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:	The Elms
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	12 and 13 April 2022
Centre ID:	OSV-0004877
Fieldwork ID:	MON-0036720

About the designated centre

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

In this centre, a residential service is provided for a maximum of seven residents over the age of 18 years. The service provided responds to individual requirements with some residents availing of a less than full-time service. The centre is comprised of three separate premises, two of which are located in the suburbs of the main town and one in a village approximately 15 kilometres from the main town. Two residents live in two of these houses. One house has an additional apartment attached; one resident resides in the apartment and two residents live in the main house. Each premises provides residents with access to their own bedroom, some en-suite facilities, shared bathrooms, sitting rooms, kitchen, dining areas, front and rear gardens. The model of care is social and staff are on duty both day and night to support the residents who live in this service. Management and oversight of the day to day operation of the service is undertaken by the person in charge supported by nominated social care leaders.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 12 April 2022	10:45hrs to 18:00hrs	Mary Moore	Lead
Wednesday 13 April 2022	09:30hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to follow-up on the findings of the last HIQA inspection of this centre completed in August 2021. Those inspection findings were not satisfactory and HIQA had renewed the registration of the centre with a condition attached that the provider address the regulatory non-compliance found within a specified timeframe. The provider has applied to HIQA seeking an extension of that timeframe. While some improvement was evident for example in the provider's fire safety arrangements, the findings from this inspection were not satisfactory and a high level of repeat non-compliance with regulatory requirements was found.

There are a number of high and moderate risks in this centre associated with the assessed needs of residents. The provider had systems for identifying, monitoring and responding to these risks. Ultimately however, the findings of this inspection did not provide assurance these systems were effective in assuring and maximizing resident and staff safety. Matters arising included the ongoing unsuitability of one premises to the assessed needs of residents and the delay in transitioning one resident to more suited accommodation. The provider did not demonstrate how it was assured residents were provided with staffing levels and arrangements that maximized their safety in the house and in the community. A review of safeguarding policy and procedures was needed as they did not demonstrate how they promoted and protected the safety of the service provided to each resident. Collectively, the inspection findings reflected governance arrangements that did not adequately and consistently ensure and assure the safety and quality of the service provided to all residents.

The inspection findings were ones of contrast. Positive feedback was received from residents and the inspector's observations of how staff and residents interacted with each other were also positive. The inspector spent time in all three houses and met with all of the seven residents who live in this designated centre. Residents presented with a diverse range of needs and requirements. For example, some residents did not receive a full-time residential service, had good independence in their activities of daily living and spent part of each week at home with family. This diversity was also reflected in the communication skills of the residents. The majority of residents were well equipped to engage with the inspector. Some residents used a combination of word, technology and manual signing to engage with the inspector and gave a good account of what life was like for them in the centre.

From these discussions it was evident that residents had good opportunity to remain connected to home and family and to enjoy meaningful occupation in their daily lives including having the opportunity to enjoy paid employment. Residents were visible and active participants in their local communities. Residents were delighted that amenities and activities they enjoyed had recommenced now that infection prevention and control restrictions had eased. Across the three houses residents

described a broad range of opportunities and activities such as attending the local men's shed group, volunteering at the local church, going to the gym and participating in a range of educational and training programmes. One resident proudly showed the inspector the portfolio of certificates they had achieved. On arrival at one house the first thing a resident wanted to do was to show the inspector the new shed that had been supplied by the provider so that residents had space for their interests and hobbies. Residents had requested and advocated for this shed themselves. The provision of this space had been included in the previous HIQA inspections of this centre. The shed was of a high standard, residents were delighted with the shed and had great plans for its use.

Residents told the inspector how much they had disliked COVID-19 and the restrictions. Residents knew that COVID-19 was not gone away but said that they were not afraid of it. Residents in one house hoped that the next time the inspector called face masks would not be needed and the inspector could enjoy a cup of coffee and a scone with them. The inspector saw how staff supported residents to use a face mask for certain activities such as traveling in the car. The provider has a good record in this centre of protecting residents and staff from the risk posed by COVID-19.

