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

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| Name of designated centre: | Curraghboy Apartment |
| Name of provider: | Health Service Executive |
| Address of centre: | Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 15 November 2022 |
| Centre ID: | OSV-0007924 |
| Fieldwork ID: | MON-0038394 |

## About the designated centre

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

Curraghboy Apartment comprises an individual apartment-style dwelling in a rural setting in East Cork, and a three bedroom bungalow in a nearby town. The centre provides full-time residential supports to four residents with an intellectual disability, including those who are autistic. The centre can accommodate both males and females. Residents who may require additional supports in areas including behaviours of concern, mental health, physical health and or medical needs can be supported in the designated centre. A social care model of service is provided. The provider offers a person-centred approach and encourages each resident to reach their fullest potential in all areas of their lives. The staff in the centre have a range of qualifications, skills and experience of supporting people with intellectual disabilities. The staff team work a rota system of day and waking night shifts.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 4 |

## 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 |
|---|---|---|---|
| Tuesday 15 November 2022 | 09:25hrs to 18:30hrs | Caitriona Twomey | Lead |

## What residents told us and what inspectors observed

Curraghboy Apartment comprises a three-bedroom bungalow in a large town in East Cork, and a one-bedroom bungalow located in the grounds of another designated centre in a nearby rural setting. The centre provides full-time residential supports to four adults with an intellectual disability, including those who are autistic. Each resident had their own bedroom and access to a kitchen, dining and living room, as well as an outdoor area. Both buildings also had bathrooms, a utility room and a staff office.

The provider had added the three-bedroom house to this designated centre since it was last inspected on behalf of the Chief Inspector of Social Services in July 2021. Residents moved into this house in December 2021. Prior to that, three residents had lived together in another designated centre operated by the provider. That centre was closed in late 2021, bringing an end to the provider's de-congregation plan. The new house was geographically close to the residents' former home so they were already familiar with the local area. However, they now had neighbours, a base in the community, and a home that was fully accessible to them.

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 adhered to these throughout the inspection. The inspector initially visited the house where three residents lived. On arrival, the inspector saw two people in a car driving away from the centre. The inspector then met with the other staff on duty who confirmed that a member of the staff team had just left in the car to attend training and that a resident who planned to spend some time in a day service had travelled with them. They were both expected back before midday. Despite the public health guidelines in place, the inspector had observed that the staff member was not wearing a face mask while in the car with the resident. The staff member who greeted the inspector advised that they were a relief member of staff and this was their first day working in this house. Staff then called the person in charge who arrived in the centre shortly afterwards. Later, another member of the management team also met with the inspector.

The inspector met a resident who was in the kitchen having their breakfast. The third resident was enjoying a lie-in at the time. The inspector spent some time in the kitchen, dining and living area and then in the staff office. The premises were bright, clean and decorated in a homely manner. The inspector had previously met with this group of residents in their former home and noted how much brighter and more accessible this premises was. Residents had full access to the kitchen area and its facilities. As there were no stairs, residents were able to move around the centre freely and independently. These were both improvements on their former living arrangements.

The kitchen was observed to be clean, well-organised and well-stocked with a variety of fresh and frozen food. The inspector noted that three plates had been

prepared with a cooked meal and covered. When asked, staff advised that this was the residents' lunch. When asked if lunch was usually prepared before some residents had breakfast, staff reminded the inspector that they had not previously worked in the house but that meals were prepared that morning due to the planned absence of the other staff to attend training. The kitchen was well-furnished with cooking facilities and equipment. These were all observed to be clean and well-maintained. The inspector noted that an open tin of pet food was stored in one of the cupboards beside a plug-in grill used for cooking. This was addressed after it was brought to the attention of staff.

