



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

Issued by the Chief Inspector

Name of designated centre:	Boherduff Services Clonmel
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	07 October 2020
Centre ID:	OSV-0005363
Fieldwork ID:	MON-0030655

About the designated centre

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

Boherduff Services Clonmel is run by Brothers of Charity Services Ireland. The centre can provide residential care for up to nine male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre is located in a town in Co.Tipperary and comprises of two single storey dwellings and a self contained apartment. All residents have their own bedroom, some en-suite facilities, shared bathrooms, sitting room, kitchen and garden area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:

5

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 7 October 2020	10:30hrs to 17:00hrs	Anne Marie Byrne	Lead

What residents told us and what inspectors observed

All five residents were at the centre on the day of inspection. The inspector was briefly in the company of two of these residents; however, due to their communication needs, they were unable to speak directly with her about the care and support they received.

The inspection was largely facilitated by the person in charge who spoke at length with the inspector about each resident and their individual care and support needs. Residents' bedrooms were personalised and the layout of the centre meant that residents had plenty of space to relax in. As all residents had assessed communication needs, emphasis was placed on maintaining consistency in staffing levels, ensuring these residents were at all times supported by staff who understood them and knew how to support them to express their wishes.

Since the introduction of public health safety guidelines, these residents' day service had temporarily ceased. The person in charge told the inspector staff were in the process of reviewing the recommencement of day services for these residents in the coming weeks. In the interim, additional staff were re-deployed to this service to support residents with their social care needs during the day. On the morning of the inspection, residents were being supported by staff to attend appointments. Residents were also supported to take part in table-top activities and encouraged to get out and about as much as possible, in accordance with public health safety guidelines.

Transport was readily available to residents and staff spoke of how they also often brought residents for out for walks in the local area. Due to the current staffing arrangement in this centre, all efforts were made to encourage residents to take part in activities during times of the day where full a staffing compliment was in place. Where activities occurred outside these times, the person in charge and staff told the inspector that these activities required advance planning, particularly in the evening time and at weekends.

Capacity and capability

Since the last inspection of this service in December 2018, the provider had implemented some measures to improve the centre's overall staffing arrangement. However, this inspection identified significant improvements were still required to ensure adequate staffing levels were at all times in place to meet the assessed needs of residents. In addition to this, the inspector also identified additional areas of improvement required to other aspects of the service, including, fire safety,

behavioural support, governance and risk management.

Following the findings of the last inspection in December 2018, the provider submitted a business case to seek additional resource funding for this centre. At the time of this inspection, this funding had not yet been granted to the provider. From the records available on the day of inspection, it was unclear what accountability and oversight system was in place to demonstrate how the progress towards addressing this issue was being effectively monitored, reviewed and formally communicated.

Various monitoring systems were in place to oversee the quality and safety of care, including, six monthly provider-led audits, which were completed in line with the requirements of the regulations. Although monitoring systems were extensive in nature, they failed to identify deficits in specific aspects of the service that were identified on this inspection. For example, although the last six monthly provider-led audit did include a review of restrictive practices, it failed to identify significant improvements required in this area. Similarly, this inspection also identified that unclear arrangements were in place, should a member of staff require support at night to safely evacuate residents. Following the outcome of the most recent fire drill using night-time staffing levels, the provider had identified that action was required to improve the overall response time. As a result of insufficient assurances that this had been addressed, a time bound urgent action plan was issued to the provider the day after this inspection requiring them to urgently address this.

A new person in charge was appointed to manage this service in August 2020. She held the overall responsibility for the service and had good knowledge of the residents' needs and of the operational needs of the service delivered to them. She was regularly present in the centre each week, which gave her the opportunity to meet with residents and staff. She was supported by her line manager and staff team in the management and running of the service. She was responsible for another service operated by the provider and told the inspector that current support arrangements allowed her to effectively manage both centres. Since the introduction of public health safety guidelines, in lieu of staff meetings, the person in charge now met individually with staff members to discuss any concerns relating to the care and welfare of residents. She also maintained regular contact with her line manager to discuss any operational issues arising within the service.