The person in charge was collecting feedback from residents to inform the annual review of the service. This feedback reflected what residents told the inspector such as the importance of home and going home, meeting their friends, having access to their monies and doing things that they enjoyed doing.

Residents were very relaxed and confident in their homes and with the staff on duty. Residents chatted freely of past and present staff, identified members of the senior management team and confirmed they knew the designated safeguarding officer. Residents came and went with staff during the inspection and enjoyed very ordinary activities such as collecting the car from the garage, taking the lawn mower to be serviced, dog-walking, going for lunch and meeting with peers. Where direct support was provided by staff it was seen to be provided in an unhurried, calm and respectful manner. Staff spoke of the importance of building familiarity and trust with residents with higher needs and this trust was evident in the interactions observed by the inspector.

While the inspector did not meet with any resident representative the inspector saw feedback that had been provided by representatives to inform the provider's pending annual review. While the response rate was currently low the feedback received was very positive.

It was evident to the inspector from what residents said and what the inspector observed there were many positives in this service. The service had the capacity to be a very good service if the provider satisfactorily addressed core repeat issues such as the management of high risks and staffing levels and arrangements. Based on the verbal feedback provided by the inspector of the inspection findings, the provider submitted to HIQA details of actions it intended to take. The provider confirmed it intended to reduce the overall occupancy of the centre by reducing the occupancy of one house. The provider confirmed that this reduced occupancy would

not lead to any reduction in staffing levels and staffing would be diverted and allocated to better manage residual risk and to promote safe community access for a resident.

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 being delivered.

Capacity and capability

Based on what the inspector read it was evident the provider had responded to the previous HIQA inspection as it sought to make this a safer and better quality service for residents. For example, the inspector saw detailed informed reviews of risks and their management, of the use of restrictive practices and of fire safety arrangements. However, by the time this HIQA inspection was undertaken it was evident that some inconsistency in management and oversight had emerged. For example, in the oversight of risk and the use of restrictive practices. There were also incidental inspection findings such as in relation to safeguarding residents from abuse and staffing arrangements. This did not provide assurance the governance structure worked as intended so that new matters arising were reported and escalated to more senior management. In addition, the planned relocation of a resident to a centre more suited to their needs was delayed. Collectively these findings did not demonstrate how systems of management ensured the service provided to all residents was safe, appropriate to their needs, consistently and effectively monitored.

The inspector reviewed the findings of the most recent six-monthly internal review of the quality and safety of the service completed on behalf of the provider in December 2021 and January 2022. The reviewer acknowledged the extensive findings and substantive action plan that issued from the review but also the progress that had been made since the previous internal review and since the HIQA inspection of August 2021. However, based on these most recent HIQA inspection findings this progress was not sustained. Much of the evidence to support this finding will be discussed in detail below when discussing staffing and in the next section of this report for example in relation to monitoring and responding to risk.

One area that did not provide assurance of good and proactive governance was the area of staffing. Based on these HIQA inspection findings there was a strong correlation between staffing arrangements, managing risk and reliance on restrictive practices. Staffing challenges across the three houses ranged from ensuring adequate staffing resources were available so that residents had some individualised support each week to the matter of responding to significant risks arising in the service. For example, management confirmed there was an open clinical

recommendation for one-to-one staffing as part of a falls prevention plan. However, this staffing arrangement was only in place two days each week. The inspector saw that even with the recommended staffing levels in place (as on the day of inspection) this did not ensure appropriate supervision for the resident. A resident's preferred time for going to bed had been altered to suit staffing arrangements in response to the risk of using the stairs. The provider did not demonstrate how it had concluded (as documented on records seen) that a second staff member was not needed to facilitate safe community access for a resident.

In addition, it was an incidental finding of this inspection from a record seen by the inspector which stated there were now only two staff members of the staff team comfortable to undertake a particular community activity with a resident. This indicated a heightening of risk and of staff concerns. Management confirmed they were not aware of this development. A pattern of resident night-time waking had also developed in this house; each house had a staff member on sleepover duty at night. This was being monitored but this monitoring was not robust. While a recent update noted a "significant improvement", 13 occasions where sleepover staff were required to get up had been logged in the month preceding that update.

