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:	Bellavista
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	11 October 2023
Centre ID:	OSV-0001701
Fieldwork ID:	MON-0041130

About the designated centre

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

Bella Vista is a designated centre operated by Sunbeam House Services CLG. The centre consists of a large community house located in an estate in a large town in Co. Wicklow. The house has ten bedrooms, a large living room, a kitchen/dining room, two bathrooms, a shower facility and a small toilet room. The centre provides residential supports for up to eight adults, both male and female, with low to moderate supports needs. The centre is intended to support residents to live as independently as possible. The support provided to residents varies depending on individual needs and requirements. The current staffing compliment is made up of social care workers and care assistants with the staff team supervised by a person in charge. The person in charge divides their working hours between this centre and one other.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 11 October 2023	09:45hrs to 17:45hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The inspector found that the person in charge and staff were striving to ensure that residents living in the designated centre were supported to enjoy a good quality life and to make choices and decisions about their care. However, some aspects of the service provision were impacted upon due to the ineffective action taken by the provider to implement plans to improve the centre.

While residents were supported to live and enjoy life as independently as they possibly could, due to the layout of their home, this was not always possible for all residents. The person in charge and staff were endeavouring to ensure residents were provided care and support in a home that was well maintained and safe. However, due to the poor upkeep and repair of the premises and ongoing inadequate fire containment issues, there was an unnecessarily increased level of risk to residents' safety in their home.

On the day of the inspection, the inspector met with five of the eight residents living in the centre. The inspector observed residents coming and going to different community activities throughout the day. Many of the residents were able to move around the house without assistance. However, three residents required support of mobility aids and in some cases additional assistance from staff to mobilise.

Some residents relayed their views of living in the centre while other residents chose not to. Overall, residents expressed through these conversations with the inspector that they were happy living in their home. They liked the layout and décor of their bedrooms and where some bedrooms had been recently re-painted, residents had been consulted about them.

Residents were aware that there home due an upgrade and refurbishment. They had also been made aware that they would be moving to a new home while the works occurred. Where appropriate, residents families had also been informed of the plans, however, the commencement dates of the plans had changed and no new date had be relayed to the residents. They advised the inspector on the day that they were not sure when they were moving. In addition, on review of family feedback, while overall, positive, families had noted about the number of times the commencement date of works had been rescheduled.

On a walk-around of the premise the inspector observed that overall, the physical environment of the house was clean and tidy. Residents bedrooms were decorated in line with their likes and wishes and were personal to them. The staff and residents were striving to provide the house with a homely and welcoming feel; there were art and craft works throughout the house that had been created by residents living in the house. There was a large fish tank in the sitting room which provided a relaxing feel to the room. There were certificates of achievements

hanging on walls and an array of photographs of residents and their family enjoying different community activities and social events.

However, despite these efforts, overall the poor upkeep and state of repair throughout took away from the homely feel to the house. It also meant that there was an increased infection prevention and control risks to residents living in the centre.

The inspector observed the kitchen, bathrooms, sitting room, bedrooms and hallways were in need of upkeep and decorative repair. For example, the paint on the walls was badly scuffed and chipped, the wallpaper in the hall corridor was torn, there were kitchen floor tiles missing, the paint on the kitchen timber window sills next to the sink to be blistered and badly worn, door saddles, doors and door frames were scuffed and chipped in areas. A number of walls in the house appeared grubby and required painting.

The inspector also observed a number of the fire doors in place to be scuffed, chipped and to have visible gaps underneath them. This meant that they were not an effective fire containment measure and as such impacted on the effectiveness of fire containment measures in the home which was an important risk mitigation precaution required to ensure good overall fire safety measures.

There was a garden area located to the rear of the house. The inspector observed there to be some ongoing maintenance work to the area. The inspector was advised that funding had been provided and a new garden and patio area was under construction. There were plans to have a sheltered seating area outside for resident to enjoy. There was also a garden to the front of the house, the inspector observed some of the garden slabs to be lifted and overall, a possible trip hazard.

For the most part, the inspector found the centre to have a friendly and jovial atmosphere. Residents informed the inspector that they were happy to be living in the house and liked where it was located as it was near shops, bus stops and close to towns where their friends lived.

Residents were encouraged and supported around active decision making and social inclusion. Residents participated in regular house meetings where they discussed household tasks, plans for the week, health and safety matters but to mention a few. On review of the minutes, it was clear that each resident, who wished to participate relayed their view at the meeting.

