. On review of staff meeting minutes, it was noted that consideration had been given to making another complaint however staff had not proceeded on that occasion. From a review of the documentation available it was clear that each complaint had

been investigated, responded to, and appropriate actions were taken. The satisfaction of the complainant was also noted however it was not always clear how this had been established. A discussion with the person in charge provided the inspector with assurances regarding this.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. This required review to reflect the current management personnel involved in the running of the centre, to accurately describe the size of the bedrooms in the centre and to ensure that the statement of purpose was specific, and made reference, to this centre only.

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The number, qualifications and skill-mix of the staff team was appropriate to the number and assessed needs of the residents living in the designated centre. There was a planned and actual staff rota in place. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques and fire safety. Not all staff were booked to attend the required training. It was also not clear if one staff member who was booked to attend a refresher session required more comprehensive training. One staff member required training in relation to safeguarding residents and the prevention, detection, and response to abuse

Judgment: Substantially compliant

Regulation 23: Governance and management

Although there was evidence of strong oversight in many areas of service provision, improvement was required in the oversight of restrictive practices and the fire safety precautions in place in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to reflect the current management personnel involved in the running of the centre, to accurately describe the size of the bedrooms in the centre and to ensure that the statement of purpose was specific, and made reference, to this centre only.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all occasions where restrictive procedures were used in the centre were reported to HIQA, as is required by this regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

An effective complaints procedure was in place. Complaints were investigated promptly and where required measures for improvement were put in place.

Judgment: Compliant

Regulation 4: Written policies and procedures

Five of the policies and procedures required to be maintained, as identified in Schedule 5 of the regulations, had not been reviewed within the last three years as

is required.

Judgment: Substantially compliant

Quality and safety

The inspector found that the quality and safety of care which was provided was maintained to an overall good standard. A review of documentation and the inspector's observations indicated that residents' rights were promoted and that residents enjoyed living in this centre. As previously outlined improvements were required in the areas of restrictive practices and fire safety. This matters are discussed in more detail in this section of the report.

Residents were involved in a variety of activities both while in the designated centre and at day services. These included day to day activities such as going to the barber, the local shop and for a coffee and others such as swimming in the sea and trips to neighbouring counties. Improvements had been made to the centre in line with residents' interests and preferences. Examples included the development of the garden areas and the redecoration and refurbishment of one room to include sensory-focused equipment. There was also a focus on skill development with plans in place to provide residents with opportunities to learn culinary and personal care skills.

Contact with friends and family was important to the residents and this was supported by the staff team. Relatives were welcome in the centre and staff also supported residents to visit their family homes. Due to the restrictions on visitors imposed by public health guidance during the pandemic, staff had tried novel ways to maintain the important relationships in residents' lives. A plan was in place to support one resident to spend more time at the weekends with a friend who lived in another designated centre run by the same provider.

The inspector reviewed both residents' personal plans which were found to be comprehensive in nature and outlined supports that residents required. Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding healthcare plan who was in place. However, it was not always possible to tell if the effectiveness of these plans had been assessed or reviewed. There was evidence of regular appointments with medical practitioners including specialist consultants, as required. There was also evidence of input from allied health professionals such as a psychologist, occupational therapist and speech and language therapist. It was noted that where residents had an assessed need and a plan to support them in the area of eating and drinking, these plans had not been reviewed the previous 12 months, as is required by the regulations. Both residents at times engaged in behaviours that indicated distress. A recently reviewed plan was in place to guide staff support for one resident but not the other. A referral had been made seeking this support. A multidisciplinary review of both residents'

personal plans had been completed in the last 12 months, as is required by the regulations.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. It was noted that residents' personal development goals had been adjusted in line with the public health restrictions at the time. For example where planned outings were not possible due to national restrictions, alternative goals were developed and achieved. There was evidence that residents had been supported to achieve goals from previous years. Personal development plans reflected a collaborative approach with the residents' day services. The goals documented were meaningful to residents and included both new opportunities and a return to activities disrupted by the pandemic.