A record was maintained of the training completed by staff. The inspector reviewed the records pertaining to the staff team that worked in one house. This record indicated that all staff listed on the rota had completed mandatory training such as in safeguarding residents from abuse, responding to behaviour that challenged and fire safety. Where refresher training was due this was monitored and scheduled. However, a record of the completion of all required and desired training was not in place for all staff. This included training such as in the prevention of falls and training in infection prevention and control measures.

Regulation 15: Staffing

The provider did not demonstrate how it's staffing levels and arrangements were suited to the assessed needs of all residents and associated risks. For example, management confirmed there was an open clinical recommendation for one-to-one staffing as part of a falls prevention plan. A resident's preferred time for going to bed had been altered to suit staffing arrangements in response to the risk of using the stairs. The provider did not demonstrate how it had concluded (as documented on records seen) that a second staff member was not needed to facilitate safe community access for a resident .

Judgment: Not compliant

Regulation 16: Training and staff development

A record of the completion of all required and desired training was not in place for all staff. This included training such as in the prevention of falls and training in infection prevention and control measures.

Judgment: Substantially compliant

Regulation 23: Governance and management

Collectively these inspection findings did not demonstrate how systems of management ensured the service provided to all residents was safe, appropriate to their needs, consistently and effectively monitored. While there was evidence of initial improvement some inconsistency in management and oversight had emerged. For example, in the oversight of risk and the use of restrictive practices. There were also incidental inspection findings such as in relation to staffing arrangements. This did not provide assurance the governance structure worked as intended so that new matters arising were reported and escalated to more senior management. The planned relocation of a resident to a centre more suited to their needs was delayed; this resulted in ongoing risk to staff and resident safety.

Judgment: Not compliant

Quality and safety

Based on what the residents told the inspector, residents were happy and liked living in this centre. Residents were connected to home and family, residents were visible in their local communities and had opportunities to do things that they liked and enjoyed. However, ongoing deficits in the management and oversight of risk, the unsuitability of the premises and the failure to ensure staffing levels were adequate and appropriate to the assessed needs of all residents limited both the safety and quality of this service.

Based on records seen, after the last HIQA inspection a review of each restrictive practice in use in the centre had been completed. However, given the level of risk to resident safety that presented in the service there was minimal reduction and an ongoing reliance on the use of a range of restrictions. There was in fact a new restriction that had not been identified by the service as a restriction. This restriction was the requirement for a resident to go to bed somewhat earlier than they would have normally done and while there was still two staff on duty. This restriction was implemented following a recent near-miss on the stairs. While it was recorded that this change in the resident's routine was discussed and agreed with the resident its implementation was not in keeping with the provider's policy on the promotion of a service free from restrictive practices. It was not evidenced what other less

restrictive options were explored such as consideration of adjusting staffing levels and staffing arrangements. In addition, records seen by the inspector clearly stated that the door between the kitchen and the utility in one house was not to be locked at any time. The locking of this door had been a concerning finding of the last HIQA inspection. However, the inspector noted the manual latch remained in place and the door was locked at intervals during the day. A staff member spoken with said the key was left in the lock and the resident could open the door if they wished. Assuring this restriction had been removed would have been better evidenced by the removal or disabling of the lock.

An incidental finding of this inspection was an open moderate risk (applicable to one house) for the risk of harm from a peer. There was nil to indicate to date to HIQA, for example in notifications submitted, that this risk presented. The person in charge explained to the inspector that the provider operated a protocol/threshold for reporting incidents that occurred between peers. The inspector saw the protocol set out for staff a scoring system for incidents that occurred between residents. This scoring system determined if the threshold for abuse had been met and the incident needed to be referred to the designated safeguarding officer for their consideration and notified to HIQA. Of concern to the inspector was the fact that this protocol was not referenced or included in the provider's overarching safeguarding policy and procedures. Consequently, there were differences and inconsistencies as to how to respond to, report and screen incidents between peers. Therefore, it was unclear how the operation of this protocol was in keeping with the requirements and principles of the policy to protect residents from all types of harm and abuse. The protocol did not appear to have been reviewed since circulated in 2016. For example, to reflect the monitoring notifications handbook issued by HIQA to providers in 2018 and guidance therein on peer to peer incidents.

