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:	Dun Aoibhinn Services Cahir
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	23 July 2024 and 24 July 2024
Centre ID:	OSV-0005066
Fieldwork ID:	MON-0044101

About the designated centre

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

Dun Aoibhinn Services Cahir is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides a community residential service for up to eight adults with a disability. The designated centre consists of two houses located within a close proximity to each other in a town in County Tipperary. The first house is a two storey house which comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were en-suite), sensory room office and staff sleepover room. The second house is also a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. There are gardens to the rear of both houses for the residents to avail of as they please. The centre is staffed by the person in charge, social care workers and care assistants. The staff team are supported by a person in charge.

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
Tuesday 23 July 2024	10:45hrs to 18:00hrs	Conan O'Hara	Lead
Wednesday 24 July 2024	09:30hrs to 15:45hrs	Conan O'Hara	Lead
Tuesday 23 July 2024	10:45hrs to 18:00hrs	Miranda Tully	Support
Wednesday 24 July 2024	09:30hrs to 15:45hrs	Miranda Tully	Support

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to follow up on progress against the registered provider's stated actions and to provide assurance that safe and good quality care was being provided to residents in this centre. This inspection was completed by two inspectors over two days.

Overall this inspection found that some actions had been implemented to improve residents' living environment and that new governance arrangements were in the early stages of establishing. However, inspectors also found that many of the issues that were previously identified remained a concern. For example, demonstrating that the staffing levels were in line with the residents needs, governance and management, fire safety, restrictive practices and residents' rights.

The inspectors had the opportunity to meet with seven of the residents who lived in this centre over the course of the inspection. One resident was attending day services and staying with relatives in line with their routine and personal plan. The inspectors spent time over the course of the inspection engaging with residents and staff, observing care practices, speaking with the staff and management team, observing daily routines and the activities in the centre as well as reviewing documentation.

On the first day of inspection, the inspectors visited the first house of the designated centre. The first house was home to four residents and the inspectors met with three of the residents. As noted, one resident was staying with their family on the day of the inspection. On arrival the inspectors met with one resident who was spending time in the kitchen watching TV after having breakfast. Two of the other residents had already left the service to meet with a family member and access the community.

In the afternoon, the two residents returned and were observed spending time in the kitchen and sitting room. One resident told inspectors of a recent purchase of a go kart. The inspectors observed the residents leaving the centre to access the community in the afternoon. Overall, the residents appeared comfortable in the centre.

The inspectors completed a walk around of this home accompanied by the person in charge and compliance officer. This house is a two storey house which comprised of a kitchen/dining room, living room, four individual bedrooms (two of which were en-suite), sensory room office and staff sleepover room. Previous inspections identified areas for improvement in the internal painting and driveway. The inspectors found that the driveway issues had been addressed and the internal painting was in progress on the day of the inspection. However, there remained areas for improvement. For example, the inspectors observed some of the kitchen cabinets in a poor state of repair and the flooring in one resident's bedroom was worn. This had

been self-identified by the provider.

On the second day of inspection, the inspectors visited the second unit which was home to four residents. On arrival the inspectors were warmly greeted by the four residents. The residents appeared content in their home. Some residents showed the inspectors around their home. Other residents spoke of their interests in country music, plans for the day and the sports they enjoyed. Later in the morning, the residents left the centre to access the community.

The inspectors also completed a walk around of this home accompanied by the person in charge and compliance officer. This house was also a two storey house which comprised of a living room, kitchen/dining room, office, four individual bedrooms (one of which was en-suite) and a staff sleep over room. The house was observed to be decorated in a homely manner with residents' personal possessions and photographs throughout the centre.

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

Capacity and capability

The previous inspection of this designated centre in February 2024 found that significant improvement was required to come into compliance with a number of regulations. The regulations included staffing, training and development, governance and management, residents' rights, positive behaviour support and fire safety. Following the last inspection, a cautionary meeting was held with the provider regarding the continuing non-compliance with key regulations.