Residents were encouraged to eat a varied diet and ere communicated about their meals and their food preferences. Residents sat with the staff and made choices of what they would like to eat for their meals. Food was appetising and served in an appropriate way to ensure that residents enjoyed their food. There was adequate amounts of wholesome and nutritious food and drink available to the residents and the inspector observed that food was stored in hygienic conditions. For example, on observing food in the fridge, for the most part, food that was opened included labels with the opening dates.

Where residents required assistance with eating or drinking, there was a sufficient number of appropriately trained staff available to support residents during mealtimes and were consistent with the residents individual dietary needs and preferences as laid out in their personal plan. The inspector observed the staff sitting with and supporting a resident during their meal and it appeared to be a positive and social event. The staff was mindful about the additional needs of the resident and supported them in a way that protected their privacy and dignity.

In summary, the inspector found that overall, the person in charge and staff were striving to ensure that residents' well-being and welfare was maintained to a good standard. The residents were encouraged and supported to live independent lives. The inspector observed that residents seemed content in the company of staff. There were positive and jovial interactions between staff and residents. However, improvements were needed to the physical environment residents were living in and a suite of fire safety upgrades were also required to ensure good fire safety precautions which could mitigate risks for residents.

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

The provider had failed to take the appropriate steps to ensure that the designated centre operated within all of the centre's registration conditions by not adhering to the time-lines and requirements as set out in a non-standard condition of their registration.

The non-standard condition formed part of the centre's overall conditions of registration and was initially assigned to the centre's registration in May 2021 requiring the provider to bring the centres' premises (regulation 17), fire precautions (regulation 28) and governance and management (regulation 23), back into compliance by a specified date. However, in 2022 it was found that the provider was not in a position to meet the time-line of the condition and following an escalation meeting with the Chief Inspector, the provider applied to vary the condition to extend the non-standard condition with an end date time-line of July 2023 with additional assurances given by the provider demonstrating how they intended and planned to come back into compliance within the allocated time-frame.

However, as of the day of this inspection, required work to the premises as well as to the fire safety systems in the house, remained outstanding which in turn meant the provider had failed to meet the matters of the non-standard condition applied to the registration of the centre.

This failure of the provider to adhere to the non-standard condition time-frames and failure to bring their plans to meet the condition within the time-frames set out, demonstrated the provider's governance and management systems did not provide sufficient oversight of the provider's regulatory responsibilities and requirements.

In addition, it also demonstrated that the governance and management systems in place were continuing to not ensure the service provided was always safe, appropriate to residents' needs and effectively monitored at all times.

The ongoing non compliance in fire safety and premises were continuing to impact negatively on the lived experience of residents in the centre creating an unnecessary and on-going increased risk to residents' safety and well-being.

For example, the upgrades to fire containment as well as other fire safety works were required, not only to meet the general requirements of appropriate fire safety precautions in designated centres, but also with due regard to the mobility needs of some residents which could impact on their ability to evacuate the centre in a timely way and would require optimum fire precautions and containment measures to be in place to support these matters

The premises upgrade works were not only required to ensure residents were provided with the most optimum home environment but also to ensure good infection prevention and control measures could be in place to mitigate the risk of spread of health-care infections.

The provider had made minimal progress towards meeting their non-standard condition requirements.

On the day of the inspection, a list of required upgrade and refurbishment work was provided to the inspector from the provider's facilities department. The inspector was also provided with document which demonstrated that funding had been approved for an architect to complete a survey of the premises.

While funding had been made available for the drafting of architectural plans, it was not demonstrated that the provider had sourced or secured funding for the works that would be required.

This meant the provider was at the very early stages of implementing their plan to upgrade and refurbish the centre despite the centre having a non-standard condition relating to these matters attached to the registration of this designated centre since 2021. The timeliness of the provider to bring the centre back into compliance and ensure the safety of the residents was not satisfactory and demonstrated poor capacity and capability of the provider to follow through on plans to address non-compliance.

Notwithstanding the above, there were a number of good centre based governance and management systems in place.

The person in charge was following up on actions from the most recent six monthly unannounced review of the quality of care and support provided to residents in the

centre. There was a monthly household audit in place which monitored a variety of areas of service provision to ensure better outcomes for residents. Team meeting were taking place where shared learning and reflective practices occurred.