Records seen indicated that the risk had been referred to the designated safeguarding officer. Residents confirmed the designated officer had spoken with them. However, records seen indicated that while residents got on well on many levels the risk to resident safety that also arose between them was not resolved. The potential for the protocol to fail residents was evident in the prescribed scoring system and the application of that scoring system. The scoring system was focused on the sustaining of a physical injury and failed to recognise the psychosocial impact of such incidents on residents. For example, the inspector reviewed the most recent incident that had occurred between peers; one resident had thrown a cup of tea at another resident. However, while the resident was described by staff as shocked and annoyed by the incident and an object that could have caused injury was thrown, the incident received the lowest possible scoring of 1.

Linked to these safeguarding findings was the reported increase in this house of behaviour that challenged. It was noted in a record of incidents seen that there was "a notable increase" to date in 2022 compared with the last quarter of 2021. Some behaviour was directed at their peer while on other occasions it was directed at staff. Staff spoken with said it was possible that the behaviours of one resident acted as a trigger for responsive behaviours in their peer. Records seen including the moderate risk assessment for peer to peer incidents confirmed this and clearly stated responsive, reactive behaviour could be instigated by a peer saying or doing

something that annoyed their peer. Therefore the dynamic between the two residents was not as clear as that presented in the risk assessment. Only one resident, the resident who demonstrated the responsive behaviour had a positive behaviour support plan. The resident who had the capacity to instigate the behaviour did not. The positive behaviour support plan while current did not set out the role played by the peer in triggering the behaviour of concern and risk including the safeguarding risk.

Better structure and better consistency was needed in the systems for developing resident understanding of safeguarding. For example, minutes of a staff meeting and a risk assessment for staff lone-working said internal visual safeguarding material was to be watched regularly with residents. However, a risk assessment for peer to peer incidents said it was to be viewed every six-months. Another record seen stated this resource had last been used with residents in February 2021.

Risks to resident and staff safety as reported by the last HIQA inspection of this centre and already referred to in this report continued. There was an open high red risk for the risk of falls including the risk of falling on the stairs. There was an open red high risk for the unsuitability of one house to the assessed needs of two residents. There was an open red high risk for a resident leaving their apartment or the company of staff when out and about in the community. There was an open red high risk for manual handling that captured the risk to staff when supporting the resident to use the stairs. There was an orange medium risk for the risk of peer to peer incidents. The provider was aware of these risks and had itself assessed these residual risk levels. The provider had controls in place but did not demonstrate it was effectively monitoring and responding to these risks. Ultimately it was not demonstrated how recognising and managing risk maximised the safety of the service provided to residents.

The inspector was not assured based on records seen and staff spoken with that the gravity of incidents, the risk that presented to resident and staff safety and the potential that existed for serious harm and injury was comprehensively understood. Existing controls were reducing the risk of more serious incidents and serious injuries from occurring rather than substantively addressing and eradicating where possible the risk that presented. For example, the ongoing requirement to use the stairs. Controls were not consistently or effectively implemented. For example, the inspector saw that a resident at risk of falls was left unsupervised, got up from their chair and mobilised. Given the available staffing levels staff were not always in a position to provide supervision. However, additional controls such as devices to alert staff if a resident got up from their chair had not been considered. The inspector noted that very simple interventions such as relocating the resident's chair may have reduced the resident's inclination to get up so as to see what was going on behind them.

