Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Cuan Mhic Giolla Bhride
Name of provider:	Inspire Wellbeing Company Limited by Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	16 September 2021
Centre ID:	OSV-0005559
Fieldwork ID:	MON-0033097

About the designated centre

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

This service provides full-time residential care and support for two adults with disabilities. The centre consists of a modern, five bedroom, two storey house situated in a peaceful, scenic and rural setting in Co. Louth. It is within driving distance to a nearby city and a number of large urban towns. There are good sized grounds and well maintained gardens surrounding the centre and ample space provided for private car parking. The ground floor of the property is essentially divided into two separate living spaces for the residents who live on the ground floor of the property. The residents have their own bedroom, bathroom and a separate living area one of which is a sensory room and the other is a sitting room. The residents share the use of a communal kitchen with a breakfast bar, a dining room and separate laundry facility. Upstairs there is one staff sleepover room, a staff room and an office. There is a full time person in charge employed in the centre. The centre is required to be staffed on a 24/7 basis by nursing staff, team leaders, and a team of support staff. Part of the service provided includes as required access to general practitioner (GP) services, allied health professionals. Residents do not attend formal day services but instead are supported by staff to choose how they want to spend their day and what social/learning activities to engage in.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 - 2015 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
Thursday 16 September 2021	10:00hrs to 18:30hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall the inspector found that the governance and management systems and the staffing arrangements were not adequate to ensure effective oversight of the centre or to ensure consistency of care was provided to the residents. As a result, significant improvements were required in a number of regulations inspected so as to ensure the residents were in receipt of a safe service. The inspector found that records in the centre were not all accessible, this posed difficulties to fully assess the quality and care being provided to the residents on the day of the inspection. This was very concerning as the staff in the centre who primarily were made up of agency staff would not have access to these records either. This had the potential to impact the safety and quality of care provided to the residents as the records were not accessible therefore staff may not be aware of care requirements for the residents.

On arrival to the centre, the inspector found there were four staff on duty to provide support and care to the residents. This staffing complement was not in line with the assessed needs of the residents where five staff were identified as being required during the day one of which was to be a nursing professional. Because of this and following an incident the inspector witnessed in the centre with a resident, the provider was issued with an immediate action to address the staff shortage. This is discussed further in Section 1 of this report: Capacity and Capability.

The shift leader on duty was an agency nurse who had worked in the centre since October 2019. They ensured that the inspector followed the health surveillance checklists in relation to COVID-19 before allowing them to enter the premises. This agency nurse was responsible for the care and support of the residents on the day of this inspection as the person in charge was on leave.

Due to the fact that there was staff shortages, a team leader attended the centre for a short period during their off duty to assist the inspector with accessing files as the other staff were busy supporting the residents. However, over the course of the inspection the inspector found that the personal plans made available to the inspector were inaccurate, not up to date and some records were not available for review.

As the staffing levels were reduced in the centre, it was difficult for the inspector to meet with individual staff members as they were needed to support and care for the residents. However, from observations made the inspector both heard and visually observed staff being respectful of the residents in the centre. Of those that did meet with the inspector for a short time, they appeared to know the residents well and spoke knowledgeably about some of their care needs. Staff spoke about the residents in a caring and dignified manner.

There was limited activities for residents to engage in on the day of the inspection due to the staff shortages. However, when additional staff arrived in the centre the

inspector observed a staff member supporting and encouraging a resident to go outside to engage in activities.

The centre was generally clean, and each resident had their own bedroom. However, some actions from the providers own audits had not been completed in relation to the premises. In addition a sensory room in the centre was not being used for its stated purpose and their was insufficient private space provided for this resident. This is further discussed under Section 2 of this report: Quality and Safety.

Overall the inspector found that this centre was not being effectively managed at the time of this inspection. These issues are discussed in further detail in Section 1 and 2 of this report below.