The provider had made improvements to the staffing arrangements of this centre, with nursing staff now available to the service and additional staff were also recently re-deployed to support residents with their social care needs during the day. This meant that mid-week morning and afternoon staffing levels increased to three, with two staff remaining on duty for the evening and one waking staff member on duty at night. Although this did improve the staff compliment available at the centre, current staffing levels still remained inadequate to meet the assessed needs of residents. For example, one resident, who required behavioural support, was assessed by allied health care professionals as requiring 24 hour one-to-one staff support, however; current staffing arrangements did not allow for this. The inspector spoke at length with the person in charge and staff regarding the level of staff support in place to support this resident with their behavioural support

needs. For the most part, staff were able to meet this resident's needs as additional arrangements were in place which allowed for the rostering of an extra staff during day-time hours, should the behavioural support needs of this resident require it. However, similar staff support arrangements for this resident were not available at night-time. All five residents living at this centre had high support needs and required staff support with most activities of daily living, including, elimination, personal care and required high levels of support and supervision at mealtimes. Due to the high support needs of these residents, along with reduced staffing levels in the evenings, weekends and at night time, this had a direct impact on the quality and safety of care that residents with specific behavioural support received. For instance, following a review of restrictive practice records, the inspector observed a marked dependence on chemical interventions at times of the day where the centre's full staffing compliment was not in place.

Regulation 14: Persons in charge

The person in charge regularly visited the centre each week to meet with residents and staff. She knew the residents and their needs very well and was familiar with the operational needs of the service. She held responsibility for another service operated by the provider and told the inspector that current support arrangements allowed her to effectively manage both services.

Judgment: Compliant

Regulation 15: Staffing

Since the last inspection, nursing staff were appointed to the service for an allocated number of hours each week. Furthermore, additional staff were re-deployed to the service to assist with supporting residents during the day. However, current staffing levels failed to meet the assessed needs of residents, particularly those requiring specific behavioural support.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had ensured that the centre was adequately resourced in terms of transport and equipment. Suitable persons were appointed to oversee and manage this service and staff regularly met with their line manager to discuss any issues arising within the service. Even though the provider had monitoring systems in place

to oversee the quality of care delivered to residents, these were not always effective in identifying specific improvements required within this service. Furthermore, although the provider was in the process of seeking additional resource funding for the centre, it was unclear what accountability and oversight system was in place to effectively monitor, review and formally communicate the progress made towards this action.

Judgment: Not compliant

Quality and safety

Overall, this was a centre that acknowledged and respected each resident's capacity and ability. Systems were in place to ensure these residents had opportunities to participate in activities of interest to them, suitable to their cognitive needs and within public health safety guidelines.

Since the introduction of public health safety guidelines, the provider had implemented a number of measures to ensure the welfare and safety of residents and staff. Daily temperature checks, appropriate use of personal protective equipment and social distancing was occurring. Due to the cognitive needs of residents, staff were supporting them to practice good hand hygiene and cough etiquette. The provider had developed contingency plans, should an outbreak of infection occur at this centre. These plans included isolation arrangements and immediate response procedures, which were subject to regular review by the senior management team.

Where residents required behavioural support, the provider had ensured that they were subject to regular assessment and that behavioural support plans were in place to guide staff on how to support them. However, some behaviour support plans required further review to ensure staff were guided on how to respond to the needs of these residents, especially at night. Records were being maintained where residents experienced behaviours that challenge, however; the inspector found that these incidents were recorded through various reporting systems. For example, some of these incidents were logged on behavioural support logs and some through the centre's incident reporting system. The system of recording didn't ensure consistency in the information being recorded, so as to accurately inform the review of residents' behavioural management.

Restrictive practices were in use and systems were in place to ensure their rationale for use was reviewed regularly by multi-disciplinary teams. A resident in this centre had behavioural support needs and chemical interventions were prescribed to support the resident in this aspect of their care. The provider had introduced guidance to support the administration of this restraint, however; this guidance did not clearly distinguish the time frame in the escalation of behaviour that would need to be displayed by this resident to warrant chemical restraint to be administered.

