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:	Hillview A
Name of provider:	Peter Bradley Foundation Company Limited by Guarantee
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	04 January 2022
Centre ID:	OSV-0001515
Fieldwork ID:	MON-0035213

About the designated centre

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

Hillview A is a centre which is run by Peter Bradley Foundation Company Limited. The centre is located in a town in Co. Clare and provides a residential neuro-rehabilitation service for up to four residents, over the age of 18 years and who have an acquired brain injury. The service aims to support recovery after a brain injury so that the person gradually regains skills and lives a meaningful everyday life. The model of support is flexible and individualised with an emphasis on independent living. Supports are provided directly by a team of rehabilitation assistants with day to day management assigned to the team leader and the local service manager who is the person in charge. Staff are on duty both day and night. The service is located near many social and recreational amenities including local shops, services and transport links. The house is purpose built and provides residents with their own bedroom two of which are en-suite. Two residents share an en-suite and there is a further standalone bathroom. Residents have access to a sitting room, adapted kitchen, a dining area and a garden to the rear of the house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 4 January 2022	10:00hrs to 16:00hrs	Cora McCarthy	Lead

What residents told us and what inspectors observed

The inspector arrived unannounced to the centre and met with a staff member initially who informed the inspector that there was confirmed case of COVID-19 in the centre. The appropriate signage was outside the house restricting visitors and the resident was self isolating in their bedroom. The inspector was wearing the appropriate FFP2 face mask however the inspector did note that the three staff on duty were not wearing the appropriate mask as per public health guidance. It was observed that there was not an adequate supply of the specialised masks in the centre on the day of inspection.

The inspector met with three residents and interacted with them throughout the day. All three had the ability to converse verbally with the inspector and were very pleasant during the inspection and offered the inspector tea and coffee. Two residents told the inspector about their past, how they had come to live in the centre and how they got along with their house mates. They all said they were very happy in the centre and the staff were very kind to them and they felt safe. Each resident had a day they cooked a meal of their choosing with staff and the residents were also very active in their community. The residents discussed the meaningful activities they were engaged in the community, they went to football matches and visits to meet family and out for meals. One resident had built wooden window boxes with the carpenter and was very proud of this. Residents were happy to show the inspector their bedrooms which were decorated with football and hurling memorabilia and family photographs. The residents had chosen the decoration in their bedroom and had TVs, radios and photographs of family occasions in their bedrooms.

The premises was in good repair and was warm and well decorated however the centre was visibly dirty, there were stains on the outside of the kitchen cupboards, crumbs and food inside them and the cutlery drawer was very dirty. The bins had stains on them as had the wall behind them, there was a smell from the bin. The inspector found that there was an inadequate supply of cleaning products to clean sanitise surfaces. The staff on the day were observed to wear surgical masks and use hand sanitizer and a staff member assigned to the resident who was isolating was observed to wear personal protective equipment.

As part of the annual review the views of the residents and family members were sought and they all responded positively. Residents said they were very happy in the centre and were good friend with the staff members. The family members said that they were very happy with the care and support their family member received and found all the staff very kind.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted the quality and safety of service being delivered.

Capacity and capability

Governance and management systems in place at this centre had not ensured that infection prevention and control measures as outlined by public health were being practised in this centre and there was no monitoring and oversight of Infection Prevention and Control. Staffing levels in the centre also required urgent review to ensure that the safeguarding plan for one resident could be effectively implemented and to ensure that all residents safety is maintained. On the day of inspection the inspector issued an urgent action around Infection Prevention and Control and staffing.