Capacity and capability

Overall the inspector found that the governance and management arrangements in place on the day of the inspection were not adequate and did not provide sufficient oversight of the quality and safety of care. The staffing levels were not in line with the assessed needs of the residents and the provider could not provide assurances that all staff (most of whom were agency staff) had up to date Garda Vetting or training completed. Significant failings were also identified under personal plans, the statement of purpose, the premises, the records stored in the centre, the notifications of incidents and safeguarding vulnerable adults. These findings had the potential to significantly impact on the safety and quality of care provided to the residents living in this centre and warranted a full review.

Prior to this inspection, the Health Information and Quality Authority (HIQA) had received unsolicited information in August 2021 where concerns had been identified about the staffing arrangements in the centre. At this time an outbreak of COVID-19 had been confirmed in the centre. This had resulted in a significant shortfall in staff numbers. At that time HIQA contacted the provider to seek assurances in relation to the arrangements in place to ensure residents needs were being met. At that time, the person participating in the management of the centre indicated that the centre was in a 'crisis' as there were times that they could not provide adequately skilled staff to meet the needs of the residents. HIQA contacted the funding body to alert them to the situation and to outline the concerns to the quality and safety of care to the residents. Written assurances were submitted to HIQA verifying that arrangements would be put in place to ensure that a skilled team were available in the centre during this outbreak.

The inspector followed up on this information and found that while provisions had been made during the COVID-19 outbreak to ensure that a skilled staff team provided care to the resident during this time, some of these staffing arrangements were not in line with the statement of purpose for the centre. In addition, the staffing arrangements in the centre were not sustainable and the provider did not have adequate contingencies in place should there be a shortfall of staff in the

centre again.

On the day of the inspection the staffing levels were not sufficient to meet the assessed needs of the residents. There were only four staff on duty as one staff member had taken unplanned leave that day. The inspector was informed that there were no available staff to fill this shift on the day of the inspection. The team leader attended the centre for a short period after which there was no staff available. During this time one resident who was assessed as requiring one to one staffing was observed leaving the centre unaccompanied. Staff were only made aware of this when they heard the front door banging as the resident left. As a result of this the provider was issued with an immediate action on the day of the inspection to ensure that additional staff were in place to meet the assessed needs of the residents. The provider was also requested to submit assurances following the inspection to address this issue going forward.

There were also times in the centre when nursing care had not being provided. This was not in line with the statement of purpose for the centre which outlined that a nurse would be rostered on duty 24 hours a day. The provider had a business continuity plan in place which risk rated staffing levels in the centre at orange. This was last updated in June 2021 and was not reflective of the contingencies in place at the time of the inspection or the crisis situation that the provider had dealt with over the last few weeks. The inspector was also not assured that the contingencies in place to manage a shortfall of staff in the centre going forward were adequate and required review. For example; the staff team primarily comprised of consistent agency staff. This had been an issue identified at the last inspection. The inspector compared the roster from the time of the last inspection until this inspection and found that the use of agency had increased since the last inspection. For example; at the last inspection ten permanent staff were employed in the centre whereas only six permanent staff were employed at the time of this inspection. This warranted significant review.

There was a planned and actual rota maintained in the centre. The inspector reviewed a number of these duty roster from January 2021 to the date of the inspection and found that there were gaps identified. From 30 April 2021 to 4 July 2021 the person in charge was not included on the roster. It was unclear from the records viewed when the person in charge had been changed in the centre. For example; the notification submitted to HIQA outlined that the previous person in charge had left the service on 07 May 2021, and a new person in charge had commenced on the 04 June 2021. However, another report viewed by the inspector noted that the person in charge had not commenced until 17 June 2021. While the person participating in the management (PPIM) gave verbal assurances to the inspector that the dates submitted to HIQA were correct, the records required significant review to ensure they were accurate.

The governance and management arrangements were also not adequate. There was limited oversight arrangements in place for periods when the person in charge was on leave. At the time of the inspection the person in charge had been on leave for almost two weeks. The interim arrangement in the person in charges absence was that the team leader or the shift leader (who was an agency nurse) oversaw the day

to day running of the centre supported by the PPIM. However, only two team leaders were employed on the day of the inspection, one of whom only worked one day a week. The inspector was informed that this person also worked in another part of the providers service and was not full time in this centre. The statement of purpose for the centre outlined that there should be 2.56 full time equivalents employed in the centre. The inspector was not satisfied that this arrangement was adequate as evidenced by the findings on this inspection. In addition; when the team leader and the shift leader were on duty they managed the day to day operations of the centre however, it was not clear who was responsible for managing other operational issues. For example; who was responsible for ensuring that actions from audits were completed or that records were kept up to date.