This inspector has already referred to the limitations of the incident scoring system above when discussing peer to peer incidents. The inspector reviewed the report of a further incident that had occurred in January 2022 where a resident was reported to have made "a sudden sweep" onto the main road and then stood in the middle of the road. A staff member had to stand on the road with the resident, signal the

approaching traffic to "slow down" and stop. Staff reported they "eventually" got the resident to return to the safety of the footpath. The staff member was reported to have been visibly impacted by this incident. However, the incident was given the lowest possible risk rating of 1. The risk assessment for this known risk and the existing controls had not been reviewed and updated after this event. This did not provide assurance as to how the provider assured itself as to the adequacy of the existing controls and satisfied itself that additional controls such as a second staff member for community access were not needed.

The provider itself had already identified one house was not suited to the assessed needs of a resident who was at risk of falls including a risk for a fall on the stairs. The resident's en-suite bedroom was on the first floor. In general, the premises did not promote accessibility with steps at the main entrance and rear exit and, steps internally due to different floor levels. The annexed apartment presented as a compact and somewhat confined space in the context of the age and needs of the resident living in the apartment. For example, the living space also operated as an office for staff. The proposed programme of upgrade works to this house had not commenced. The planned transition of one resident to ground floor accommodation was also delayed. Residents in the main house and in the apartment had divergent needs but shared the compact rear garden space. Works were underway to develop and enhance the garden.

The one area that did demonstrate improvement that had been sustained was the area of fire safety. However, there were still actions that needed to be completed and some evidence of possible inconsistency in oversight arising. Generally residents understood, responded well and participated with staff in simulated evacuation drills. The inspector saw that following the last HIQA inspection simulated evacuation drills had been completed to confirm that when there was only one staff member on duty all three residents could be safely and effectively evacuated. The centre emergency evacuation plan (CEEP) and residents' personal emergency evacuation plans (PEEP) had all been updated to reflect the findings of these drills and the particular needs of each resident. Staff maintained good records of simulated drills that reflected their knowledge of the CEEP and the PEEP's. Equipment such as the fire detection and alarm systems, emergency lighting and fire-fighting equipment were all inspected and tested at the required intervals. Devices designed to close doors in the event of fire were seen to be working. Staff had been provided with a master key where a number of residual manual locks were in use.

However, while there was a displayed schedule of planned simulated drills this did not include the names of staff members due to participate in these drills. There were staff listed on the staff rota who were not included in the analysis of completed drills.

Works needed to protect the stairwell that was the main escape route from the first floor were not complete. However, the area beneath the stairs was noted to be free of clutter and no longer used for storage.

Overall, there was much evidence of practice that was consistent with the National

Standards for infection prevention and control in community services (2018). For example, all staff on duty were seen to wear well-fitting FFP2 masks. Residents were supported to understand the risk posed by infection and to take measures to protect themselves. Generally all three houses were visibly clean but some repairs such as to kitchen cupboards were needed so that surfaces could be effectively cleaned. Some areas such as a shared shower needed a more thorough and comprehensive cleaning.

Regulation 13: General welfare and development

The majority of residents had the skills and ability to give good feedback on what life was like for them in this centre. Residents confirmed they had good access to home and family, could meet with their friends and do things that they enjoyed doing whether that was enjoying the experience of paid work or participating in training and education programmes. All residents were seen to come and go with staff over the two days of inspection for example, to attend off-site programmes or to go for a walk. However, these positive findings are qualified somewhat by the findings in relation to staffing and staffing arrangements specifically where a resident had higher needs. It was evident from a record seen that additional staffing had the potential to expand the scope of activities that could be offered to a resident. This is addressed in Regulation 15: Staffing.

Judgment: Compliant

Regulation 17: Premises

One house was not suited to the assessed needs of a resident who was at risk of falls including a risk for a fall on the stairs. The resident's en-suite bedroom was on the first floor. In general, the premises did not promote accessibility with steps at the main entrance and rear exit and, steps internally due to different floor levels. The annexed apartment presented as a compact and somewhat confined space in the context of the age and needs of the resident living in the apartment. For example, the living space also operated as an office for staff. The proposed programme of upgrade works to this house had not commenced.The planned transition of one resident to ground floor accommodation was also delayed.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were a number of high and moderate risks to resident and staff safety ongoing in this centre. The provider was aware of these risks and had itself assessed these residual risk levels. The provider had controls in place but did not demonstrate it was effectively monitoring and responding to these risks. Ultimately, it was not demonstrated how recognising and managing risk maximised the safety of the service provided to residents. Existing controls were reducing the risk of more serious incidents and serious injuries from occurring rather than substantively addressing and eradicating where possible the risk that presented. Controls were not consistently or effectively implemented. Oversight of incidents and their impact on existing risk assessments and the support provided to residents was not consistent. This did not provide assurance as to how the provider assured itself as to the adequacy of the existing controls and satisfied itself that additional controls such as a second staff member for community access were not needed so that residents and staff were safe.