Prior to the person in charge's arrival, the inspector had observed a medicine cup containing medicines on the table near the resident who was eating their breakfast. When in the office, another cup containing medicines was seen on a shelf. The inspector asked the staff member on duty about this. They advised that these were the morning medications, already dispensed, for the third resident who was in bed. These had been prepared by the staff member who was no longer in the centre. On review of the medication administration records, the inspector noted that one resident's medications, still visible in the cup on the kitchen table, had been signed by the absent staff member as administered 40 minutes previously. This poor practice was highlighted to the person in charge on their arrival who immediately ensured that both residents were administered their medications as prescribed. In the days following the inspection, further assurances were received from management regarding this acknowledged poor practice.

The inspector had the opportunity to meet with all three residents living in this house. This group clearly enjoyed living together. There was a warm and friendly atmosphere in the house with residents laughing and joking with each other and with members of the staff team. While the inspector was there, residents went out on a number of occasions. One resident chose to stay in the house and was heard enjoying a conversation with the staff member who remained with them. Residents clearly knew the management team well and expressed delight at seeing them in the house. They were also very welcoming to the inspector. Two residents chose to show the inspector their bedrooms and were clearly proud of them. These were comfortable, recently decorated rooms reflective of residents' interests and personalities. Residents spoke with the inspector about things they liked in their bedrooms and showed them items they had chosen. All three residents were positive about their home with one clearly telling the inspector they preferred it to where they had lived before.

Two staff were rostered to work in this house during the day. One staff completed a waking shift overnight. Both staff working on the day of this inspection were members of the relief support team. One had worked with this group of residents many times before, the other staff was working in this house for the first time. All interactions observed were warm, respectful and unhurried. Although this staff member was new to the residents, each of them appeared at ease in their company. The inspector had asked about the induction this staff member had received, especially as they were working alone with two residents that morning. They spoke about a verbal handover from the other staff member and their plan to review personal plans later in the day. Later the person in charge showed the inspector a

folder of key information that is to be used to guide the induction process. Despite this, when asked the staff member did not know key information such as which of the three residents was prescribed emergency medication.

Later in the day, the inspector visited the sole-occupancy house in the company of members of the management team. This resident chose to meet briefly with the inspector. They too were very positive about where they lived, mentioning how peaceful it was. The resident spoke about where they were from originally, various places they had lived, and people they knew. They had gone on a holiday for the first time earlier that year and spoke with the inspector about their hopes to go on another one in the new year. This resident enjoyed going on day trips to towns and tourist attractions. This was reflected in their personal development plan. They had been out earlier that day and returned to the centre for their evening meal. This resident had the support of two waking staff at all times. One staff member sat with the resident and inspector when they met. This staff member clearly had a good understanding of, and relationship with, the resident. The resident was happy for staff to show the inspector their home. The premises was clean, well-maintained and furnished in line with the resident's wishes. The resident enjoyed speaking with the inspector about some photographs on display in their living area. The resident appeared at ease in their home and in the company of those supporting them.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review the consultation with, and feedback from, residents and some relatives documented as part of the annual review process. This feedback was all very positive with residents referencing the support they received to personalise their homes and highly praising the staff team.

As well as spending time with the residents in both houses in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included 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. Staff training and rosters were also reviewed. The inspector read the complaints log for one house and while there was evidence of follow up actions, there were inconsistencies between the information recorded in the log, staff meeting minutes and what was relayed to the inspector. The inspector also looked at a sample of residents' individual files. These included assessments and 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 remainder 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

Good management practices were in place. The provider adequately resourced and staffed the service, and collected information in order to improve the quality of life of residents. Management systems ensured that all audits and reviews required by the regulations were being conducted. There was evidence of management presence and leadership in the centre. As will be outlined, some areas for improvement were identified.

There were clearly-defined management structures 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. Staff reported to a nurse manager, who reported to the person in charge. Both managers were also responsible for one other designated centre, made up of four houses, in the same region. The inspector met with both members of the management team during this inspection.

The person in charge was fully supernumerary. They and the manager who reported to them usually worked opposite shifts to each other, with some shifts scheduled to facilitate meeting each other. The inspector was informed that both houses in the centre were regularly visited by one or both members of the management team. Management presence in the centre provided all staff with opportunities for management supervision and support. It also supported the development and maintenance of relationships with the residents.