The PPIM attended the centre on the afternoon of the inspection. They were very transparent in their dealings with the inspector however, the inspector found that they were not familiar with all aspects of the care and support of the residents. For example: they could not verify if all staff were trained. The inspector had to seek assurances on a number of occasions about the care and support of residents as both the PPIM and the shift leader provided conflicting information about some of the residents needs or they were unaware of some of the recommendations made following multidisciplinary (MDT) review meetings held about one resident. This did not provide assurances to the inspector as staff involved in the management of the centre were not clear about the support needs of the residents.

The provider representative visited the centre to meet the inspector who outlined that they were assured that they had consistent agency in place to support the resident and was not concerned about the governance and management of the centre or the quality of care being provided. This was concerning particularly given the findings on this inspection.

At this time the inspector outlined the concerns around the use of agency employed in the centre and the contingencies in place to manage staff shortages in the future. The inspector also found that the team leaders who had significant managerial responsibilities in the centre including staff supervision and managing duty rosters had not been afforded supernumerary hours while the person in charge was on leave. In addition they were not required to have completed any management training despite their remit prior to taking up their role. This required significant review.

An annual review of the quality and safety of care and support in the designated centre had been conducted for 2020. This outlined some actions for improvement. While some of these had been completed such as a residents shower room had been repaired and their television had been moved but some had not been completed. For example; the review outlined that one resident should be referred for occupational therapy and speech and language therapy. However, the resident had not been referred to a speech and language therapist at the time of the inspection.

The registered provider had also conducted a six monthly visit to the centre in July 2021 from which actions had also been outlined to improve the quality and safety of

care. The inspector again found that not all of the actions had been addressed within the time frames. For example; it had been agreed that a residents bedroom would be made more homely by 30 July 2021, this had not been completed at the time of the inspection. Another resident was to start attending a day service however, the information received from the shift leader and the PPIM was conflicting about this. The PPIM said they had no day placement secured where as the shift leader said that they had a placement secured. In addition some of the wooden floors were also due to be replaced in the hallway and one dining area and this had not been completed.

Of the staff briefly met, they said that they felt supported in their role and they said that supervision was facilitated by the team leader. Staff meetings were supposed to be held every four weeks in the centre. However, there was no records to support that a team meeting had been held in April and May 2021. There were also no minutes of staff meetings that had occurred in the centre on 25 March 2021 and 30 June 2021.

In addition, while staff files were not reviewed at this inspection, the PPIM for the centre could not verify whether all agency staff had up to date Garda vetting completed. They were required to submit assurances to HIQA around this the day after the inspection.

The inspector was also not satisfied from the records viewed that staff had up to date training provided. At the last inspection some bespoke training in professional management of aggression and violence (PMAV) had not being provided to agency staff in the centre. This was also the finding at this inspection as two new agency staff had not completed this training. Some staff employed permanently did not have refresher training in safeguarding vulnerable adults and one did not have refresher training in medication management. Only one staff had completed training in peg feeds and other training was planned for the 22 and 23 September 2021. This meant that on one occasion during the COVID-19 outbreak there was not staff on duty with this training. Two staff had no records to indicate that they had infection control training completed. In addition, the PPIM of the centre could not verify whether all agency staff had completed refresher training as required. This was of particular concern given the recent outbreak in the centre and the possible impact this would have on the safety of resident in this regard going forward.

Significant improvements were also required in the records stored in the centre. Some of them were not available to the inspector on the day of the inspection. There was no comprehensive assessment of need for one resident made available when the inspector requested it. Information stored in the residents personal plan was not always up to date. For example; individual risk assessments for residents had not been updated to reflect changes. Behaviour support plans contained in the personal plans were not up to date. Given that the residents living in this centre had high support needs and particular care requirements the lack of up to date information this the the potential to have significant negative impacts on the care being delivered.