Judgment: Not compliant

Regulation 27: Protection against infection

Generally all three houses were visibly clean but some repairs such as to kitchen cupboards were needed so that surfaces could be effectively cleaned. Some areas such as a shared shower needed a more thorough and comprehensive cleaning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there was a displayed schedule of planned simulated drills the planned schedule did not include the names of staff members due to participate in these drills. There were staff listed on the staff rota who were not included in the analysis of completed drills.

Works needed to protect the stairwell that was the main escape route from the first floor were not complete

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a meaningful and purposeful sample of assessments and

plans in two houses. The inspector noted that residents and their representatives were consulted with and had input into the plan. For example, some plans seen were signed by the resident. The inspector saw staff and residents working together to progress goals. There was evidence of MDT input into the plan and the review of the plan. For example from the behaviour support team and psychology. The provider did not have in one house the arrangements needed to meet the assessed needs of a resident; this is addressed in Regulation 17: Premises.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being and ensured that residents had access to the care, services and clinicians that they needed for their continued health and well-being. For example, records seen confirmed that residents had access as needed to their general practitioner (GP), their dentist, speech and language therapy, psychiatry, chiropody, podiatry and physical therapy.

Judgment: Compliant

Regulation 7: Positive behavioural support

Given the level of risk to resident safety that presented in the service there was minimal reduction and an ongoing reliance on the use of a range of restrictions. There was in fact a new restriction that had not been identified by the service as a restriction.

Records seen by the inspector clearly stated that the door between the kitchen and the utility in one house was not to be locked at any time. Assuring this restriction had been removed would have been better evidenced by the removal or disabling of the lock.

Records seen clearly stated responsive, reactive behaviours could be instigated by a peer saying of doing something that annoyed their peer. However, only one resident, the resident who demonstrated the responsive behaviour had a positive behaviour support plan. The resident who may have instigated the behaviour did not. The positive behaviour support plan while current did not set out the role played by the peer in triggering the behaviour of concern and risk including the safeguarding risk.

Judgment: Not compliant

Regulation 8: Protection

The provider operated a protocol/threshold for reporting incidents that occurred between peers. The inspector saw the protocol set out for staff a scoring system for incidents that occurred between residents. Of concern to the inspector was the fact that this protocol was not referenced or included in the provider's overarching safeguarding policy and procedures. Consequently, there were differences and inconsistencies as to how to respond to, report and screen incidents between peers. Therefore, it was unclear how the operation of this protocol was in keeping with the requirements and principles of the policy to protect residents from all types of harm and abuse. The potential for the protocol to fail residents was evident in the prescribed scoring system and the application of that scoring system. The scoring system was focused on the sustaining of a physical injury and failed to recognise the psychosocial impact of such incidents on residents.

Better structure and better consistency was needed in the systems for developing resident understanding of safeguarding.

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 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Elms OSV-0004877

Inspection ID: MON-0036720

Date of inspection: 12/04/2022 and 13/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
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, by ensuring the following actions are completed:

• A business case is in progress for submission to the HSE for the provision of additional funding for one resident currently funded for full-time 1:1 supports; who, based on assessed level of needs/ risk, actually requires 2:1 supports for community access.
• Risk assessment in place for this residents' community access and supports required relating to this risk, escalated to senior management; accepted by SMT.
Business case to be submitted to HSE by: 31/05/2022.
Anticipated date of implementation of appropriate level of supports (dependent on funding approval from HSE): 31/12/2022.
• Night-time disturbances will be risk assessed in relation to overall staffing levels for the centre, and an additional, related request for additional funding to transfer from overnight sleepover supports, to overnight waking supports; will be submitted to the HSE. This will be a lower priority for approval, than the request for additional day-time supports for community access.
Business case to be submitted to HSE by: 31/05/2022.
Anticipated date of implementation of appropriate level of supports (dependent on funding approval from HSE): 31/12/2023.