Although the management team had plans and procedures in place regarding staff induction, infection prevention and control, and a protocol in place for when staff required assistance regarding administering medications, as outlined in the previous section of this report, evidence on the day of this inspection was that these were not implemented. Improvements were required to ensure the staff team were aware of, and working in line with, the provider's policies and procedures.

Staff meetings were scheduled separately for the groups working in each house. These took place approximately every two months. Video and telephone conferencing was used to maximise attendance at these meetings. The inspector reviewed the minutes of the most recent meeting held in September 2022. The importance of recording residents' progress in achieving their goals was discussed at this meeting. This was consistent with a finding of this inspection which will be outlined in the next section of this report. One-to-one staff supervision sessions had taken place for each member of the team this year, with follow-up sessions scheduled.

The provider had arranged for the completion of an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in January 2022 and involved consultation with residents and their representatives, as is required by the regulations. The positive feedback received at this time was

referenced in the opening section of this report. An unannounced visit had taken place in January 2022 and again in July 2022. Where identified, actions to address areas requiring improvement were being progressed or had been completed. For example, at the time of this inspection most staff had completed training in food hygiene. A number of other audits and checks were being completed on a regular basis in the centre. Areas monitored included residents' personal plans, medication management, fire safety, and practices associated with infection prevention and control (IPC).

There was a culture in the centre that welcomed complaints. Residents reported that they would feel comfortable raising any issues with either staff or management. A review of the complaints log in one house demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded, as is required by the regulations. However, when reviewing the two most recent complaints, it was noted that the information outlined in the complaints log was not consistent with what was reported to the inspector and what was referenced in staff meeting minutes. The person in charge, who had completed the complaints log, advised that this was an error and that the record would be an amended.

The inspector also reviewed staff training records regarding the areas identified as mandatory in the regulations. It was identified that one staff member required training in fire safety. Planned and actual staff rotas were available in the centre. From a review of a selection of weeks in one house, the inspector assessed that staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose. Management advised that on occasion, during staffing shortages, one of the management team had based themselves in the three-bedroom house to be available to support staff and residents, as required. This management presence facilitated community-based activities, if requested, and staff breaks.

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 and facilities provided, the resident profile, and the governance and staffing arrangements in place. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the organisational structure and staffing whole-time equivalents outlined were accurate. Additional information regarding the emergency procedures in the centre was also required.

## Registration Regulation 8 (1)

The registered provider had applied for the variation of a condition of registration using the form determined by the Chief Inspector.

Judgment: Compliant

## Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

## 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 and skill-mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had recently attended the majority of trainings identified as mandatory in the regulations. One member of the staff team required fire safety training.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

A directory of residents was in place and met the requirements of this regulation.

Judgment: Compliant

## Regulation 23: Governance and management

The management structure in place ensured clear lines of authority and accountability. The provider had sufficiently resourced the centre. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was evidence that where issues had been identified, actions were completed to address these matters. Management presence in the centre provided all staff with opportunities for management supervision and support. Staff meetings and one-to-one meetings were regularly taking place which provided staff with opportunities to raise any concerns they may have. While there was evidence of effective management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs, findings of this inspection indicated that some improvements were required to ensure that all members of the staff team were aware of, and implementing, the provider's policies and procedures regarding staff induction, medication management, and infection prevention and control.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

There were recently reviewed written service agreements in place which outlined the fees to be charged to live in the centre. Residents had the opportunity to visit the designated centre before moving in.

Judgment: Compliant

## Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the organisational structure and whole-time equivalent (WTE) hours were accurate. Additional information regarding the emergency procedures in the centre was also required.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

One incident was not notified to the Chief Inspector within the timeframe specified

in this regulation.

Judgment: Not compliant

## Regulation 34: Complaints procedure

An accessible complaints procedure was in place. A review of the complaints log in one house demonstrated that any complaints made were investigated promptly and the satisfaction of the complainant was recorded. However there were inconsistencies between the details documented in the complaints record and relayed to the inspector. Management advised that the record was inaccurate and would be reviewed and revised.