The inspector found that details recorded of one incident that had occurred in the

centre in August 2021 did not match the information submitted to HIQA. The person in charge had not notified this incident as required under the regulations.

The statement of purpose was not kept under review or revised when necessary. The statement of purpose available in the centre on the day of the inspection was dated 18 June 2021. On review it did not reflect the actual staff numbers employed in the centre. For example; it outlined that 2.56 WTE team leaders were required in the centre however, it did not record how many were actually employed. The same was recorded for support workers with 13.81 whole time equivalents being required but it did not record how many staff were actually employed.

Regulation 15: Staffing

The staffing arrangements in the centre were inappropriate in providing consistent care to the residents as the vast majority of staff employed were agency staff.

On the day of the inspection an immediate action was issued to the provider as there was not sufficient staff on duty to support the residents.

Nursing care was not always provided as outlined in the statement of purpose for the centre.

The person participating in the management of the centre, could not verify whether all of the agency staff employed in the centre had up to date Garda vetting on file. They were requested to submit assurances the day after the inspection to verify this.

The actual rota did not record the days on which the person in charge worked from 30 April 2021 to July 04 2021.

Judgment: Not compliant

Regulation 16: Training and staff development

The person participating in the management of the centre could not verify on the day of the inspection whether all of the agency staff employed in the centre had up to date training (including refresher training) to ensure they had the necessary skills to support the residents in the centre.

Two new agency staff had not completed training in PMAV in order to support one resident in the centre.

Some of the staff in the centre had not completed infection control training,

refresher training in safeguarding vulnerable adults.

With the exception of the agency nurses and the team leader, none of the staff had completed training in peg feeding.

Judgment: Not compliant

Regulation 21: Records

Significant improvements were required in the records stored in the centre. Some records were not available to the inspector on the day of the inspection.

There was no comprehensive assessment of need for one resident made available when the inspector requested it.

Information stored in the residents personal plan was not always up to date. For example; individual risk assessments for residents had not been updated to reflect changes. Behaviour support plans contained in the personal plans were not up to date.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre were not assuring a safe quality service to the residents at the time of this inspection.

Findings from audits were not always been implemented.

Team leaders who were employed were not required to have any management training completed prior to taking up their role, despite their significant managerial responsibilities and oversight of a large workforce.

The providers business continuity plan to ensure that contingencies were in place to assure safe quality care to the residents had not been updated or reviewed to reflect the current practices in the centre.

All of the records in relation to staff meetings held in the centre were not available on the day of the inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was not kept under review or revised when necessary. The document viewed it did not reflect the actual staff numbers employed in the centre.

Nursing care had not been provided at all times as outlined in the statement of purpose for the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that details recorded of one incident that had occurred in the centre in August 2021 did not match the information submitted to HIQA. The person in charge had not notified this incident as required under the regulations.

Judgment: Not compliant

Quality and safety

Overall the inspector found that while residents health care needs appeared to have been met on a day to day basis, significant improvements were required in a number of regulations inspected. These included the premises, personal plans, access to allied health supports, infection prevention control and protection. The inspector found that given the lack of managerial oversight in the centre and the over reliance on agency staff that this potentially posed significant risks to the residents.

The premises were found to be clean and each resident had their own bedroom. However, some actions regarding the upkeep of the premises from the providers own audits had not been implemented at the time of the inspection. This included making one resident's bedroom more homely and some of the flooring that required attention had not been addressed.

The inspector also found that a sensory room in the centre was not being used for its stated purpose. This sensory room was also supposed to be a space for the resident to relax in. However, on the day of the inspection this was room was being used instead as a changing area for the resident. In addition, the inspector was informed by staff that this resident did not have access to a shared dining area in the centre and only accessed the kitchen area. While the environment for this

resident was bespoke for their specific and assessed needs, it was not homely and required some upgrading. For example, the chair used to support the resident was old and worn. It also meant that the resident had limited access to their home and had limited space to relax in other than their bedroom.