The inspector reviewed records relating to the most recent administrations of chemical restraint for this resident and observed an increased dependence on this medication in response to behaviours that concern during times where the centre's full staffing complement was not in place. Inadequate records were maintained to demonstrate that the de-escalation techniques as set out in this resident's behaviour support plan were exhausted prior to the administration of restraint. As a result of these gaps in practice, the provider was unable to clearly demonstrate that all other measures were consistently taken prior to the administration of this restraint.

During this inspection, the inspector identified that unclear arrangements were in place to support staff lone-working in the centre at night, should they require support with the safe evacuation of residents. In addition, following the outcome of a fire drill in July 2020 using minimum staff levels, the provider identified that improvements were required to improve the overall evacuation time of residents from the centre. However, it was unclear what action the provider had taken to date to address this. On the day of inspection, this was brought to the attention of the provider and the day after the inspection, a time bound urgent compliance plan was issued requiring them to address this. The inspector also observed that some fire doors in the centre were not effective. This was brought to the attention of the person in charge, who rectified this before close of the inspection.

The provider had fire safety arrangements in place, including fire detection and regular fire safety checks and multiple fire exits were available in the centre. The fire procedure for the centre was readily available; however, it required further review to ensure it accurately guided staff on the specific procedure to be followed at night to ensure the safe evacuation of all residents. Personal evacuation plans were in place for residents and although these, for the most part, informed on how to support residents to safely evacuate, they didn't guide staff on what to do should some residents require specific behavioural support during an evacuation. Even though there was emergency lighting available inside the centre, lighting arrangements to the front of the centre required review to ensure the safety of those exiting from front fire exits.

The identification of risk was largely supported by the centre's incident reporting system, which was maintained under regular review by the person in charge. Although a risk register was maintained for the centre, significant improvement was required to ensure risk assessments were in place to demonstrate the provider's response to specific risks in the centre, particularly those relating to staffing levels, behavioural support and fire safety. The absence of clear risk assessments for these areas didn't support the provider in demonstrating how the impact of these risks was being effectively monitored.

Regulation 26: Risk management procedures

The provider had a system in place for the identification, response and monitoring of

risk at this centre. However, improvement was required to ensure risk assessments were in place to demonstrate the provider's identification and response to specific risks in the centre, particularly those relating to staffing levels, behavioural support and fire safety.

Judgment: Not compliant

Regulation 27: Protection against infection

Since the introduction of public health safety guidelines, the provider had implemented a number of measures to ensure the welfare and safety of residents and staff. Daily temperature checks, appropriate use of personal protective equipment and social distancing was occurring. Due to the cognitive needs of residents, staff were supporting them to practice good hand hygiene and cough etiquette. Plans were in place should an outbreak of infection occur at the centre and these plans were subject to regular review by senior management.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fire safety arrangements in place, including fire detection and containment arrangements and regular fire safety checks. Although there was a fire procedure in place for this centre, it required further review to ensure it accurately guided staff on the specific procedure to be followed at night to ensure the safe evacuation of all residents. Personal evacuation plans were in place for residents, however; these did not guide staff on what to do should some residents require specific behavioural support during an evacuation. Even though there was emergency lighting available inside the centre, lighting arrangements to the front of the centre required review to ensure the safety of those exiting from front fire exits.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Where residents required behavioural support, the provider had ensured that they were subject to regular assessment. Although behavioural support plans were in place, some required further review to ensure staff were guided on how to respond to the needs of these residents at night. Restrictive practices were in use at the

centre and their rationale for use was reviewed regularly by multi-disciplinary teams. However, the administration of some chemical restraint was not supported by a clear protocol. Furthermore, the administration of chemical restraint also required review to ensure the least restrictive practice was at all times used.

Judgment: Not 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Boherduff Services Clonmel OSV-0005363