Judgment: Substantially compliant

## Quality and safety

Overall, residents were very happy living in this centre. They were positive about the services they received and exercised choice and control in their daily lives. All residents participated in their local communities in line with their wishes and preferences. They were safe in the centre and had positive relationships with the staff supporting them. While there was evidence of a high standard of support provided to residents, poor practices observed on the day of inspection resulted in some non-compliances with the regulations.

The three residents who lived together had busy, active lives. They were regular customers of local coffee shops and enjoyed a range of other activities including going for walks, aromatherapy, listening to the radio, spending time with relatives, and visiting a local beach. Two residents were attending local adult education classes. There were magazines, puzzles, and other items of interest available in their home. These residents had televisions in their bedrooms and there was also one in the living room area. They enjoyed watching television and could be heard laughing at one of their favourite comedy programmes while the inspector was there. On the day of the inspection a chiropodist called to the house and the residents enjoyed catching up with this person while receiving their treatments.

Staff had supported the resident who lived alone to participate in a number of activities for the first time in the last year. These included a holiday and a hot towel shave. Both activities had been a success and the resident was looking forward to enjoying them again in the future. Other activities had been considered but the resident had changed their mind and this was respected. As outlined in the opening section of this report, this resident enjoyed going on day trips and there was

evidence that they had visited a large number of towns in Cork, neighbouring counties, and beyond.

Residents' meetings took place weekly in the larger house. A review of these meeting minutes showed that there was a regular meeting agenda in place which included safeguarding, complaints, activities, and meal planning among other topics. There was evidence that matters were raised by residents at these meetings. Although it was not always documented, management advised that these were addressed and it was a recent action for the staff team to document this in subsequent meeting minutes. One resident living the centre had previously received the support of an advocate. This advocate was not currently supporting the resident with a specific issue but still maintained contact. Visitors were welcome in the centre and some residents also visited relatives in their family homes or met them locally.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. The plans regarding personal and intimate care were noted to be very detailed and outlined each resident's specific personal preferences. Personal communication dictionaries were available to support staff to understand how residents communicated. Communication guidelines were also available to ensure staff communicated in a way that was meaningful to residents. Multidisciplinary reviews of each resident's personal plan had taken place in the last 12 months. It was noted that these reviews did not take the form of a meeting but that instead multidisciplinary professionals involved in the residents' supports were asked to contribute to a review document. Some of these were very lengthy. Not all reviews included an action plan regarding any recommendations made. It is a requirement of the regulations that any recommendations arising out of a multidisciplinary review, including those responsible for following up on those recommendations, are recorded. Management advised that these were stored and updated on the person in charge's computer.

Residents' healthcare needs were well met in the centre. Residents had an annual health and wellbeing assessment. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. Residents participated in national health screening programmes. There was also evidence of input from dentists and health and social care professionals such as occupational therapists and physiotherapists. Two residents had recently received equipment to support their mobility. Some residents had documented speech and language therapy recommendations regarding feeding, eating, drinking and swallowing. Staff spoken with were familiar with these. Staff reported one resident's sleep habits had recently improved, as had other health conditions. A summary document had been developed for each resident to be brought with them should they require a hospital admission.

Residents' personal plans also included plans to maximise their personal

development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests. From the documentation available, it was not always possible to determine what, if any, progress had been made in achieving these goals. For example, it was documented that a resident was offered opportunities to take part in activities but it was not clear if they had participated. For another resident, whose plan had been developed over May and June 2022, there was no documented review or progress for a number of their goals five months later. The importance of documenting residents' progress in achieving their goals had been highlighted by management at the most recent staff meeting, held two months prior to this inspection.

As outlined in the opening section of this report, three residents moved to this centre in December 2021. Four months prior to the move, members of the current staff team began supporting them in their former home. Individual transition plans had been prepared, implemented, and reviewed to support this move. These included visits to the house in advance of moving in. The inspector reviewed the associated documentation and could see from their time spent in the house that this transition had been a success for each resident involved.