Residents personal plans also required review, the inspector reviewed of one residents plan and found it was not up to date and contained information that was not currently used to support them. A comprehensive assessment of the health, personal and social care support needs of each resident was not available for review and at times, there was no link between some of the information stored in the residents' personal plans and the care and support that was delivered to them. For example; one residents intimate care plan was not the most up to date version available in the centre. This was particularly concerning given the complex needs of the residents and that the provider was very reliant on agency staff some of whom were new to the centre and who therefore may not be guided by the most up to date relevant support needs of the residents. This had the potential to impact the safety of the residents as the care provided may not be correct.

At the last inspection one resident had recently been admitted to the centre, this resident had complex needs in relation to behaviours of concern and peg feeding. The resident at the time required nursing support and the support of five additional staff so as to meet their assessed needs. There had been significant improvements noted to this persons care and support needs at the time of that inspection. However, the inspector was unable to establish what improvements (if any) had been made to the quality of life of the resident as there was limited records made available to the inspector on the day of the inspection. However, it was evident from a review of incidents notified to HIQA that the number of times the resident had required admission to a hospital when they removed their peg feeding tube had decreased. Staff were also able to tell the inspector that the resident no longer required the use of a specific restrictive hold at night.

According to the PPIM and the provider representative, regular MDT reviews were held to discuss the care and support of one resident. However, only one record of these minutes were made available to the inspector on the day of the inspection.This meant that the inspector could not assess the recommendations from these reviews nor could the staff working in the centre.

The inspector was satisfied from a sample of health care plans viewed which included the assessed health care needs of the resident that generally health care needs were being met and reviewed weekly by the nursing staff. However, residents did not have timely access to some allied health professionals in line with their assessed needs. For example; the annual review conducted by the provider highlighted that a resident needed to be referred to an occupational therapist and a speech and language therapist. The PPIM informed the inspector a speech and language therapist had not been sourced as yet. According to other minutes recorded in February 2021, a speech and language therapist was also to review communication strategies for this resident. As this resident had not yet received a referral to a speech and language therapist this also warranted review.

In addition, the inspector followed up on another referral made for another resident regarding speech and language therapy. However, the PPIM was not aware of this referral and could not verify to the inspector if it had taken place.

The provider had systems in place to manage an outbreak of COVID-19 in the centre. However, these systems were not effective in ensuring that a skilled workforce would be available in the event of another outbreak. In addition, some of the staff had not completed infection control training to ensure they had the necessary up to date skills to manage or prevent an outbreak occurring again in the centre.

As already discussed under training some staff had not received refresher training in safeguarding vulnerable adults. The inspector also reviewed an incident that had occurred in the centre regarding a situation where a resident potentially had not received good quality care. The inspector found that the person in charge had not initiated and put in place an investigation in relation to this incident to establish if the resident had suffered harm. The person participating in the management of the centre could not verify if this had been completed either. While the inspector was assured that the resident was safeguarded at the time of this inspection, the lack of an investigation into this matter was not in line with the regulations. This required review.

Regulation 13: General welfare and development

On the day of the inspection residents were not engaged in activities due to the staff shortages in the centre.

It was not clear whether one resident had secured a placement in a day service on the day of the inspection. This was because the PPIM informed the inspector on the day of the inspection they had not secured a placement while the agency nurse said that they had. However the PPIM confirmed that the residents was currently awaiting a start date for a placement in Day Service in a nearby town.

Judgment: Substantially compliant

Regulation 17: Premises

Some actions from the providers own audits had not been implemented at the time of the inspection. This included making one resident's bedroom more homely and

some of the floors which required attention had not been addressed.

A sensory room in the centre was not being used for this purpose. This sensory room was also supposed to be a space for the resident to relax in. On the day of the inspection this was room was being used as a changing area for the resident. This meant that other than the residents' bedroom, they had no other available space to relax or enjoy other activities. In addition, the inspector was informed by staff that this resident did not have access to a shared dining area in the centre and only accessed the kitchen area.

An area in which one resident received their nutritional feeds was not homely and the chair used to support the resident was old and worn.