The person in charge was on leave on the day of the inspection, so the deputy manager supported the inspection in their place. The deputy manager had commenced their role in June 2023. The inspector found that they were knowledgeable about the assessed needs of residents and the supports required to meet those needs.

Overall, staffing arrangements included enough staff to meet the needs of residents. There was continuity of staffing so that attachments were not disrupted and support and maintenance of relationships were promoted. Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre. The inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of residents through person-centred care and support.

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents. The training needs assessments demonstrated that overall, the majority of staff training was up-to-date, including refresher training.

For the most part, there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements. However, improvements were needed to ensure that where restrictive practices were in use, that these were notified to the office of the chief inspector on a quarterly basis as required.

Regulation 15: Staffing

There was sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents living in the centre. The staff roster was maintained appropriately and identified the times worked by each staff member. Primarily there were three to four staff working each day and three staff working at night; one waking night staff and two sleep-over staff. Where there were additional staff in place, this was to provide one-to-one support to residents during different community activities.

Staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

The deputy client service manager position was filled in June 2023. The deputy provided administrative support to the person in charge to support them oversee the

residential service and meet its stated purpose, aims and objectives. The deputy manager also covered a number of social care worker shifts each week.

There were agency staff employed in the centre. The roster demonstrated that the same agency staff had worked in the centre for a long period of time. For the most part, they covered annual leave including other types of staff leave as they arose. Where there had been a slight increase in use of agency staff, this was to cover unexpected sick leave.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents.

The inspector reviewed the centre's staff training needs assessment document. This system supported the person in charge to monitor the training needs of staff and to ensure training was up-to-date. Where refresher training was needed, the person in charge contacted the staff member and provided a training date and location for the required course.

Staff completed training in areas such as, fire safety, safeguarding of residents, infection prevention and control, feeding, eating drinking (FEDs), Dysphagia, restrictive practice, food hygiene, human rights, rescue medicine and safe medication management.

The person in charge had identified a training need following an adverse incident relating to food consumption. To enhance training already in place, the person in charge organised in-house training that was specific to the needs of resident concerned. Most of the staff had completed the training however, as of the day of inspection, five staff had yet to complete it. The inspector was advised on the day, that another set of training in this area was upcoming.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to take the appropriate steps to ensure that the designated centre operated within all of the registration conditions.

In 2022, the provider was required to attend an escalation meeting with the office of the Chief Inspector as it had not completed all actions to bring Premises (regulation

17), Governance and Management (regulation 23) and Fire Precautions (regulation 28) back compliance by the agreed time-line.

The provider submitted an application to vary to extend the non-standard condition. In addition, the provider submitted a quality improvement plan which included actions and time-lines to bring regulation 17, 23 and 28 back in to compliance by 10/07/2023.

In quarter one of 2023, a meeting was held with the provider regarding upgrade and refurbishment plans for premises works throughout the organisation. The provider was requested to submit a strategic plan in quarter one and again in quarter three and to include commencement dates of projects and likely duration of the works. The upgrade and refurbishment works for this designated centre was included on the plan. However, the quarter three strategic plan commencement dates for this centre had been moved out from July 2023 to January 2024.

While the provider had self-identified changes to time-lines, (which were outside their non-standard condition time-frame), they had not made adequate arrangements to address the matter or submit an application to vary their non-standard condition time-line to reflect the change in circumstances.

As such, the provider did not demonstrate that there were adequate governance and management systems in place to monitor and have oversight over their regulatory requirement.

In addition, the provider had not put in place any mitigation arrangements in the centre to ensure the service provided to residents was safe while waiting for larger upgrade works to commence.

For example, the provider had not enhanced the containment measures in the centre to ensure the promotion of good fire safety precaution arrangements as an interim risk management measure.

This was impacting negatively on the lived experience of residents in the centre and in particular, posed an unnecessary increased fire safety risk to residents.

During the inspection, the inspector was provided with a list of upgrade and refurbishment works required to the centre however, the plan of works was at a very initial preliminary stages and it was unclear if funding was in place to implement the scope of works that would be required.

This is discussed further under regulation 17 and 28.

Judgment: Not compliant

Regulation 31: Notification of incidents

For the most part, there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge was endeavouring to ensure that incidents were notified in the required format and with the specified time-frames.

However, on the day of inspection, the inspector found that improvements were required to ensure all notifications relating to restrictive practices were notified on a quarterly basis as required.