Residents who required one had a behaviour support plan in place. The plan reviewed by the inspector was very comprehensive and outlined proactive approaches to prevent or reduce the likelihood of an incident occurring, and also response plans to be implemented if required. This plan had been developed with input from a number of people involved in this resident's support, and was regularly reviewed. This plan included the use of PRN medicines (medicines only taken as the need arises) and a physical restraint. There was evidence that there were clear guidelines in place regarding the use of these strategies, that their use was regularly reviewed, and that they were used as a last resort. The use of each restraint had been risk assessed and these assessments were also under regular review.

As outlined in the opening section of this report, poor practice was identified regarding the administration of medicines and the inaccurate signing of associated documentation in one of the houses in the designated centre. This practice was inconsistent with the medication management training that both staff involved had received, and the provider's own policies and procedures. In addition this practice removed safety checks and increased the risk of medication errors being made. This was addressed by management on the day and evidence of further follow-up actions was submitted to the Chief Inspector in the days following the inspection.

As outlined in the opening section of this report the centre was bright, decorated in a modern style, and generally clean. However, some damaged surfaces were noted in the centre. These included the shelving in some kitchen units. Due to the damage observed, it would not be possible to effectively clean these surfaces. Laundry equipment was available in well-organised utility rooms. Systems were in place to ensure that clean and unclean items were kept separate. Posters on display indicated that a colour-coded cleaning system was in use in the centre whereby certain coloured equipment was used in specific areas to reduce the risk of cross

contamination. Equipment was stored according to this system.

There was evidence of many good infection prevention and control (IPC) practices and systems in the centre. The provider had an identified IPC lead available to the staff and management team. Regular IPC audits were completed. All staff had completed IPC training, including hand hygiene. Supplies of PPE were available. However, as outlined previously not all staff were observed to use personal protective equipment (PPE) in line with the guidance in place. Hand washing facilities were available and pedal bins were in place. A sharps container was stored safely. The provider had a contingency and isolation protocol in place to be implemented if required. This plan reflected the individual needs of the residents living in this centre. Templates were available for staff to use to record observations of residents who were unwell. There had been one confirmed case of COVID-19 in a resident of the centre since the last inspection and they had been supported to recover in their home. Management were aware of the most recently published public health guidance regarding COVID-19 and other respiratory infections and the provider's current policies and procedures were under review in light of this recent revision.

## Regulation 10: Communication

Staff were aware of residents' communication needs, supports and preferences. Residents had access to televisions, telephones and the internet.

Judgment: Compliant

## Regulation 11: Visits

Residents were free to receive visitors if they wished and both communal and private spaces were available to facilitate this.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. Opportunities were provided to participate in a wide range of activities in the centre and the local community.

Judgment: Compliant

## Regulation 17: Premises

The centre was clean, suitably decorated, well-maintained and accessible to the residents living there. The premises were laid out to meet the aims and objectives of the service and the needs of residents. Each resident had their own bedroom and access to communal spaces.

Judgment: Compliant

## Regulation 18: Food and nutrition

There was evidence that choices were offered at mealtimes and that staff had a good knowledge of residents' individual dietary needs. Residents were supported to be involved in meal preparation in line with their wishes.

Judgment: Compliant

## Regulation 25: Temporary absence, transition and discharge of residents

Residents were supported to be involved in the preparation for their move to this designated centre. Information on the supports and services available was provided in advance of, and following, the transition.

Judgment: Compliant

## Regulation 27: Protection against infection

A COVID-19 contingency and isolation plan specific to the residents and layout of this centre was in place. The staff team had completed training in infection prevention and control, including hand hygiene. Despite this, one member of staff was observed not using the personal protective equipment (PPE) outlined as required in current public health guidance and the provider's own policy. When in the kitchen of one house it was noted that an open can of pet food was stored beside a piece of equipment used for food preparation. In general both premises were observed to be clean however there were some damaged surfaces observed. As a result of this damage it would not be possible to effectively clean these

surfaces.