Judgment: Not compliant

Regulation 27: Protection against infection

The systems in place to manage an outbreak of COVID-19 in the centre were not effective in ensuring that a skilled workforce would be available in the event of another outbreak. In addition, some of the staff had not completed infection control training to ensure they had the necessary up to date skills to manage or prevent an outbreak occurring again in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was no comprehensive assessment of need in place for one resident.

The records stored in the residents up to date personal plan were not updated. This included behaviour support plans, intimate care plans and individual risk assessments for residents.

Judgment: Not compliant

Regulation 6: Health care

Residents did not have timely access to some allied health professionals in line with

their assessed needs.

Judgment: Not compliant

Regulation 8: Protection

The person in charge had not initiated and put in place an investigation in relation to this incident to establish if the resident had suffered harm. The person participating in the management of the centre could not verify if this had been completed either. While the inspector was assured that the resident was safeguarded at the time of this inspection, the lack of an investigation into this matter was not in line with the regulations. This required review.

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 - 2015 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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Cuan Mhic Giolla Bhride OSV-0005559

Inspection ID: MON-0033097

Date of inspection: 16/09/2021

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 staff rota is issued 4 weeks in advance. PPIM will have oversight of the rota going forward, and will communicate with HIQA on a weekly basis to confirm that there are adequate staffing levels on the rota every day for the week ahead. Inspire are committed to the ongoing recruitment of staff for the Service, our recruitment campaigns have been ongoing since this Service was opened. Inspire are also currently working with recruitment agencies in a bid to recruit permanent staff for the Service, and to also introduce and induct new block booking agency staff, this piece of work commenced prior to the inspection and is ongoing. Discussions have been held at the monthly MDT meetings re the prospects of moving to a more social care led model of care, this will mean a gradual reduction in the current Nurse led medical model. The role of the Nurse in the Service is to administer nutrition and medication via PEG, we have provided our staff with PEG training, as we prepare to move towards a social care model in this Service. During this interim period the PPIM will ensure that a Nurse is on duty seven days a week, and will communicate a weekly email confirmation of this going forward. Future agreements with the HSE regarding the skill mix and staffing requirements will be communicated as appropriate with HIQA, and the Statement of Purpose amended as appropriate to accurately reflect the changes. Statement of Purpose updated and amended to reflect the current requirements for Nurses over a 24 hour period in the Service, and also the number of current permanent staff employed, number of relief staff employed, and the total number of employed staff required.

All staff are subject to Gardai Vetting and satisfactory references prior to commencing in post, these checks are carried out during each staff members pre-employment checks, upon confirmation of satisfactory references and Gardai Vetting, a staff member is issued a start date for their employment. All recruitment agencies that we work with have the same pre-employment checks in place for their staff prior to commencing work. On inspection day some of the agency staff profiles on file in the Service did not detail that the staff member had a satisfactory Gardai Vetting, the PPIM has contacted the agencies for all staff working in the Service, and all agency staff have a confirmed satisfactory

Gardai Vetting is in place, this information was shared with HIQA on 17.09.2021, a new up to date agency staff profile has been issued to the PPIM for all agency staff, including a records of satisfactory Gardai Vetting. The PPIM will also review the rota for accuracy, to ensure that all hours worked by all staff are recorded accurately. PPIM will provide a fortnightly email update to HIQA regarding the ongoing recruitment and retention of permanent staff into the Service. Weekly recruitment update meetings take place with HR Manager and PPIM, this includes looking at additional creative ways of recruiting staff. There is a cohort of experienced staff from Inspire NI Services, who have commenced a secondment within Cuan Mhic Ghiolla Bhride, 2 days per week each, to carry out the role of Team Leader. Recruitment continues and four candidates were shortlisted for Team Leader/Support Workers post.