On the day of inspection there were three staff on duty however on review of the rota and other records in the previous weeks it was apparent that the staffing regularly was not sufficient to meet the needs of the residents. There was notes and annual leave records which indicated that staff were off on sick leave or annual leave and no cover had been secured to ensure the recommended number of staff were on duty. The evidence observed was triangulated with staff and the person in charge and it was confirmed that there was a regular deficit in staff numbers. A recent incident when a resident went missing had resulted in a provider assurance report being sought by the inspector. The provider submitted same and assured the case holder that the required number of staff would be on duty to ensure the safety of the residents at all times. This according to the provider assurance report was to be reviewed on a weekly basis. There was also a safeguarding plan in place for this resident who was at risk of going missing in which adequate staff numbers was one of the control measures to safeguard the resident, it was not possible to implement this safeguarding plan with the level of staff that were on in the weeks prior to the inspection. There was a risk assessment for in place for a resident who was at risk of going missing also in which it stated that one of the control measures was that the provider would ensure that at all times there is sufficient staff on so that in an event of any incident there will be enough resources. The COVID - 19 contingency plan stated that if a resident tested positive with COVID 19 that a staff member was to be allocated to them for the duration of their isolation. As one resident had tested positive for COVID-19 and was isolating, one staff was allocated specifically to them which meant the team were short staff for the other three residents.

The statement of purpose stated that there are six neuro-rehabilitation assistants, a team leader and a person in charge on the team. There was no team leader on the day of inspection and there had not been a team leader for the previous two months. A new team leader was in the process of being recruited. Several of the neuro-rehabilitation assistants had been on sick leave or annual leave.

Staff had received training in infection prevention and control and the other mandatory training such as safeguarding of vulnerable adults, fire training and manual handling. They had completed training in hand hygiene, breaking the chain of infection and cough etiquette. However there was little indication that the training received in infection prevention and control was implemented in practice. There was

a cleaning schedule and it was signed that the cleaning had been completed but it was evident on the day that it had not been. There was no enhanced cleaning schedule in place as per COVID-19 contingency plan and policy on infection prevention and control. There was also very little cleaning products for the staff to carry out cleaning regularly.

An annual review had been completed for the centre in 2021 however it had not identified the issues with poor infection prevention and control. It had highlighted the need for consistent staff and numbers and had reviewed systems for responding to emergencies such as a resident testing positive for COVID 19 however the need for enhanced cleaning and infection prevention and control had not been identified as a area for improvement. At a recent team meeting it had been noted that the oven required cleaning however this had not been followed up. The need to recruit a new team leader had been highlighted on the internal audit process and is in the process of being recruited for. As part of the annual review the views of the residents and family members were sought and they all responded positively. Residents said they were very happy in the centre which was reiterated on the day of inspection. They said they were very fond of staff who were very good to them. The family members said that they were very happy with the care and support their family member received and found all the staff very approachable.

Regulation 15: Staffing

On the day of inspection there were three staff on duty however on review of the rota and other records in the previous weeks it was apparent that the staffing regularly was not sufficient to meet the needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had received training in infection prevention and control and the other mandatory training such as safeguarding of vulnerable adults.

Judgment: Compliant

Regulation 23: Governance and management

Given that management systems were not in place in the designated centre to ensure that good infection prevention and control was maintained in line with public health guidance Regulation 23 was found to be not compliant. The designated

centre was not resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Judgment: Not compliant

Quality and safety

The inspector reviewed the quality and safety of care received by the the residents in the centre and had concerns in the areas of risk management, infection prevention and control and protection.

The premises were maintained to a good standard and were warm and comfortable. The centre was laid out to meet the needs of the residents. Two of the residents were wheelchair users and there was good accessibility within the centre and the residents had ample space to navigate their home. The residents had input into the decoration of their bedrooms and had personal items such as photographs throughout the house. However the centre was not clean as discussed in the next paragraph. .

