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:	A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 February 2025
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0046383

About the designated centre

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

The designated centre is comprised of three individual units and is located on a shared campus setting in West County Dublin. It provides 24-hour residential support services to persons with intellectual disabilities and at the time of inspection was registered for 15 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a person in charge, a social care leader, staff nurses, carers, an activity coordinator and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Monday 10 February 2025	19:20hrs to 22:00hrs	Karen Leen	Lead
Tuesday 11 February 2025	10:00hrs to 17:00hrs	Karen Leen	Lead
Monday 10 February 2025	19:20hrs to 22:00hrs	Marie Byrne	Support
Tuesday 11 February 2025	10:00hrs to 17:00hrs	Marie Byrne	Support

What residents told us and what inspectors observed

From what residents told us and what inspectors observed, it was evident that residents were content living in this designated centre. However, the inspection found mixed levels of compliance with the regulations. While there was evidence of good practices around safeguarding residents from abuse and ensuring their houses were comfortable and homely, improvements were required in governance and management, staffing, and risk management. These are discussed in the body of the report.

This designated centre comprises of three houses on a campus in Dublin which provides residential care for up to 15 residents with an intellectual disability, at the time of the inspection nine residents were living in the centre with six vacancies. The centre was homely and comfortable and there were family photos and art work on the walls. On the first evening of the inspection there was a relaxed and calm atmosphere in each of the houses, with soft lighting and calm music in the background. Each residents' room was personalised in line with their life story. They had their favourite possessions on display and had space to take part in some of their favorite activities in their rooms. For example some residents had chairs to do their knitting in their rooms or desks to compete puzzles and activities.

At first, the inspection focus was on safeguarding of residents and the inspectors visited the centre in the evening; however, the focus of the inspection was changed once inspectors became aware of some presenting risks in the centre, particularly those relating to the safe evacuation of residents in the event of an emergency.

Through review of resident supports inspectors found that two residents residing in the centre required support of two staff for emergency evacuation, manual handling and personal care. The provider had completed a review of two residents in the designated centre and proposed a possible internal move within the campus setting. The residents were supported in this process by the person in charge, staff team, social work and an independent advocate and the decision was made that this move with not be in line with residents will and preference as they had lived in the centre for the majority of their adult lives. Furthermore, inspectors found that changing needs of one resident in the centre required that additional staffing support was required depending on the resident's health status.

Inspectors had an opportunity to meet the nine residents living in the centre over the two days of the inspection. In addition, they had an opportunity to meet and speak with seven staff, the night sister, the person in charge, the Chief Executive Officer, and assistant director of nursing and a director of nursing.

Residents had a variety of communication support needs and used speech, vocalisations, gestures, facial expressions, and body language to communicate. Throughout the inspection, staff were observed to be very familiar with residents' communication styles and preferences. Some residents told inspectors what it was

like to live in the centre, and inspectors used observations, discussions with staff and a review of documentation to capture the lived experience of other residents.

Inspectors had an opportunity to sit and spend time chatting with residents over the two days of the inspection. Residents were engaging in a number of activities both at home and in their local community. A number of residents went shopping for valentine cards, presents and treats, while others went to day services. Residents were observed using their electronic tablets, watching television, and taking part in the upkeep of their home.

Over the course of the two day inspection, inspectors had the opportunity to observe residents during evening meal, breakfast and dinner. Inspectors observed that staff took the opportunity to sit with residents during meal times to promote a safe and homely environment. However, this was observed to be a busy time for both staff and residents. In one house inspectors observed that staff were required to leave the dinning area during a meal time and support or observe another resident in order to provide reassurance or assistance.

Warm, kind, and caring interactions were observed between residents and staff throughout the inspection. Residents were observed laughing and smiling when interacting with staff and to seek them out if they required their support. They were also observed moving around their home to spend time in their preferred spaces.

Inspectors met with one resident in their home. The resident was relaxing in the sitting room with staff assisting them to prepare for their evening meal. The inspectors greeted the resident who was smiling and dancing with staff to music playing in the background. The inspectors found that the staff member had worked with the resident for a long period of time and could tell the inspectors a great deal of the resident's life story. The staff member spoke to the resident about telling the inspectors a little bit of their history in the centre, this was greeted with encouragement and smiles from the resident. Inspectors found that interactions with the resident and staff were warm and familiar.

