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:	Coolcotts
Name of provider:	An Breacadh Nua
Address of centre:	Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	08 October 2020
Centre ID:	OSV-0005239
Fieldwork ID:	MON-0025566

About the designated centre

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

The services is described as offering long term residential care to 12 adults, both male and female with a mild intellectual disability who require low levels of support with some nursing oversight available. It is located in a community setting in a regional town with good access to all amenities and services. There are day services attached to the service which residents can use if they wish. Residents can also access external day services if they choose. The premises comprises two adjacent purpose built houses. All residents have their own spacious bedrooms and there is ample community living space and suitable shower and bathroom facilities. They are furnished and maintained to a high standard. Both houses are suitable for the current and changing needs for residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 8 October 2020	10:00hrs to 17:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the twelve residents living in the centre on the day of inspection. Residents used verbal and non verbal methods to communicate their thoughts. Throughout the inspection day, residents appeared happy, at ease and comfortable living in their home. The inspector observed kind and familiar interactions between staff and residents.

One resident showed the inspector around their home and appeared proud of their space. The resident showed the inspector some pictures and CD's that they liked to keep in their room. Residents normal daily routines had been impacted by the COVID-19 pandemic and instead residents were enjoying doing other in house activities including artwork, baking, cooking, walks, and gardening. Two residents were enjoying sitting by the fire and watching an old movie in their sitting room. Prior to the pandemic residents and staff communicated that they regularly enjoyed going to local shops, pubs and restaurants.

Mealtimes appeared to be a pleasant experience for residents. The inspector observed some residents having breakfast in the morning and then some residents enjoying their dinner of homemade shepherds pie in the afternoon. Three residents communicated that they enjoyed their dinner when asked by the inspector. Residents had weekly meetings with staff where they discussed food choices for the week ahead.

There were no complaints or concerns expressed to the inspector on the day of inspection.

Capacity and capability

This was an announced inspection and overall findings from this inspection were positive. The provider demonstrated the capacity to provide a person centred and effective service to the residents living there. The provider had addressed any actions noted during the centres most previous inspection. Additional infection control safety measures were implemented by the inspector and staff on the day of inspection due to the COVID19 pandemic. These included use of personal protective equipment (PPE), social distancing, limiting contact times, and cleaning.

There was a clear management structure in place. There was a full time person in charge in place who shared their role and had the skills and experience required to manage the centre. The person in charge had a regular presence in the centre, and lines of accountability were clear. The person in charge was supported by two social care leaders in both houses and communicated with them each two to three times

per week or more regularly if required. Operational management meetings also took place on a regular basis. The service annual review and six monthly review were completed, and social care leaders were completing regular internal audits on areas including residents plans, medication, daily records, risk assessments and personal possessions. However, audits were not highlighting and some issues like overdue staff training, supervisions and staffing vacancies and subsequently were not highlighting the action plan in place to address these matters.

Staffing levels and skill mixes were in place to meet the assessed needs of the residents. There was a clear staff rota that accurately reflected staff on duty. Some staff supervision was taking place, however, formal one to one staff supervisions were not being completed six weekly in line with the service policy. The inspector reviewed a sample of staff files and found that all Schedule 2 documents were in place as required. However, there was no service policy in place for the re-Garda-vetting of staff and this meant that some staff had not been vetted for a number of years since their initial employment with the service.

Training was provided in line with the assessed needs of the residents. This included training in behaviour management, fire safety, safeguarding and manual handling. Staff had completed additional training in infection control, use of PPE, donning and doffing, and hand hygiene due ot COVID-19. Following a review of the staff training records, it was identified that some mandatory refresher training was overdue. Four staff needed refresher fire safety training and one staff needed refresher safeguarding.

There was a clear complaints procedure in place and this was prominently displayed in the centre. There was a designated person nominated for the management of complaints. Satisfaction surveys were completed annually with residents and their families. There were no complaints expressed to the inspector on the day of inspection.

Regulation 15: Staffing

Staffing levels were in place to meet the assessed needs of the residents. However, formal one to one staff supervisions were not being completed on a regular basis in line with service policy. Furthermore, there was no service policy in place for the re-Garda vetting of staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training was provided in line with the assessed needs of the residents. However some mandatory refresher training was overdue. Four staff needed refresher fire

safety training and one staff needed refresher safeguarding.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place and clear lines of accountability. However, the service audits like the annual review and six monthly were not highlighting some issues like overdue staff training, over due staff supervisions and staff vacancies.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place and a designated person nominated for the management of complaints. There were no complaints expressed to the inspector on the day of inspection.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were enjoying a safe service. Residents appeared happy living in their home with their fellow residents.

The premises was well maintained internally and externally and was personalised to suit the needs and preferences of the residents living in the centre. The centre comprised of two identical buildings with six residents residing in each house. The buildings were visibly warm, homely and welcoming on the day of inspection. Ample communal space was provided to residents in the kitchen and living areas. The registered provider had ensured the provision of all matters set out in Schedule 6.