For example, practices relating to an alarm monitoring system for one resident, practices relating money management, and limited access to websites.

Judgment: Substantially compliant

Quality and safety

The inspector found that the person in charge and staff team were endeavouring to ensure that each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the centre's management and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs.

However, due to the ongoing fire safety issues, infection prevention control issues and premises issues there was an increased and continuous potential risk to residents' that required the provider to put in place effective and suitable measures in order to mitigate and manage those risks.

The provider had not taken adequate precautions against the risk of fire in the designated and in particular, had not provided adequate arrangements for detecting and containing fire. This meant that there was an unnecessary increased risk to residents' safety ongoing in the centre for a lengthy period of time.

The designated centre was a large two story premises which was divided into different areas by corridors and doors. There were a number of residents living in the centre who used mobility equipment when moving around inside and outside the house. These residents required specific supports when evacuating the centre in the case of a fire.

The level of compliance found on inspections of the centre in 2020, 2021 and 2022, did not provide assurances that the provider had taken all necessary steps to come in to compliance with Regulation 28: Fire Safety Precautions.

The provider had put a plan in place and time-lines to complete actions that would improve the fire safety management systems in the centre, ensure the safety of residents and bring fire precautions back in to compliance with the regulation,

however, most actions had not been completed with the time-frame and remained outstanding.

Overall, the physical environment of the house was not in good decorative and structural repair. As such the design and layout of the premises was not ensuring that each resident could enjoy living in an accessible, safe, comfortable and homely environment. This impacted on the promotion of independence, recreation and leisure and negatively impacted on the safety of residents living in the centre.

Since the last inspection, there were some improvements found to the systems in place that better ensured the effectiveness of the infection, prevention and control measures in the house. However, the poor condition and state of repair throughout the house meant that the arrangements put in place by the person in charge and staff team could not always be entirely effective in the promotion of good infection prevention and control at all times.

The inspector found there to be suitable amounts of wholesome and nutritious food and drink available to the residents. Residents' food and nutritional needs were assessed and used to develop person plans that were implemented into practice. Staff were provided appropriate training in feeding, eating and drinking (FEDS). Where appropriate food and beverages for residents were prepared for in line with their feeding, eating and drinking (FEDS) support plans that were contained within residents' care plans.

Residents were protected by good safeguarding arrangements in the centre. Staff were provided with appropriate training relating to keeping residents safeguarded. Safeguarding measures were in place to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity. However, a review of the location of residents safeguarding plans was needed to ensure that, at all times, they were easily accessible to residents, staff and all management.

Medicine management arrangements and practices were appropriate and in accordance with the provider's associated policy; The practice relating to the ordering; receipt; prescribing; storing; disposal; and administration of medicines was appropriate. There were suitable arrangements in place to ensure that medication was stored appropriately and administered as prescribed. Residents' medication was administered by staff who were provided with appropriate training. There were guidance documents in place to ensure that medicines were administered as prescribed and overall, these were accurate and sufficiently detailed.

However, in line with the provider's safe medication policy, a review of the PRN protocol document (a medicine only taken as required), was required. This was to ensure that appropriate oversight of the protocols was clearly documented.

Regulation 17: Premises

The poor state of upkeep and repair of the premises was impacting on the accessibility needs of residents, the quality of their environment and could not promote optimum implementation of infection prevention and control standards and precautions.

The provider had not taken sufficient action to complete recommended works that would better promote residents' independence and accessibility in their home.

A ramped entrance/exit at the front of the house, which had been recommended by a health professional in 2019 but was not put in place by the provider until 2022. Despite this however, a raised fixture to the base of the door frame meant that residents, who used mobility equipment, continued to require support when entering or leaving this doorway and therefore the measure put in place remained ineffective.

The inspector observed a number of raised door saddles on internal doorways which reduced optimal access and egress through these doorways and overall, impacted on residents ease of movement around their home independently. When speaking with staff, the inspector was advised of the difficulty some residents experienced when moving from one room to another, due to the door saddles.

Furthermore the steps from the kitchen to the garden at the back of the house meant that not all residents could exit the kitchen without support.

In addition, at the front of the house the inspector observed broken and raised patio slabs, which posed a possible trip hazard.

Despite a focused IPC inspection occurring in the centre in 2022, which found non-compliance and highlighted the requirement for premises improvements to ensure good IPC arrangements, the provider had not completed all premises-related actions from that inspection.