There was a defined governance and management system in place in the centre. The provider has reviewed and reconfigured the governance arrangements in the centre since February 2024. This included a new person in charge who was supported in their role by a compliance officer. In addition, on the day of the inspection, the inspectors were informed of recent changes in reporting arrangements to senior management. Overall, the inspectors found that there was an establishing governance team and structure in the centre. However, as noted a number of the areas identified in previous inspection had not yet been addressed in a timely manner and remained in need of improvement.

The staffing arrangements in both houses required further review. While the staffing arrangements had been enhanced in both houses following the findings of previous inspections, it was not demonstrable that it was sufficient at all times to meeting the assessed needs of residents. For example, two-to-one staffing was not available for one resident in line with their documented assessed need after 16:00 during the weekdays and on weekends. The inspectors reviewed tracker sheets developed by the provider for the recording of incidents and behaviours in order to inform a

review of staffing arrangements.In addition, the compliance office noted that practices and routines in the centre and the related staffing requirements were being reviewed. However, from the inspectors review the assessed staffing needs on paper did not match the staffing provision in practice.

Regulation 15: Staffing

While there had been recent enhanced staffing levels in both houses, the provider could not demonstrate that the current staffing arrangements were sufficient to meet the needs of all residents at all times.

For example, in house one, one resident was assessed as requiring two-to-one support for significant parts of the day to assist with activities of daily living including mobilising and personal care. While, there was evidence of enhanced staffing levels in place for 36 hours a week, the resident was not staffed two-to-one after 16:00 during weekdays or at weekends. In addition, a review of documentation indicated a resident could not leave the centre on occasions due to a shortfall in staffing.

In house two, a safeguarding plan identified the requirement for ongoing supervision and support for one resident. While there was evidence of two staff from 17:00-21:00 and at weekends, the four residents were supported by a lone member of staff from 21:00 in the evening until the following morning. The inspectors reviewed the updated safeguarding plan. The inspectors were informed that the provider was reviewing staff practices and residents' routines in order to inform the providers review of staffing arrangement. For example, the provider had developed tracking sheets for the recording of incidents and behaviours and had reviewed safeguarding plan.

The process of reviewing the staffing arrangements, practices and routines was in progress at the time of the inspection and the inspectors acknowledge the provider was within their compliance plan timeline of September 2024. However, the inspectors found that it remained unclear that the current staffing arrangements were sufficient to meet the needs of all residents at all times.

Judgment: Not compliant

Regulation 16: Training and staff development

There were appropriate systems in place for the training and development of the staff team. From a review of staff training records, the staff team had up-to-date training in safeguarding and de-escalation and intervention techniques. However, some further work was required to ensure all staff had up to date training in areas including manual handing, fire safety and medication management. The provider

had self-identified this and there was evidence of refresher training being booked.

Judgment: Substantially compliant

Regulation 23: Governance and management

Overall, the inspectors found that there was an establishing governance and management structure in place as the provider had recently reconfigured the governance and management arrangements in the centre. However, continued work was required to address the areas identified for improvement in a timely manner and to ensure the delivery of quality care and support to residents.

The centre was managed by a person in charge, who was appointed in July 2024, and supported in their role by a compliance officer, who was in place since May 2024. In addition, there was changes in the reporting arrangements to senior management. Documentation reviewed demonstrated that senior management attended staff meetings and were present in the centre regularly.

There was evidence of quality assurance audits including the annual review and six-monthly provider visits. These audits identified areas for improvement, however continued progress against actions identified was required to bring about sustained improvement in the centre.

In addition, the inspectors found that some actions had not been completed in a timely manner. For example, a practice which impacted on residents' privacy which had not been upheld by the human rights committee in May 2024 continued in practice without clear rational for use. This is further discussed under Regulation 9. In addition, the provider outlined in their compliance plan response that behaviour support plans would be reviewed, fire safety concerns would be addressed and interior painting would be completed. While, these actions were in progress on the day of inspection, they had not been completed within the time frame set by the provider.