The person in charge had ensured that each resident had a comprehensive assessment of need and a care plan in place that was subject to regular review. These clearly identified the different levels of care and support that resident required. There was a staff key working system in place and key workers reviewed person centred plans fortnightly. It was evident that residents had regular input into their plan of care. Annual person centres planning meetings with residents and their representatives were being facilitated by phone due to COVID-19.

Residents had access to a range of multi-disciplinary support and relevant referrals were being made by staff when required. Recommendations made by allied health care professionals were made clear in the residents care plans.

There was a system in place for the identification, management, mitigation and review of actual and potential risks in the designated centre. There was a centre specific risk register in place that outlined any risks. This was subject to regular review. The inspector reviewed risk documentation in place for one residents at risk of falls. Mitigating actions had been taken by staff to support the resident following a previous fall, including increased supervision, referral to the residents GP and physiotherapy and the implementation of a call bell for the resident. Actions in relation to risk management from the centres previous inspection had been addressed.

The centre, staff and residents had sufficiently implemented protocols for protection against infection and the management of the COVID19 pandemic. The centre was visibly clean on the day of inspection and cleaning schedules had been enhanced to promote infection control. There was service contingency plan in place for in the event of an outbreak of COVID-19 in the centre. There was an information folder in place with up-to-date guidance on the management of COVID-19 for staff and residents. Staff were observed using PPE and the centre had ample supplies of same. Visitation had ceased in line with national guidance for residential care facilities and staff were supporting residents to facilitate some window visits with family and friends. Staff shifts and allocations had been re-structured and a cohort of staff from day service was available to the centre for in the event of an outbreak.

The registered provider had ensured that effective fire management systems were in place in the designated centre. Following a walk around the centre, the inspector observed containment systems, detection systems, emergency lighting, signage and fire fighting equipment. Monthly evacuation drills were being completed by staff and residents in an efficient manner. Each resident had an emergency evacuation plan in place and there was a centre fire evacuation plan in place which clearly highlighted actions to take in the event of a fire. Staff were completing daily hazard checks and this included reviewing emergency exits, lighting, the fire panel and signage. Fire fighting equipment was regularly serviced.

Residents in the centre were safeguarded. Any safeguarding concerns were treated in a serious and timely manner and in line with national guidance. All residents had intimate care plans in place to guide staff supporting resident with personal care. The inspector reviewed documentation around the management of one recent safeguarding concern and found that measures in place and actions taken to safeguard residents were appropriate and robust. Safeguarding social stories had been devised for some residents in an accessible format to the residents.

Residents had appropriate access to multidisciplinary professionals to support them to manage their behaviours. There was a service behavioural therapist who was available to residents when required. Residents had positive behavioural support plans in place that were subject to regular review. These clearly identified residents target behaviours, direct intervention techniques, environmental supports and

reactive strategies. Restrictive practices in use in the centre were minimal, however, there was a press and a room in the house that were locked and that residents could not access at all times. While the person in charge highlighted that this was for safety reasons, they had not been appropriately identified as restrictive practices and there were no risk assessments in place to evidence these potential risks. These had not been notified to the Chief Inspector quarterly, as required by Regulation 31.

Regulation 17: Premises

The premises was well maintained internally and externally and was personalised to suit the needs and preferences of the residents living in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a system in place for the identification, management, mitigation and review of actual and potential risks in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

Staff and residents had sufficiently implemented protocols for protection against infection and the management of the COVID19 pandemic in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire management systems were in place in the designated centre including containment systems, detection systems, emergency lighting, signage and fire fighting equipment.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each resident had a comprehensive assessment of need and a care plan in place that was subject to regular review.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had appropriate access to multidisciplinary professionals to support them to manage their behaviours. Residents had positive behavioural support plans in place that were subject to regular review.

There was a press and a room in the house that residents could not access at all times. While the person in charge highlighted that this was for safety reasons, they had not been appropriately identified as restrictive practices. There were no risk assessments in place to evidence potential risks.

Judgment: Substantially compliant

Regulation 8: Protection

Residents in the centre were safeguarded. Any safeguarding concerns were treated in a serious and timely manner. Residents had intimate care plans in place.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Coolcotts OSV-0005239

Inspection ID: MON-0025566

Date of inspection: 08/10/2020

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Ard Aoibhinn Supervision policy was updated to reflect the supervision processes taking place across the service. This was completed in November 2020. There is Garda vetting policy in place since Jan 2021 clearly outlining the frequency of re vetting for all staff across the service	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: One staff member has completed refresher safeguarding training. Due to the ongoing pandemic it has been difficult to arrange face to face refresher fire Training. This trainings was scheduled for Jan 2021 however due to the impact of Covid_19 and associated risks this training was rescheduled and is taking place Monday 22nd of Feb 2021.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Going forward from Jan 2021 the service led unannounced six monthly Audits will identify any mandatory refresher training or supervision if it is overdue. They will also identify any staff vacancies.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Risk assessment now in place for the linen press and the laundry room. This will also be recorded on the restrictive practice register going forward from Jan 2021	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	02/02/2021
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	22/02/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	02/02/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall	Substantially Compliant	Yellow	31/03/2021

	carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	02/02/2021