Interim Measure:
• One individual has now moved from this DC to another single story premises which is more suitable for him and his current mobility needs – completed 09/05/2022. Said residents' 1:1 funding of 16 hours per week, has been diverted and allocated to the other resident in this centre, to promote his safe community access.
• The PIC and PPIM will ensure that the current roster is reviewed fortnightly to ensure the resident is provided with the opportunity for community access daily, while awaiting the approval of additional funding to enhance supports.

[Complete]

• Open clinical recommendation for 1:1 staffing as part of a falls prevention plan, no longer relates to this centre.
• Restriction relating to risk of use of stairs for this resident is also no longer in place, as resident has moved from the centre.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. This will be actioned as follows:
• 2 x relief staff members have completed all mandatory trainings, and have been requested to complete the additional desirable training. [Date for completion: 31/05/2022]
• PIC will thereafter review and update training matrix quarterly to ensure that all staff who are rostered across the DC have up to date mandatory and site specific training completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Assurances relating to the governance and management systems within the designated centre will be delivered as follows:
• One individual has now relocated to a single story DC which is more suited to his current mobility needs. [Completion Date: 09/05/2022]
• An independent consultant has been contracted to carry out an assessment, and staff training, specific to the team supporting one individual. This assessment will incorporate the residents' overall needs and living environment. Scheduled to occur in September 2022. [Completion Date: 30/09/2022]
Recommendations arising from this assessment will lead the individuals' personal plan.
• See action plan outlined under Regulation 15: Staffing & Regulation 26: Risk Management Procedures for additional actions relating to this regulation.
• Mentorship programme between PIC & PPIM will continue until both parties are

satisfied that there is effective governance and oversight across the DC and that service provision has been improved to ensure best quality care and support for all residents. This mentorship programme specifies the roles and detail the responsibilities for all areas of service provision. • The provider will at all times going forward, 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. [Overall completion date linked with action plan relating to Staffing – 31/12/2022]

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The registered provider will ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. This will be ensured as follows: • Renovations to both the main house, and apartment in Mountain View are in progress: • Renovations include a) upgrade of bathroom in apt initially (upgrade works will be staggered with to prevent disruption to residents). b) Renovations to current staff sleepover room and en-suite/ utility room; to in turn remove staff office from living area in apartment; and so enhancing living space for one resident. c) in main house of 2 x bathrooms, re-flooring of first floor, painting, and fire safety measures including installation of cladding on stairs and replacement of 3 x regular doors upstairs to fire doors and one downstairs (hot press/ service doors/ utility room doors). [Completion Date: 30/09/2022] • Sensory space for one resident in the back patio area is in progress. [Completion date: 31/05/2022] • One individual who was at risk of falls including falls on the stairs has now relocated to a single story designated center therefore this risk is now closed and the restrictive practices associated with this risk have been ceased. [09/05/2022] • As individual who was at risk of falls has moved to another location, a planned integration of apartment and main house has commenced since 09/05/2022. This integration will remain under review by PIC, and both residents needs and wishes are being monitored.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 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. This will be actioned as follows: • A comprehensive review of risk management in relation to one resident accessing the community was carried out by the PIC & PPIM, this open risk has been escalated to senior management on 29.04.2022 and has been accepted. Existing and additional controls have been amended to further manage the risk going forward so that individual continues to have access to the community but with added measures to increase the safety for staff and resident. The risk will remain open and reviewed monthly or sooner should any incidents occur while resident is accessing the community. See action plan outlined under Regulation 15: Staffing for additional actions relating to this risk. • PIC & PPIM will carry out a comprehensive review of the 3 x risk registers; including the implementation of effective controls across all risks and to ensure all related risks are consistent in their risk ratings and their existing and monitoring controls. This review will ensure that all risks are being effectively monitored and responded to. This will be carried out as part of the current mentorship programme in place to support the PIC in her new role. [Completion date: 30/08/2022] • Risk assessment relating to peer to peer abuse in one service area has been comprehensively reviewed, and actioned. See action plan outlined under Regulation 8: Protection for additional actions implemented relating to this risk. [Completed]	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. This will be actioned as follows: • A request has been sent to landlord of property regarding the repair of the kitchen cabinets. Assurance that a contractor has been assigned this work, has been received. [Completion date: 30/07/2022] • Plans have been progressed to upgrade shower facilities in 2 x services within the DC, following review of facilities with the organization's Facilities Officer. [Completion date: 30/09/2022]	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The registered provider shall ensure that effective fire safety management systems are in place. This will be ensured by:
• Updated schedule of planned simulated fire drills to include all staff names including relief staff. [Completed]
• installation of cladding on stairs and replacement of 3 x regular doors upstairs to fire doors and one downstairs (hot press/ service doors/ utility room doors) will be completed as part of overall renovation works.
[Completion Date: 30/09/2022]