Judgment: Substantially compliant

## Regulation 29: Medicines and pharmaceutical services

The practices observed by the inspector regarding the administration of medicines, and the associated documentation, in one of the houses was not consistent with the training provided to staff and the provider's medication management procedures and policy. This was addressed immediately once brought to the attention of the person in charge.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs had been completed for each resident. Each resident had a comprehensive personal plan. An annual review, involving multidisciplinary professionals, had taken place. Residents had been involved in the development of a personal development plan. Improvements were required in the review and documentation of residents' progress in achieving their goals.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents were supported to receive the services of a variety of medical practitioners and health and social care professionals.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents who required one had a recently reviewed behaviour support plan in place. Any restrictive procedures in place in the centre were closely monitored and

regularly reviewed.

Judgment: Compliant

## Regulation 8: Protection

The provider had systems in place to protect residents from all forms of abuse. There were no safeguarding concerns in the centre at the time of this inspection. All staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

The centre was operated in a manner that respected residents' rights. Each resident received a service tailored to their individual needs, preferences and requests. Residents were encouraged and supported to exercise choice and control while living in the centre.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 8 (1) | Compliant |
| Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities | Compliant |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 25: Temporary absence, transition and discharge of residents | Compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Curraghboy Apartment OSV-0007924

## Inspection ID: MON-0038394

## Date of inspection: 15/11/2022

**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:<br>Fire safety training is scheduled and will ensure 100% compliance by 24/01/2023. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A comprehensive review has been completed for medication administration – 21/11/2022.<br>The incident of poor practice has been addressed in line with relevant HSE policies within 5 working days of the event – Action completed 20/11/2022.<br><br>The guidance in relation to Infection prevention and control - specifically guidance in relation to use of centre vehicles was reviewed and updated on 20/11/2022.<br>Staff responsibilities in relation to infection prevention and control communicated to all staff Action completed 21/11/2022.<br><br>Process in place for staff induction has been reviewed and strengthened and the updated version has been active since 20/11/2022. | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>The organizational structure and the whole time equivalent number were corrected on the day of inspection 15/11/2022. In the event that a residence has been deemed unsafe to be occupied, alternative arrangements as outlined in the emergency plan have been | |

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| added to the statement of purpose on 21/11/2022. | |
| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>Process in place to ensure compliance with notification requirements has been strengthened from the 20/11/2022. | |
| Regulation 34: Complaints procedure | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 34: Complaints procedure:<br>The discrepancy identified on inspection in relation to a complaint and the documentation supporting same has been addressed on 16/11/2022. | |
| Regulation 27: Protection against infection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 27: Protection against infection:<br>The guidance in relation to Infection prevention and control which includes guidance in relation to use of centre vehicles was reviewed and updated on 20/11/2022, staff responsibilities in relation to infection prevention and control has been re-communicated to all staff on 20/11/2022. The opened can of pet food was removed on the day of inspection. The defect on the work surface has been addressed 06/01/2023. | |
| Regulation 29: Medicines and pharmaceutical services | Not Compliant |
| Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:<br>A comprehensive review has been completed for medication administration, the incident of poor practice has been addressed in line with relevant HSE policies within 5 working days of the event – Action completed 21/11/2022. | |
| 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:<br>A PCP audit tool has been developed and an initial audit was completed on 01/12/2022. This audit will be completed going forward 3 monthly by the CNM2 and the findings will be discussed with the PIC and the staff team, all identified actions from this audit will be completed within 4 weeks of the audit. | |

## 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 | 24/01/2023 |
| 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 | 21/11/2022 |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare | Substantially Compliant | Yellow | 06/01/2023 |

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| | associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | | | |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Not Compliant | Orange | 21/11/2022 |
| 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 | 21/11/2022 |
| Regulation 31(1)(g) | The person in charge shall give the chief inspector notice in writing within 3 working days of the | Not Compliant | Orange | 20/11/2022 |

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| | following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff. | | | |
| Regulation 34(2)(f) | The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied. | Substantially Compliant | Yellow | 16/11/2022 |
| 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 | 01/12/2022 |