When inspectors met with one resident in one of the houses, the resident discussed how at the time of the last inspection they had been waiting to move into a vacant room in the house. This had been delayed while the room was being refurbished. The resident informed the inspectors that they had moved into their new room and were very happy with the decoration they had chosen. The resident showed the inspectors their room and commented that they had much more space and that the room had much more sunlight during the day. The resident discussed that they were very happy in their home and that they often had visitors from other centres or family to their home.

In another house, two residents spoke with inspectors about a recent trip to a hotel with their family. They also spoke about and showed inspectors pictures of the important people in their life. One resident spoke with inspectors about buying a valentines card for their boyfriend.

Inspectors found that the staff team were focused on implementing a human-rights based approach to care and support for residents in this centre. Residents were

being supported to make choices around how and where they wished to spend their time, how involved they wished to be in the upkeep of their home, and what and when they would like to eat and drink. They were supported to buy, prepare and cook or bake if they wished to. However, a number of staff spoke about difficulties relating to staffing numbers, at times. They spoke about how motivated they were to keep people safe and support them to enjoy meaningful activities; however, due to one staff being on duty in the houses at times, and in line with the care and support needs of residents, staff told inspectors it was not always possible to engage in community based activities.

Residents were supported to contact or visit the important people in their lives. They had access to phones and electronic tablets to contact them. They had opportunities to visit or be visited by their family and friends and there were a number of areas where they could spend time together in the centre.

In summary, from what residents told us and what inspectors observed, it was evident that residents were supported by an experienced staff team to lead enjoyable and active lives. However, a number of risks were evident in the centre which could negatively impact residents.

The next two sections of this report will 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 provided.

Capacity and capability

This inspection was unannounced and completed to review the arrangements the provider had to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013 and the National Standards for Adult Safeguarding (2019). However, due to presenting risks relating to staffing levels and fire safety, particularly at night time, the inspection was changed from a safeguarding focused to a risk-based inspection.

There was a clear management structure in the centre which was outlined in the statement of purpose. The person in charge was full-time and reported an assistant director of nursing. Inspectors reviewed the minutes of staff and management meetings and found that meetings were occurring at least every six months in the centre and were resident focused.

Inspectors found that there were good local systems for oversight and monitoring; however, improvements were required in relation to recognising and reporting restrictive practices, and in the implementation of actions and additional control measures by the provider once a significant risk relating to fire safety had been identified in the centre in October 2024. This will be discussed further under Regulation 26: Risk Management Procedures. In addition, the provider had not

ensured that the designated centre was resourced to ensure the effective delivery of care and support in accordance with residents' care and support needs. This will be discussed further under Regulation 15: Staffing.

Regulation 15: Staffing

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The inspectors found that the centre was not staffed to meet the current assessed needs of residents. The staffing levels present had an impact on the provider's ability to ensure safe care could be afforded to residents at all times. Inspectors found that the staffing levels in the centre, particularly night time staffing ratios were having a significant impact on the ability of staff to safely evacuate residents in the event of a fire. This required the provider to address the staffing levels in the centre and to carry out fire drills with appropriate staffing levels to meet the evacuation needs of residents. The provider was required to provide these assurances to the Chief Inspector within 14 days, which the provider submitted with the assurance that the risk was adequately addressed after the inspection.

The centre is made up of three houses. At night, each house has one staff on duty who is supported by a staff who also has responsibility for another centre on the providers campus. During the day there is one healthcare assistant assigned in each of the three houses and a nurse and healthcare assistant floating staff who provides support across the three houses at different times during the day, including providing direct support to residents, administering medicines and covering staff breaks. Inspectors found that during the day in addition to supporting residents to have their care and support needs met and ensuring they had opportunities to take part in meaningful activities, nursing staff were administering medicines to residents in the centre up to six times per day, and staff were entitled to four breaks during which they were covering for each other. Furthermore, inspectors observed that during the course of the inspection floating staff were required to spend a large portion of time between two houses in the centre to support residents with personal care and to assist residents with meals. This meant that the third house within the centre was required to wait for the floating staff or the nurse in order to assist with residents who required support of two staff. Staff spoken to discussed that residents in the third house enjoyed longer periods of rest and they would call for assistance if required. However as previously discussed floating staff were required for support in a number of essential areas for residents and would not be readily available to provide support.