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
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. This will be ensured by:
• A review of restrictive practices in place within the centre has been carried out by the PIC/ PPIM, and the transfer of one resident from the centre has removed three restrictive practices that were in use. [Completed: 09/05/2022]
• One additional restrictive practice protocol has been devised, relating to one residents' restricted access to the community, due to insufficient staffing resource. This protocol has been reviewed with the SMT & the residents' multi-disciplinary team. [Completed: 09/05/2022]
• Manual lock has been disabled from door between kitchen and utility room in one service area. [Completed]

The person in charge shall also ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. This will be ensured as follows:
• A positive behavior support referral request has been sent to Principal Clinical Psychologist & PBS team for one resident who has never previously had this multidisciplinary intervention. Referral has requested support relating to the residents' possible triggering of responsive behaviours by their peer.
• The second residents' PBSP will be reviewed with the PBST to review the role played by the peer in triggering behaviour of concern and to further explore the dynamic between the two residents.

[Completion Date: 30/09/2022]	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The registered provider shall protect residents from all forms of abuse; and shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. This will be ensured by: • Retrospectively a CP1 form was sent to DO on 14.04.2022 relating to incidents of peer to peer abuse that had occurred between 2 residents in one service area within the centre. Following this a NF06 was submitted to HIQA. DO screened the CP1. [Complete] • A safeguarding plan is now in place in relation to the Safeguarding risk between the 2 residents. Review by DO & PIC scheduled for 19/05/2022. • The implemented safeguarding plan outlines timelines for safeguarding awareness revision for residents and is to be completed quarterly by a different staff member each time. [Commenced: 28/04/2022; quarterly review thereafter] • Team meeting scheduled for 19/05/2022 - How to respond to and report incidents between peers will be clearly outlined to all staff. [Completion date: 19/05/2022]. • PIC will review incident reporting with all teams within the designated centre at their next scheduled team meetings to ensure shared learning across the designated centre. This review will include review of incident scoring system and the potential for serious harm and injury in addition to actual harm/ injury, and the psychosocial impact that may result from an incident. [Completion date: 30/07/2022] • The provider will review the use/ removal of the protocol in their overarching National Safeguarding policy and procedures. [Completion date: 30/08/2022] • As an immediate action, the aforementioned protocol/ threshold for reporting incidents that occurred between peers is no longer in use in the region; and the provider will ensure they operate in keeping with the requirements and principles of the Safeguarding policy to protect residents from all types of harm and abuse. [Complete]	

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	31/12/2022
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	31/05/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	30/09/2022

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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	31/12/2022
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	30/08/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and	Substantially Compliant	Yellow	30/09/2022

	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.	Substantially Compliant	Yellow	30/09/2022
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	13/05/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/09/2022
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the	Not Compliant	Orange	30/07/2022

	knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	13/05/2022