On the day of the inspection, the inspector was provided with a document that listed the plan of upgrade and refurbishment for each area of the house. The plan included new flooring in many areas of the house, new kitchen, new walls, replacement of wardrobe doors, additional plug sockets, replacement of light fittings, upgrades to shower, toilet and bathroom facilities, but to mention a few.

However, there was no time-line in place for the plan and a number of the items on the plan had been outstanding for a number of years.

The inspector found that overall, the outstanding repair work to the premises was negatively impacting on residents' accessibility, independence and safety in their own home.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were encouraged to eat a varied diet and were communicated about their meals and their food preferences. The inspector found there to be adequate amounts of wholesome and nutritious food and drink available to the residents.

Residents food and nutritional needs were assessed and used to develop person centred plans that were implemented into practice. Where required, there were supports in place to ensure that all residents could enjoy eating their food as independently as they were capable of. For example, one residents, in line with their assessed needs, was provided with a special type of spoon that enabled them to eat with minimum assistance.

The inspector observed staff preparing and serving food to residents who had special dietary requirements. The inspector found, that at times when a resident needed assistance, staff offered help in a respectful and dignified way alongside promoting their independence.

Overall, the inspector observed the residents' food and drink to be stored in hygienic conditions and that there were systems in place to monitor the appropriate storage of food and drink, such as labelling open food items, temperature checks and cleaning schedules.

Judgment: Compliant

Regulation 27: Protection against infection

Since the last inspection, there were new and improved cleaning checklists in place, including deep cleaning schedules. The person in charge had also implemented cleaning checklist for residents' mobility equipment. There were flushing checklists in place for water outlets that were not used frequently and improvements had been made to cleaning equipment, such as colour coded mop buckets and mops.

A walk-around of the centre demonstrated that while the premises was generally clean and tidy, not all areas of the premises were conducive to a safe and hygienic environment. Many of the rooms in the house, including kitchen, sitting room, a number of bedrooms and bathrooms required upkeep and repair.

The inspector observed walls to be badly scuffed and chipped, wallpaper to be torn, kitchen floor tiles missing, the paint on the kitchen timber window sills next to the sink to be blistered and badly worn, door saddles, doors and door frames to be scuffed and chipped in areas. A number of walls in the house appeared grubby and required painting.

While referred to in regulation 17 premises, the significant upkeep and repair work required to the premises were overall, impacting on the systems that mitigated the risk of spread of healthcare-associated infection occurring.

For example, due to the poor state of repair of fixtures, fittings, facilities as well as internal walls, doors and door-frames, these areas could not be cleaned to the optimum standard. This meant that areas of the house posed a risk to the infection, prevention and control measures in place and overall, the safety and quality of care provided to each resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

An external fire safety assessment was completed in May 2021 for the centre and recommendations made. Some of the recommendations were red risk rated and needed to be completed within six months of the report findings, other recommendations were orange risk rated which needed to be carried out within six to twelve months with the remainder of the recommendations to be carried within 24 months.

On the day of the inspection, the majority of the recommendations remained outstanding, a number which had been risk rated red and orange.

For example, a number of existing fire doors and frames required to be replaced as there were excessive gaps observed under the fire door which would allow the passage of smoke. There was damage to some fire doors which reduced the performance of the fire door and overall its effectiveness. The integrity of a number of walls and ceilings was highlighted and in particular in relation to their fire resistant capacity.

The upgrade and refurbishment plan of works for the centre included the required fire safety works. The plan included replacing the majority of the existing fire doors and frames in the centre included new door fixtures and fittings. Upgrading of walls, a new fire panel that would link to door closers, upgrade of hot-press door, upgrade to ceilings and installation of new fire resistant hatch to attic. While these works would ensure effective fire safety management systems in the centre, there was no time-line in place for the plan and the funding to complete the works had not yet been approved.

While there were a number of safety measure in place attempting to reduce the fires safety risk not all were found to be effective. There were regular fire drills taking place included night-time/simulated drills where maximum resident and minimum staff took part.

The most recent drill demonstrated the reluctance of one resident to leave the house there was a recommendation to update their personal evacuation plan with

the detail. however, on review of the plan it had not been updated. There were local fire checks in place such as daily evacuation route check to ensure they were clear and weekly fire alarm check to ensure alarm was working. However, other daily, weekly and monthly checks as referred to the provider's fire safety policy and fire safety register were not in place.