Staff working in the centre were strong advocates for the residents. In addition, one resident had been supported to access an independent advocate to support them with specific matters. At the time of this inspection, they continued to be involved in this resident's supports. It was evident throughout the inspection that there was a focus on ensuring residents had opportunities to make choices regarding their lives and to further develop their skills.

As previously outlined the centre was separated into two living areas. Residents living in the centre did not spend time with each other and only spent time in their own assigned living area. When walking around the centre it was noted that several doors were locked. In one living area these included the doors to a small toilet, the cupboard where the fire alarm panel was installed, one resident's former bedroom (where the majority of their clothes continued to be stored), and a room assigned for storage. On the day of inspection, it was noted that the toaster that had been previously available in the kitchen was locked in this storage area. Staff explained that there were safety concerns around a resident accessing this and multidisciplinary support was to be provided regarding this matter. There were references in staff meeting minutes from December 2021, reviewed by the inspector, to the referral made for these supports and also to a plan to reintroduce this resident's access to their own clothes. In the second living area, a storage area was locked as were a number of cupboards in the living room. The storage area contained a well-stocked refrigerator and several shelves of food. This food belonged to both residents. Despite the number of environmental restraints in place in the centre, none of them had ever been notified to HIQA, as is required by the regulations.

Later when reviewing one resident's file, it was documented that one psychiatrist had deemed the use of PRN or 'as needed' medication as a chemical restraint. This had also not been notified, as required. As well as not being notified, none of these practices had been recognised by management or by those who completed governance audits as restrictions. As a result, they had not been subject to the provider's own policies and procedures regarding the use of restrictive practices. At the close of this inspection, management committed to reviewing these practices to assess if they were necessary and if so to address them in line with provider's policy.

As outlined previously in this report, the centre was observed to be homely and all accessible areas were clean on the day of inspection. Some maintenance works were required and were planned. Parts of the centre had been recently painted and decorated. The layout of the premises was unusual in that the largest room available to one of the residents was unfurnished with the exception of an island unit with some storage underneath. Staff informed the inspector that the resident enjoyed spending time in this area and regularly did. This was also observed during this inspection. As well as having a view of neighbouring farmland, this area had recently been decorated with large posters that the resident enjoyed looking at. When the inspector asked why no seating was available in this area for the resident, management advised that this room was a corridor. As outlined previously, this room did not meet the typical description or purpose of a corridor. It also had no external exits. This impacted on the fire safety precautions in the centre.

Systems were in place and effective for the maintenance of the fire detection and alarm system and emergency lighting. Both residents had a personal emergency evacuation plan (PEEP) in place, which had been recently reviewed. Although the provision of these fire systems and processes was welcome, a substantial number of fire safety risks were identified in the course of this inspection. Some of these were related to the layout of the building.

As referenced in the opening section of this report it was identified that both the staff and one resident's bedrooms were inner rooms. This meant that exit from these rooms was only possible by passing through another room. This risk was further increased by the assessed needs of the resident affected. It was documented that they may sleep through an alarm at night and required staff support and possibly the use of visual cues and incentives to evacuate. These items were not readily available, with staff advising the inspector that they would go to the area where food was stored to get them if needed.

When walking through the centre, it was observed that some fire doors had been fitted with peepholes. In some door frames it was noted that the fire seals had been painted over. Although regular fire safety checks regarding the doors were completed by staff, these issues had not been identified. The inspector requested a review by a competent fire safety professional to ensure that the fire doors could still serve as effective containment measures if required in the event of a fire. It was also noted that the fire panel for staff to reference when the alarm sounded was installed in a cupboard that was routinely locked. At the close of the inspection, management advised that this door would no longer be locked.

The fire exits identified on the centre's evacuation plan were routinely locked. These locks were not linked to the fire alarm system. Break glass units had been installed on the wall but these were not all visible, with one installed behind a curtain. There was no documented risk assessment in the centre regarding the routine locking of doors that formed the escape route.