Inspection ID: MON-0030655

Date of inspection: 07/10/2020

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: The Services will continue to advocate to its funder, the HSE, for additional staffing resources for this location in order to meet the assessed needs of the residents. The HSE have advised that this request has been entered into the 2021 budget estimates. A meeting has been scheduled with Head of Service (Disability) CHO5 for 23rd November 2020 to further progress this issue.</p> <p>In the interim the Service has and will continue to provide temporary additional staffing into the residence at times where a named individual is unwell. This has occurred on 69 occasions in the last 6 months.</p> <p>The Services have devised a plan to provide additional staffing where an urgent issue arises such as illness, behavioural support and emergency evacuation. This plan includes;</p> <ul style="list-style-type: none">- The identification of a number of staff members living in close proximity to the Centre as well as PIC and PPIMs who can be called for assistance on in the event of an emergency. An Emergency Call button that is in place in the house has been updated to include these staff member's contact details.- The identification of two other service locations within 4 and 10mins drive respectively that have on duty staff that can be called on in the event of an emergency.- The availability of a manager on call to the centre 24 hours a day, 7 days a week who can direct additional supports to the house from service areas other than the above and can provide hands-on assistance in the event of an emergency arising.	
Regulation 23: Governance and	Not Compliant

management	
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Registered Provider will review and amend the monitoring tools currently in place used to assess the safety and quality of care provided. These amendments will support the identification of improvements required within the centre in the use of restrictive practices and determine whether;</p> <ol style="list-style-type: none"> 1. Staff members are adequately guided in the use of restrictive practices in the form of clear and accessible support plans that utilize the least restrictive interventions possible in responding to an individual's needs. 2. Reviews of such plans by MDT personnel occur in a timely fashion. 3. The Person in Charge reviews and analyses the implementation of such plans and the use of psychotropic medications on a regular basis to ensure staff members are recording the circumstances around their use, adhering to written guidance and where such reviews indicates that this is not the case identifies the improvements to be made and follows through on same. <p>The Registered Provider has put in place an accountability and oversight system to effectively monitor, review and formally communicate the progress made towards achieving additional funding for this centre.</p>	
Regulation 26: Risk management procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>The Risk Register in this centre has been revised to ensure that it demonstrates the provider's identification and response to specific risks in the centre, particularly those relating to staffing levels, behavioural support and fire safety.</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>The Personal Emergency Evacuation Plans in the centre have been revised to ensure they guide staff on how to respond to specific behavioural needs when conducting an evacuation.</p>	

The fire evacuation procedure in the centre has been revised to ensure that staff are guided on the specific procedures in place for the safe evacuation of the centre at different times of the day reflective of the varying staff levels at these times.

Measures to support the evacuation of the house also include the use of a call button to call on staff living in close proximity to the house who are available in the event of an emergency and the availability of two nearby residential services who have staff that can be called on in the event of an emergency. In addition there is a Manager on call to the centre at all times who can direct further additional resources to the house and provide hands-on assistance if required.

Exterior lighting has been installed to the rear, front and sides of the house to ensure the safety of those exiting during a night time evacuation.

The schedule of fire drills in the centre has been revised to include the conducting of monthly simulations to assure the Provider that individuals can evacuate the centre in the required timeframe with varying levels of staff support and at different times of day and night.

There is an L1 fire alarm system and emergency lighting in place.

All rooms have FD30 fire doors in place. The Services have arranged for the installation of alarm activated free swing door closers to all bedrooms to assist in the safe conducting of night time checks.

The fire place in the centre has been decommissioned. High risk appliances such as the dishwasher, oven and tumble dryer are not in use at night.

The Services' Health and Safety Officer undertook a full review of the fire safety measures in the centre on the week of the 19th October 2020 and any actions identified have been responded to.

Regulation 7: Positive behavioural support	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

Support plans have been reviewed and amended to ensure staff are guided on how to respond to the needs of the residents at varying times of day and night, how to record such responses in a consistent manner and how and when to escalate matters of concern.

The protocol to guide staff on how to respond to a named individual's mental health needs has been revised to ensure clarity for staff members on the tiered, holistic approach required to supporting this individual and the associated time frames to be

adhered to prior to the use of prescribed medications.

The Person in Charge reviews and analyses the implementation of such plans and the use of psychotropic medications on a regular basis to ensure staff members are recording the circumstances around their use, adhering to written guidance and where such reviews indicates that this is not the case identifies the improvements to be made and follows through on same.

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	23/11/2020
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.	Not Compliant	Orange	01/12/2020
Regulation 26(2)	The registered provider shall ensure that there	Not Compliant	Orange	14/10/2020

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	09/10/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	16/10/2020
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	09/10/2020
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	Substantially Compliant	Yellow	14/10/2020

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	05/11/2020