Timeframe: Complete and with recruitment ongoing

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All agency staff had a staff profile in place on the day of inspection which detailed the mandatory training that each staff had completed prior to them commencing their first shift in the Service. PPIM has contacted all agencies and has received an up to date staff profile for all agency staff members in the Service, will all of their up to date completed training in place. These records will be kept within the Service going forward and updated as appropriate. A new monitoring system in now in place for a monthly update with all agencies regarding their staff training, all agency staff training records will be retained at the Service. There is a requirement for new start staff PMAV in the Service, PPIM has contacted the training provider for potential dates that this training can be facilitated. Whilst awaiting this PMAV training, new staff can carry out many different support and care tasks for both Residents, staff who are awaiting their PMAV do not participate in PMAV. Training compliance for all permanent and relief staff in the Service is currently at 100% for Infection Prevention & Control, Safeguarding of Vulnerable Adults, Fire Safety, Children First, Manual Handling, First Aid, Food Hygiene, and COSHH. PPIM has liaised with our Inspire training department to confirm face to face training for permanent staff who are now due their MAPA refresher, as well as Medication training for one staff member. The PPIM can confirm that on the day of the inspection there were and continues to be training certificates in place to evidence that Support Workers also have PEG training in addition to this, there are long serving agency staff who Inspire have also provided PEG training for who are currently working regular shifts in the Service. PPIM is currently working with an independent training provider to facilitate PEG training for the new staff, as well as for other permanent staff who are in need of a refresher. The training matrix is monitored for compliance as part of the monthly monitoring visits. PMAV training is scheduled for 29.10.2021, and PEG Training is scheduled for 27.10.2021 and 28.10.2021.

Timeframe: All training up to date with exception of MAPA. 100% compliance in MAPA will be achieved by 14th Dec 2021

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All information relating to the care and support for both Residents have been updated, and are stored in the staff office. The information is clear, accurate and easy to navigate. Residents have a comprehensive care plan, risk management plan, and behaviour support plan. This information is clearly identifiable, and is available for all staff and new staff commencing their induction in Cuan Mhic Giolla Bhride.

Timeframe: Completed

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PPIM has reviewed all of the governance arrangements within the Service. PPIM is managing the staffing arrangements, and has oversight and responsibility for the rota. PPIM has appointed a senior staff from another Service as a secondment for two days per week, along with a further cohort of senior staff from Inspire NI Services who will commence a secondment within the Service once the satisfactory Gardai Vetting has been issued, to carry out a full audit of the systems and governance within Cuan Mhic Giolla Bhride, and implement improvements and more robust systems in line with our other Services across Ireland. Minutes of the staff meetings have been reviewed, and are available in the team meeting file within the staff office. There is a schedule for team meetings available for all staff in the office. Inspire provide a full suite of induction training to all staff. Persons carrying out the role of Team Leader are recruited into the position with a level of experience and competence as set out in the job description and personnel specification. Further support and training, is provided using the Induction, Supervision and Probationary Processes; this includes on the job learning as well as coaching and mentoring. In addition to this all new Team Leaders are scheduled to attend formal training modules within the rolling First Line Management Programme. As part of the organisations governance and management oversight, the findings from this inspection are escalated and discussed as part of our Services, Quality & Development Meeting, which is chaired and includes representation from Inspire’s Board and Executive

Leadership Team. The learning from this inspection is also shared across all our services. Timeframe: Completed and ongoing	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: PPIM has carried out a review and updated of the Statement of Purpose, further discussion to be had with the MDT to agree a further update to the current Statement of Purpose to reflect the potential changes to the care provision for one Resident who receives nutrition via PEG. Current staffing levels are included within the Statement of Purpose, as well as the vacant posts. Timeframe: Completed	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Assurances provided going forward that all notifications of incidents are communicated to HIQA via the Portal. In relation to the discussion held with the PPIM on the day of the inspection, no Resident was harmed, or was at risk of harm in the incident discussed. PPIM has carried out an Event Analysis Review & Learning (EARL) investigation and report following the information shared in the incident report, follow up discussions held with Agency, where the contents of the incident report were shared, and actioned accordingly by the Agency. Upon review of the medication records the resident did receive PRN paracetamol at the time referenced in the incident report. Timeframe: Completed.	
Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
PPIM confirmed during the inspection that one resident was currently awaiting a start date to begin an introduction to Day Services to enhance a range of meaningful activities, this information was correct. PPIM has contacted Day Services in the absence of the PIC to request an update of resident's start date. PPIM has reviewed the daily notes of both Residents to gain an overview of what activities they would engage in throughout a typical day. Residents engaged in activities of his choice throughout the day of the inspection, records reflect the same. Staff continue to encourage residents with activities. One resident will commence assessment with the Sensory OT on 13.10.2021, this will assist in learning more about the sensory needs and preferences with a view that staff will be able to slowly introduce and plan new activities into the residents routine.