On review of the records of evacuation drills completed in the centre, it was identified that one resident did not always participate. This issue was referenced in the February and August 2021 six-monthly unannounced visit reports completed in

the centre. In response to this identified risk, drills were to be completed monthly in the centre. While this had initially proved effective, in the three most recent drills, completed in October 2021, November 2021 and January 2022, one resident did not evacuate on two occasions. In the third drill, it took five minutes to fully evacuate the centre. Multidisciplinary support had not been requested regarding this matter and the issue was not discussed at the November 2021 multidisciplinary review of this resident's personal plan.

Given the complexities regarding the layout of the premises and the fire safety risks identified during the inspection, further assurances will be sought from the provider regarding fire safety in this centre.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. Suitable private areas were available to each resident to receive visitors.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access to opportunities and facilities for occupation and recreation. Residents were supported to both develop and maintain relationships with their wider community.

Judgment: Compliant

Regulation 17: Premises

There were some maintenance issues that needed to be addressed. These works were planned for the weeks following the inspection. The layout of the centre did not meet the needs of one of the residents as the largest room available to them, where they chose to spend a lot of time, was not furnished.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Two bedrooms in the centre were inner rooms. Doors that formed part of the escape routes in the centre were routinely locked. Recent evacuation drills indicated that the provider did not have adequate arrangements in place to evacuate all persons in the centre and bring them to safe locations. Some fire doors required review by a competent fire professional to ensure that they would be effective containment measures if required in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment that resulted in the development of a personal plan. However not all elements of residents' plans had been reviewed in the previous 12 months, as required. It was also identified that the effectiveness of some healthcare plans was not assessed.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was provided to residents in line with their personal plans. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

One resident who required one, did not have a recently reviewed behaviour support plan in place. A referral had been submitted requesting specialist input in this area. The environmental and chemical restraints used in the centre had not been identified as such and had therefore not been subject to the requirements of the provider's own restrictive procedures policy. Identified training gaps are referenced in Regulation 16.

Judgment: Not compliant

Regulation 8: Protection

There were no safeguarding concerns in the centre at the time of this inspection. Both residents had an intimate and personal care plan in place that considered their dignity and areas of independence. It was identified that one staff member who worked in the centre on a relief basis required training in relation to safeguarding residents and the prevention, detection, and response to abuse. This was addressed in Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the residents' individual needs. Residents were encouraged and supported to increasingly exercise choice and control in their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially 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 No 4 Brooklime OSV-0005147

Inspection ID: MON-0031556

Date of inspection: 09/02/2022

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will ensure that staff have access to all appropriate training, including refresher training. Staff that required full training on the management of behaviour that challenges including de-escalation and intervention techniques have been submitted to the training department and are scheduled to attend this training on the 9/5/2022. Staff overdue fire safety training have completed same on the 10/4/2022, and all staff completed local fire safety training on the 6/4/2022. Staff requiring epilepsy management training will be scheduled to complete this by 31/5/2022 One staff member that required training in relation to safeguarding residents and the prevention, detection, and response to abuse completed this training on the 29/3/2022.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that the system of Governance and oversight includes the	

following key controls:-

• The Person in Charge has completed a restrictive practice audit with the Team Leader on 16/3/2022. Where practices are restrictive, referrals have been submitted to Services Behaviour Standards Committee for sanctioning.
• The Person in Charge receives a Weekly Service Area Report of all significant issues.
• The Person in Charge has a Compliance Checklist that ensures monitoring of regulations.
• The Person in Charge has regular supervision meetings and contact with PPIM.
• The Provider has a system of unannounced six-monthly visits and a schedule of audits to be carried out in the Designated Centre. The Provider will review the robustness of these audits in relation to the ensuring systems are in place to identify restrictive practices and the fire safety compliance in the centre. 30/04/2022

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Provider will review and update the Statement of Purpose of the Centre to reflect the current management personnel involved in the running of the centre, to accurately describe the function of all areas, the size of the bedrooms in the centre and to ensure that the statement of purpose is specificto this centre. 22/4/2022

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge has completed a restrictive practice audit with the Team Leader on 16/3/2022. Where practices are restrictive, referrals have been submitted to Services Behavior Standards Committee for sanctioning.