The inspectors also found that the management of data present in the centre required review. Locating specific information that may be required to support the staff team in carrying out their role was challenging with large volumes of information present, pertinent information not always stored where expected, duplication, inaccurate or outdated information was also present at times. A review of the provider's incident record system indicated that over 40 incidents had not been 'authorised' within in the system as per the provider's procedure. Oversight and learning from incidents at a local level was not demonstrable between January and May 2024. On discussion, inspectors were advised that where there were trends in incidents these were reviewed at multi-disciplinary team meetings. It is recognised that improved practices were in place from May 2024.

The previous inspection found that the access to appropriate transport required review. This had been addressed and it was evident that residents were accessing

the community more often.

Judgment: Not compliant

Quality and safety

Overall, the management systems in place did not ensure quality, care and support was provided to residents at all times. While, the inspectors found that the provider had taken some actions to address the areas of improvement identified in the previous inspections, continued work was required to address areas for improvement including fire safety, premises, positive behaviour support and rights.

The systems in place for positive behaviour support required improvement. For example, not all behaviour support plans had been reviewed within the required time frame or reflective of the current support arrangements in place. A number of restrictive practices were in use in the centre. While the restrictive practices had been reviewed by the provider's human rights committee, some restrictive practices required further review to demonstrate they were proportionate and least restrictive.

In addition, improvement was required in the systems in place for fire safety. For example, while the provider had reviewed the guidance to support residents to evacuate in the event of a fire in response to the findings of the last inspection, it was not completed for all residents. In addition, further improvement was required in relation to night-time fire drills. For example, while night-time drills had been completed since the last inspection, in house one it was a simulated night-time drill with staff and did not include the residents.

Regulation 17: Premises

Overall, the designated centre was designed and laid out to meet the needs of the residents. The inspectors found that the two houses were decorated in a homely manner.

The previous inspection found that areas of improvement in house one included the gravel surrounding the premises which caused accessibility issues for one resident and areas of internal painting/decoration in need of attention. The inspectors observed on the day of inspection, the gravel surrounding the house had been addressed and the interior painting was in the process of being completed.

However, the kitchen in house one required attention as inspectors observed some parts of the cabinets in need of repair, water damage to ceiling of the sensory room roof and worn flooring in one residents bedroom.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire safety systems in place required improvement. While there was evidence of some actions taken to address the areas for improvement identified on the previous inspection, the inspectors found that continued work was required to come into compliance.

For example, the last inspection found that the arrangements in place for the containment of fire required improvement - a number of fire doors did not close fully. This had been addressed. However, the inspectors observed some fire doors in house one requiring further review to ensure they closed appropriately.

In addition, some personal evacuation plans required further review to ensure the staff team were appropriately guided to support residents to evacuate in the event of a fire.

While a night-time drill had been completed in both houses, one was a simulated drill which did not include residents. The inspectors found that further review was required to ensure residents were involved in fire drills as appropriate.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The systems in place to support residents manage their behaviours required improvement.

Behaviour support plans were in place for residents were required. However, a number of behaviour support plans had not been reviewed within the indicated time frame set by the author. On review of documentation, practices in response to behaviours of concern were not consistent with guidance, for example instances were 'time out' practices was used.

There were a number of restrictive practices in use in the designated centre. A restrictive practice audit was carried out in February 2024 which made a number of recommendations. Overall, the inspectors found that restrictive practices were suitably identified and reviewed by the Human Rights Committee. Following review of documentation, it was evident that some restrictions within in the centre had reduced.

However, one restrictive practice in place had not been upheld by the human rights committee and its use was still under review at the time of the inspection. The

inspectors found that this was not reviewed in a timely manner as outlined under Regulation 09.

In addition, some restrictive practices required further review as it was not demonstrable that that they were in keeping with best practice and were the least restrictive. For example, the use of external metal shutters in one bedroom or blackout coverings on one resident's bedroom windows. The inspectors were informed that the practices were under review at the time of the inspection.

Judgment: Not compliant

Regulation 8: Protection

Notwithstanding the areas for improvement identified under Regulation 7 Positive Behaviour Support and Regulation 9 Rights, there were systems in place to keep the residents safe. All staff had up-to-date training in safeguarding. Residents appeared content and comfortable in their home and in the presence of the staff team.