Timeframe: Completed

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The environment for residents is bespoke, and was developed with their specific needs taken into account, based heavily on the environment that he had been residing in prior to coming to Cuan Mhic Giolla Bhride. As a follow on from the Inspection an immediate review took place and all areas identified have been actioned and completed.

Timeframe: Completed

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
There is a completed HIQA Infection Self-Assessment Tool available within the Service. All staff and all agency staff are trained in Infection Prevention and Control. Refresher training information has been facilitated with all staff and agency staff. COVID19 Contingency Plan has been reviewed and updated, to apply all of the learning from the last COVID19 outbreak within the Service, where the Service was under significant pressure due to the high number of staff testing positive. Residents have been supported to have their vaccines, there has also been a high uptake of the vaccine from the staff team and the agency staff team. A PPE stock take is completed and shared

internally with Inspire every fortnight. A review of the current health and safety systems has been carried out, with improvements implemented, for more robust health and safety checks to be carried out by different shifts. The training matrix is monitored for compliance as part of the monthly monitoring visits

Timeframe: Completed and ongoing

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Residents have an individual assessment and personal plan, the PPIM has reviewed all documentation for residents, and updated all information. This information is stored in the general office and is available to all staff.
Timeframe: Completed

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Residents have up to date Health Care Plans in place, which were within the Staff Nurse filing on the day of the inspection. The PPIM has provided a copy of all Health Care Plans for residents, which are available within their care and support files in the main office, for all staff to access. Upon the day of the inspection, the PIC had been in touch with the sensory OT for one resident, to commence an assessment, the PPIM has picked this up in the absence of the PIC, the assessment is commencing on 13th October 2021. The MDT have recently discussed the possibility of having a swallow assessment from a SALT. PPIM is currently liaising with SALT Services in the area to explore this further, and agree dates for this work to commence. One resident is in receipt of dietician services, Consultant Dietician has regular input. The resident also receives dietician support, and is managing to lose weight at this time with support from staff. Inspector queried on the day a SALT referral, PPIM was not aware of a referral for SALT on the day of the inspection, and has since followed up with the MDT Team. The Consultant Dietician had assessed, and does not require a SALT assessment. There is a reference to an MDT meeting in November 2020 where an action was for a referral to be made to SALT, PPIM has queried this with his MDT, and the PIC who was in attendance at the time. This action was in reference to the staff exploring the use of social stories and PECS, which has been implemented and remains a form of communication used. Residents receive support from Positive Behaviour Support Consultant, and are reviewed

regularly. Residents are also in receipt of podiatry input.

Timeframe: Completed

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Upon review of the medication records the resident was administered paracetamol on 19.08.2021. The PPIM has also carried out a follow up Event Analysis Review & Learning (EARL) investigation into this incident, with further discussion with the agency, in addition to this the investigation assured there were no safeguarding concerns. The agency actioned this accordingly. EARL report and findings also discussed and shared with Clinical Lead (HSE).

Timeframe: Completed

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	18/11/2021
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	15/10/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is	Not Compliant	Orange	15/10/2021

	required, subject to the statement of purpose and the assessed needs of residents, it is provided.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/01/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	17/09/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Red	17/09/2021
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	Not Compliant	Red	14/12/2021

	programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	18/11/2021
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/09/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	15/10/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the	Not Compliant	Orange	15/10/2021

	chief inspector.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	02/10/2021
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	15/10/2021
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	15/10/2021

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 control of healthcare associated infections published by the Authority.	Not Compliant	Orange	15/10/2021
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	15/10/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	18/09/2021
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health	Not Compliant	Orange	19/09/2021

	care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	15/10/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	11/11/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is	Not Compliant	Orange	18/10/2021

	harmed or suffers abuse.			