The PIC will return all restrictive practices, including the locking away of a kettle and toaster, the food storage press in one apartment and a chemical restraint, in the next quarterly notifications to the Authority. 30/4/2022

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Provider will ensure that all policies required under Schedule 5 are updated 30/6/2022

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider has ensured that the maintenance plan developed with the Facilities Department will be completed by the 10/06/2022.

The Provider will ensure that the layout of the Centre is reviewed with the Person in Charge and the Team Leader with the Fire Safety officer to ensure that it best meets the needs of the residents and addresses all fire safety issues. Renovation works in this regard are scheduled to be completed by 30/6/2022

The Person in Charge has ensured that one resident with sensory support needs is supported by the Services Occupational Therapy department and Positive Behaviour Support Services to support their sensory needs within their living environment. This work is ongoing.

As evidenced in PSR meetings with the staff team and the involved Intensive support worker, every effort to introduce furniture items to all areas of the resident's apartment over the last number of years was unsuccessful. The resident prefers to stand, whether they are looking out the window or engaging in activities and has clearly indicated that they prefer a minimalist environment.

The Provider will continue to support new furnishing options in the apartment although past efforts of providing seating for the resident have resulted in the resident choosing to sit on the floor or physically tried to remove furnishing where they did not want them. The Provider will be guided by clinical opinion in relation to this matter in the context of the individual's preferences.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider has ensured a plan with the serivces Fire Safety Officer for work to commence on a new entrance door in one apartment off the area identified as the corridor. This will be completed by 10/06/2022. This plan also includes access controls to the central door in the centre with a digital keypad that will be linked to the fire alarm panel in the event of a fire. This work will be completed by the 10/6/2022. The Provider is also reviewing the layout of the centre which may lead, if possible, to further enhanced work as outlied under Regulation 17 above. The Provider has ensured that the Services Fire Safety Officer has reviewed that containment measures in place in the centre, including the fire doors, access to firm alarm panel and break glass systems are effective in the event of a fire. 5/4/2022 The Provider has ensured that adequate arrangements are in place to evacuate all persons supported in the centre and bring them to the assembly points to the exterior of the centre. The PIC has reviewed the residents Personal Emmergency Evacuation Plans with the Social Care Leader on the 7/4/2022. To support one resident who may refuse to evacuate on occasion, the Services Fire Safety Officer has developed a plan with the local team to run fire drills on monthly basis as the most effective way to support the resident to evacuate. The local team will continue to support this resident with visuals and incentive items. A referral to Positive Behaviour Support Services has been made in this regard and a consultation is scheduled. [31/05/2022].	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The PIC has reviewed all personal plans with the SCL with the Keyworkers on the 6/4/2022. The PIC and the SCL will ensure that protected time is given to all Keyworkers on the roster to ensure that plans are reviewed as required. A referral has been made to Speech & Language Therapy Department for a review of the residents Eating & Drinking Plans and to Positive Behaviour Support Services for a review of Behaviour Support Plans [see Regulation 7 below] The PIC has ensured that the Services Nurse Oversight reviewed the effectiveness of each residents identified healthcare plans. This was completed 29/3/2022.	
Regulation 7: Positive behavioural	Not Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider has ensured that
• The referral submitted to Positive Behaviour Support Services was tracked. The PIC and the SCL have had a phone consultation with an Intensive Support Worker on the 29/3/2022 to discuss this referral.
• The Current Behaviour Support Plan will be reviewed and updated Guidance if required will be made available to all staff by the 31/5/2022.

• Staff that required full training on the management of behaviour that challenges including de-escalation and intervention techniques have been submitted to the training department and will attend this training on the 9/5/2022.

• The Person in Charge has completed a restrictive practice audit with the Team Leader on 16/3/2022. Where practices are restrictive, referrals have been submitted to Services Behaviour Standards Committee for sanctioning in accordance with Provider Policy.

• The PIC will return all restrictive practices in the next quarterly notifications to the Authority. 30/4/2022

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	31/05/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/06/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	10/06/2022

	state of repair externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	05/04/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	10/06/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	05/04/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the	Not Compliant	Orange	30/05/2022

	event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	22/04/2022
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	30/04/2022
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2022

Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/05/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	06/04/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/05/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Not Compliant	Orange	31/05/2022

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			