At the time of the inspection the centre was operating on 2.5 staff vacancies. The inspectors found that improvements had been made in relation to staffing numbers and continuity of care for the designated centre and a plan to reduce the use of agency and relief staff. However, on review of rosters from September 2024 to January 2025, inspectors found that an average of 12 agency or relief staff were utilised per week in order to cover vacancies or sick leave. The provider had

submitted a business case in November 2024 to their funding body identifying further staff supports required to residents particularly in relation to safe evacuation of residents. At the time of the inspection no additional funding had been allocated to increase staffing in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Effective systems were in place to record and regularly monitor staff training in the centre. The inspectors reviewed the staff training matrix and found that staff had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents. These included training in mandatory areas such as fire safety, managing behaviour that is challenging, and safeguarding of adults at risk of abuse. In addition, training was provided in areas such as assisted decision making act, first aid, infection prevention and control (IPC), food safety, and safe administration of medication.

All staff were in receipt of supervision and support relevant to their roles from the person in charge. The person in charge had developed a schedule of supervision for 2025 for all staff members. The inspectors reviewed ten staff supervision records, and found that they were in line with the provider's policy and included a review of the staff members' personal development and also provided an opportunity for them to raise any concerns.

Judgment: Compliant

Regulation 23: Governance and management

The provider's systems for oversight and monitoring included six-monthly reviews and an annual review. Inspectors reviewed the latest annual review by the provider and the latest two six-monthly reviews. The provider’s latest six-monthly review had not been completed in line with the timeframe identified in the regulations, as the latest one was completed in July 2024. Inspectors were informed that the latest six-monthly and annual review were being drafted at the time of the inspection.

As previously mentioned inspectors found that the provider’s systems for oversight and monitoring were not proving effective, due to the ongoing risk relating to fire and safe evacuation of residents. The inspectors found that the person in charge had escalated concerns in relation to fire evacuation for residents in one house in the centre following a fire evacuation drill completed on the 31 of October 2024. This risk was escalated to the provider's organisational risk register, with the provider identifying the risk to residents in relation to staffing resources. The

provider escalated this concern to their funding body, however, the inspectors found no evidence that the provider had initiated the necessary control measure to reduce the identified risk to residents in the designated centre.

During a walk around of the three houses that make up the centre, inspectors observed a number of restrictive practices such as bed and chair sensors in place for residents which were not being returned to the Chief Inspector of Social Services. Furthermore, inspectors found that practices in place were being utilised to ensure resident safety when staff were assisting other residents with activities of daily living. For example, three residents had sensor mats in place on personal chairs. These sensor mats were prescribed for residents identified as a falls risk. However, inspectors found that sensor mats were being utilised when staff were required to leave a room and support another resident in an aspect of their care.

Judgment: Not compliant

Quality and safety

Overall, inspectors found that residents were making decisions about how they wished to spend their time and supported to develop and maintain friendships and relationships with the important people in their lives. They lived in a warm, clean and comfortable home. However, improvements were required in relation to the management of risk in the centre and this will be discussed further under Regulation 26: Risk Management Procedures.

Inspectors found that residents were not fully protected by the fire safety and risk management policies, procedures and practices in the centre. The systems for responding to emergencies required review to ensure that each resident could be supported to evacuate in a timely manner. Overall, inspectors found that the provider's systems to manage and review risks required review.

Staff had completed safeguarding training and staff who spoke with the inspector were found to be knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. Safeguarding plans were developed and reviewed as required.

Regulation 17: Premises

Inspectors carried out a walk around the centre, which confirmed that the premises was laid out to meet the number and assessed needs of residents. Each of the houses were found to be warm, clean and well maintained during this unannounced inspection.

Each resident had their own bedroom which were decorated to their individual style and preference. There was ample communal space for residents to meet family and friends. Residents had access to suitable space and storage for their personal items. Residents also told the inspectors that they were happy with the premises, and the facilities it provided. They said that their house was comfortable and provided enough space and that paint work had been completed in a number of individual bedrooms upon request.

Assistive aids and equipment were also available to residents including mobility aids and communication devices.