In addition to the above, on the day of the inspection the inspector found a number of other fire safety concerns. For example, the use of candles in the centre. There was a half door with a slide bolt lock at the top of a fire escape stair well which potentially impacted on optimal ease of evacuation for residents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Medicines used in the designated centre were found to be used for their therapeutic benefits and to support and improve each resident's health and well-being.

Medication was reviewed at regular specified intervals as documented in residents' personal plans.The inspector observed medicines to be securely and appropriately stored in a locked medicine cabinet. There were numerous local checks in place to ensure safe medicine practise. Medicine were counted on a weekly bases when signed in and out of the house from the pharmacy. In addition, there were documented checking systems in place that ensured the safe transfer of residents' medicines to and from the location (i.e. community activities, family visits and trips away).

Residents' medication was administered by staff who were provided appropriate training in the safe administration of medicine, including regular refresher training. On speaking with staff, the inspector found that they were knowledgeable of the associated medication policy and procedures in place and were confident and knowledgeable regarding safe medicine practices and arrangements in the centre. Overall, the processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation.

The guidance documents in place endeavoured to ensure that medicines were administered as prescribed and overall, the inspector found that they were accurate and sufficiently detailed. Where there was PRN medication, (a medicine only taken as required), there were protocols in place to support and guide staff around their administration. While these documents had been signed by each resident's keyworker and the person in charge, they did not include document evidence to demonstrate oversight by an appropriate health professional and overall warranted review to ensure they were in line with the organisation's policy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' personal plans. The person in charge ensured that there was a comprehensive assessment for each resident, taking into account their changing needs. The assessment informed residents' personal plans which guided the staff team in supporting residents with identified needs and supports.

Residents were consulted about and participated in the development and review of their personal plan supported by their keyworker, multidisciplinary team, family and where appropriate, their representative

The plans were under regular review and contained clear guidance on how staff members could maximise each resident's personal development in accordance with their wishes. Key working sessions were completed regularly. These sessions were carried out using a person-centred approach where the input and decision-making of residents was prioritised as much as possible.

There was an auditing system in place that regularly reviewed the documentation within the person plan. The system identified where items required review and updating as well and demonstrating when they had been completed.

Judgment: Compliant

Regulation 8: Protection

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff who spoke with the inspector were familiar with reporting systems in place, should a safeguarding concern arise.

Staff facilitated a supportive environment which enabled residents to feel safe and protected from abuse. The inspector found that staff treated residents with respect and that personal care practices regarded residents' privacy and dignity.

Overall, the inspector found that residents were protected by practices that promoted their safety. Residents personal plans included safety assessments when in their home, the community or at day service. There were support plans in place to meet any of the needs that arose from the assessment. There were easy-to-read information on safeguarding within the plans to support residents better understanding and awareness of protecting themselves.

Where safeguarding incidents had occurred in the centre, the person in charge had satisfactorily followed-up on them. Appropriate screening had occurred and the

appropriate organisations, including the office of the Chief Inspector, had been notified.

Where appropriate, there were safeguarding plans in place for residents. The person in charge was currently engaging with the national safeguarding team to ensure, that where required, appropriate individualised plans were in place.

However, on the day of the inspection, there was a difficulty in accessing the safeguarding plans on the centre's online system. In addition, a copy of the plan, which are personal to each resident, was not included in their personal plans. This meant that the plans were not easily available to management, staff or residents in the absence of the person in charge.

Subsequent to the inspection, the person in charge advised the inspector that there was a specific safeguarding folder in place which contained interim safeguarding plans and that the plans had been emailed to staff.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bellavista OSV-0001701

Inspection ID: MON-0041130

Date of inspection: 11/10/2023

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Provider recruited a new architect as the previous architect pulled out of works 15.09.23 Building surveyor visited to location on the 24.10.23. Utility surveyor attended Bellavista 01.11.23. Architect currently drawing up scope of work. This will identify the type of contractors and estimate of full cost of works. 30.11.2024 Business case will be completed and submitted by the 31.12.2023. Fire seal to correct gap in fire doors will be ordered and fitted by the 30.11.2023	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Alarm monitoring system: All alarms will be removed by the 30.11.2023 Money management: Money boxes moved to client's room Both residents who had their savings money boxes and personal keys kept in the office, have now agreed to store their savings boxes in their bedrooms and request staff support as they wish with counting and guidance. Completed	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In order to improve accessibility for residents and quality of environment, the provider is progressing with the following works as listed:

Replacement of broken slabs present in the back garden completed on the 20.12.23.