Judgment: Compliant

Regulation 9: Residents' rights

The systems in place to promote and protect residents' rights required improvement.

For example, two of the residents in house one spent significant portions of the day separately out of the house in order to manage possible negative peer-to-peer interactions. The compatibility of the resident group.and suitably of this practice was identified as an area for review in the previous inspection and in response the provider was reviewing staff practices and residents routines. This remained ongoing at the time of the inspection.

The inspectors also observed practices on the day of the inspection which required further review in order to ensure the dignity and respect of residents. For example, personal and intimate care tasks for one resident required a bathroom door to remain open with staff supervision. It is acknowledged that the practice is under review in order to seek a safe and appropriate alternative.

In addition, one daily practice in place to manage a historical safeguarding concern which impacted on one resident's privacy and dignity. This practice was identified as a practice in need of review by the internal restrictive practice audit and was reviewed by the Human Rights Committee in May 2024. The Human Rights Committee did not uphold the restrictive practice. However, on the day of inspection, this practice remained in use and was pending further review by the

management and monitoring committee team in August 2024. The inspectors found that the review of this restrictive practice was not timely given the impact on the resident's privacy and dignity.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Dun Aoibhinn Services Cahir OSV-0005066

Inspection ID: MON-0044101

Date of inspection: 23/07/2024 and 24/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The documentation around staffing levels for all residents has been reviewed and inconsistencies have been identified. The inconsistencies identified will be reviewed and clarified by the MDT before 14/10/2024. • Local management will then review rostering on the back of this information and ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents. • Should any gaps in staffing resources these will then be notified to senior management and funder through completion of a DSMAT.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Medication Management training is now complete for all staff. • One staff remains outstanding in Manual Handling. This has been rebooked. • Nineteen staff are in date in Fire Training. The remaining three will be completed by 08/11/2024. • The PIC will ensure that all mandatory training is kept under close review and all staff	

who require training do so in a timely manner.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The practice outlined which was impacting on a resident's privacy and dignity has now been discontinued.

• The newly established local management team at the centre continues to work through all actions that have been identified in previous compliance plans.

• The local management team have developed a new system for records management which they continue to implement. Archiving of old information and review of duplicated, inaccurate and outdated information is underway.

• The incidents on the providers incident record system that had not been authorised within the system are in the process of being closed as per the providers own procedure. Learning and review from these incidents has already taken place.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Kitchen cabinets have now been repaired and painted as required.

• Painting works have been completed in many areas of the centre. Other identified painting will be completed where required.

• Water damage to ceiling of sensory room will be repaired as required.

• Worn flooring for one resident's bedroom will be replaced as required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: • All works in relation to fire doors have now been completed. • All personal evacuation plans for residents have been reviewed to ensure that staff are appropriately guided to support residents to evacuate in the event of a fire. • A night time fire drill is currently being planned and will be completed on 08/10/2024.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • The practice outlined which was impacting on a resident's privacy and dignity has now been discontinued. • Five behaviour support plans have been reviewed. Two behaviour support plans are currently being reviewed. Multidisciplinary team meetings are scheduled and support plans will be updated to be consistent with guidance. • The restrictive practices outlined are under review and the provider will endeavor to ensure that the least possible restrictive practices are being used in line with best practice.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The practice outlined which was impacting on a resident's privacy and dignity has now been discontinued. • The provider continues to review the practices in relation to the management of interactions between all residents at the centre. All residents move freely in the common areas of the centre unless an immediate risk has been identified. Staff have clear guidance through risk assessments and behavior support plans in relation to supervision guidelines. • The level of supervision of one resident while receiving intimate and personal care has been reduced and will be kept under review to ensure the dignity and respect of the	

individual is upheld in the safest possible way.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/10/2024
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	30/11/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/11/2024

	are of sound construction and kept in a good state of repair externally and internally.			
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	30/11/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/10/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable,	Not Compliant	Orange	31/10/2024

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/11/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/11/2024