Judgment: Compliant

Regulation 26: Risk management procedures

Fire drills completed in the centre in August and October 2024 demonstrated that evacuation of two residents from one of the houses were not being completed in line with the safe evacuation time of 3 minutes and 32 seconds which had been established by the provider. The drill in August 2024 had taken 4 minutes and 50 seconds and the drill in October 2024 had taken 5 minutes and 20 seconds. The delay in evacuation time was attributed to insufficient response time from the additional support staff from another centre as they were supporting a resident in another centre with personal care. This risk was rated red in the fire risk assessment for this house, in the risk register for the centre, and in the organisations risk register. The provider had highlighted their concerns in relation to safe evacuation of residents at night time to their funding body; however, the risk remained evident in the centre on the day of the inspection.

As previously mentioned following a review of staffing rosters, residents' assessments and incident reports, inspectors found that staffing numbers during the day and night required review by the provider to ensure they could meet implement the control measures detailed in residents' assessments. For example, inspectors reviewed a sample of risk assessments in residents' plans and the risk register for the centre and found that in addition to risks previously described relating to fire safety, one resident presented with risks associated with their epilepsy diagnosis, four residents presented with a choking risk, and four residents presented with a falls risk. Inspectors reviewed incident records for the centre for 2024 and there had been six falls for residents, five of which were unwitnessed.

Judgment: Not compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy in place with supporting procedures, which clearly directed staff on what to do in the event of a safeguarding concern. Inspectors reviewed a sample of five residents' plans and found that they each had an intimate and personal care plan which detailed their support needs and preferences.

Inspectors reviewed the documentation relating to four allegations of abuse and found that each had been recorded, reported and followed up on in line with the provider's and national policy.

From reviewing the staff training matrix for the centre, each staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Five staff who spoke with inspectors were knowledgeable about their roles and responsibilities should there be an allegation or suspicion of abuse.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for A2 OSV-0005387

Inspection ID: MON-0046383

Date of inspection: 11/02/2025

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: 1. The risk has reduced significantly due reduced resident capacity in the Centre. Prescribed safe evacuation time is 3 minutes 34 seconds. On 19th February 2025, an early morning evacuation was completed in 2 minutes 50 seconds. 2. Following the recent transfer of a resident and closure of a bungalow, 2 WTE staff have been identified and redeployed to Centre A2. This brings the number of vacant posts to 0.5 WTE, and a regular relief is allocated to this vacancy. 3.PIC will ensure that SAM's trained staff in roster is utilized effectively. Daily staff allocations are completed by the PIC or the nurse in charge of each shift to ensure appropriate skill mix of staff are allocated according to resident's requirements.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The risk has reduced significantly due reduced resident capacity in the Centre. Prescribed safe evacuation time is 3 minutes 34 seconds. Early morning fire drills were completed on 19th February 2025 and 24.02.2025. The evacuation time was within the safe time. 2.The schedule for the 6 monthly and annual reviews has been revised to ensure the turnaround and submission of the reports are completed within a timely manner. The schedule for the June 2025 reports will reflect the revised submission dates. 3.The PIC has a system in place to record, monitor and review the unplanned and/or emergency use of restrictive practice and to monitor restrictive practices in the center to ensure that they are used in line with regulations.	

The PIC is aware of the obligation to record and report all restrictive practice used in the centre.
The ADON has recirculated an FAQ document on Restrictive Practices for staff.
4.The PIC will send the restraint register to the ADON monthly for review and it will also be sent when a change to any restrictive practice occurs. The MDT meet six monthly to review and monitor these practices as required. The CNS records, monitors and reviews these procedures.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The risk has reduced significantly due reduced resident capacity in the Centre. Prescribed safe evacuation time is 3 minutes 34 seconds. Early morning fire drills were completed on 19th February 2025 and 24.02.2025. The evacuation time was within the safe time.
1 resident is in the process of transitioning to a center to support the needs of the residents which will reduce the dependency in the centre.
The PIC will ensure fire drills are completed in each individual house on a quarterly basis, communicate outcome to staff and update PEEPs as required.
2.PIC will review rosters to ensure the skill mix, staffing compliment is appropriate for residents identified needs to mitigate risks.
The PIC updates the risk register regularly in consultation with Health & Safety/Risk Management Co-Ordinator. The PIC ensures individual risk assessments are completed for residents identified needs, these are reviewed regularly and controls are communicated to all staff. Identified risks will be communicated to line manager if additional controls are required.
The PIC and ADON are notified of any incidents that occur in the centre and these are documented.
The PIC will review roles and responsibilities and training needs to ensure that there are adequate numbers of designated staff to implement fire safety arrangement.

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	Red	25/02/2025
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	20/02/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	20/02/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	20/02/2025