In order to improve mobility and accessibility of clients from room to room in the designated center, saddle on the floor under fire door to be removed and replaced with anti slip lino. A brushed smoke seal will be attached to the bottom of the fire door to bridge any gaps 02/02/2024

Full Fire Door Inspection
Inspection on all doors with qualified fire door contractor to identify any works required to improve current doors
23/02/2024

Exterior Back

Step at the back door of kitchen will be raised to meet lip of door. Additional large wide step with handrails will be installed to improve accessibility. 29/02/2024.

Staff Bedroom
Two windows above staff room doors will be closed up with fire treated board and painted by the 02/02/2024 to increase privacy.

Upstairs bathroom front of house
Toilet be pulled out and white rock placed behind and toilet to be reinstalled so that it can be cleaned more effectively. 30/04/2024

Downstairs Hallway & Landing
Install motion sensor lighting so that lights don't have to be constantly switched on- 29/03/2024

Downstairs Bathroom /Wet Room
Dig up tiled floor
Repair work to drain
Level floor and install altro flooring
Whiterock over tiled walls- 30/04/2024. This will improve the general appearance of the bathroom as well as ensure that cleaning is completed more efficiently.

Hot Press Upstairs
Holes in hot press will be filled with fireproofing 02/02/2024.
Hot Press door to be replaced by a fire treated door. 30/04/2024.

Downstairs Bedroom

Remove electrical panel and fire panel from bedroom into hallway.
Electrician will visit location on the 31/01/2023 to assess works required and costing.

Fire Doors

Two firedoors in the sitting room to be replaced with FD30 AND FD60 fire doors by the 30th of April 2024.

Maintenance are also due to complete a course in Fire Door Maintenance which will allow maintenance to carry out the inspections and general repair on our fire doors from April onwards.
This course is booked for the 4th March 2024 with PCCE

A steering group is in place to oversee the work required and its progress. This group meets on a fortnightly basis and it includes the facility manager, person in charge and PPIM.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Provider recruited a new architect as the previous architect pulled out of works 15.09.23
Building surveyor visited to location on the 24.10.23.
Utility surveyor attended Bellavista 01.11.23.
Architect currently drawing up scope of work. This will identify the type of contractors and estimate of full cost of works. 30.11.2024
Business case will be completed and submitted by the 31.12.2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Provider recruited a new architect as the previous architect pulled out of works 15.09.23
Building surveyor visited to location on the 24.10.23.
Utility surveyor attended Bellavista 01.11.23.
Architect currently drawing up scope of work. This will identify the type of contractors

and estimate of full cost of works. 30.11.2024
Business case will be completed and submitted by the 31.12.2023.

Fire seal to correct gap in fire doors will be ordered and fitted by the 30.11.2023

Personal evacuation plan for resident who is reluctant to leave the house during fire drills has been updated. Completed

Additional fire safety measures include the increase of daily fire checks to twice daily. Completed.
The weekly alarm checks are now being completed twice a week. Completed.
Fire evacuations are completed monthly. Completed.

Health and safety assessed the half door on the 8th of November. It was identified on the ORS in 2021 that due to the location and incline of the stairs a protective waist size door would be required. The 800mm wooden door will be replaced by a metal 1200mm door that will readily open when pushed, therefore not delaying evacuation. 30.11.2023

There are 2 sleep over staff on shift upstairs to support evacuation, should the need arise, during the night. A waking night is located in the sitting room downstairs to support quick evacuation of the most vulnerable clients.

Candles have been disposed of and will be replaced with battery operated tea lights by the Completed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
PRN Protocols to be signed by SHS Medication Trainer. Completed.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/04/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/04/2024
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of	Substantially Compliant	Yellow	30/04/2024

	purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/04/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2024
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	30/04/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Substantially Compliant	Yellow	31/12/2023

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/04/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	30/04/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/04/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Substantially Compliant	Yellow	30/04/2024

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
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.	Substantially Compliant	Yellow	10/11/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which	Substantially Compliant	Yellow	30/11/2023

	a restrictive procedure including physical, chemical or environmental restraint was used.			