On the day of inspection the centre was visibly dirty, there were stains on the outside of the kitchen cupboards, crumbs and food inside them and the cutlery drawer was very dirty. The bins had stains on them as had the wall behind them, there was a smell from the bin. The inspector looked for a clinical waste bin and there was not one in use in the house however outside the back door there was a bin used for disposing of personal protective equipment. This bin was noted not to have a bin liner in it and it was overflowing. The oven in the kitchen was very dirty and this had been noted on the house audit and at the team meeting however had not been addressed. The resident who was isolating in their bedroom on the day of inspection did not have their cutlery or dishes separated from the rest of the resident group although staff did inform the inspector that they were washed separately in the dishwasher and that their laundry was washed separately There was a cleaning list which was signed however it was not observed to have been adhered to as the items ticked as completed were dirty. The inspector found that there was an inadequate supply of cleaning products to sanitise surfaces, these were purchased on the day of inspection and the specialised masks were procured also. The COVID-19 policy within the centre stated that an enhanced cleaning regime would be implemented once there was a suspected or confirmed case in the centre however this had not been implemented nor was it available to staff. Therefore frequently touched surfaces such as the door handles were not being cleaned and were observed to be dirty. The staff on the day were observed to wear surgical masks, use hand sanitizer and a staff member assigned to the resident who was isolating was observed to wear personal protective equipment. Good and effective infection prevention and control was not being practised in the designated

centre.

The provider had a risk management policy in place however risks in relation to low levels of staffing and infection prevention and control were not identified on the risk register. The provider ensured that there was a system in place in the centre for responding to emergencies.

As part of a previous inspection it was noted that behaviour support guidance was not in place for one resident. On this occasion a comprehensive behaviour support plan was noted to be in place by the inspector for this resident. This included an in depth functional analysis of the residents behaviour thus identifying the behaviour and making every effort to alleviate the cause of this behaviour. The person in charge had also developed a one page quick reference guide document which was very effective. Staff demonstrated knowledge of how to support the resident to manage their behaviour and were very familiar with the needs of the resident and the behaviour support strategies that were in place.

The inspector observed that there were systems and measures in operation in the centre to protect the residents from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons and were very familiar with the active safeguarding plan in place. The inspector spoke with the person in charge and staff regarding safeguarding of the resident. They were able to clearly outline the process of recording and reporting safeguarding concerns. However due to the staffing deficit the staff were unable to implement the safeguarding plan fully.

Regulation 17: Premises

The premises were maintained to a good standard and were warm and comfortable. The residents had input into the decoration of their bedrooms and had personal items such as photographs throughout the house. The centre was not clean, this will be addressed under Regulation 27.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place however risks in relation to staffing and infection prevention and control were not identified on the risk register.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had not ensured that residents who may be at risk of a health care associated infection are protected by adopting procedures consistent with the standards for the prevention and control of health care associated infections published by the Authority.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that a comprehensive positive behaviour support plan was in place and staff were aware of these supports.

Judgment: Compliant

Regulation 8: Protection

The inspector observed that there were systems and measures in operation in the centre to protect the residents from possible abuse. Staff were facilitated with training in the safeguarding of vulnerable persons and were very familiar with the active safeguarding plan in place. However due to the staffing deficit the staff were unable to implement the safeguarding plan fully.

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	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Hillview A OSV-0001515

Inspection ID: MON-0035213

Date of inspection: 04/01/2022

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 rota is reviewed by the LSM on a weekly basis to ensure that there are sufficient staff to cover safety of all Residents. • The LSM has contacted agency and this is reviewed on a weekly basis and staff are recruited where there is insufficient staff on the rota. • If there is insufficient staff at any stage, the community staff will be asked to work in the Residential house. • There is a contingency plan in place in the case of emergency staffing requirements.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The rota is reviewed by the LSM on a weekly basis to ensure that there are sufficient staff to cover safety of all Residents. • The LSM has contacted agency and this is reviewed on a weekly basis and staff are recruited where there is insufficient staff on the rota. • If there is insufficient staff at any stage, the community staff will be asked to work in the Residential house. • There is a contingency plan in place in the case of emergency staffing requirements. • There is a nominated Staff member in place with support of the LSM to ensure good infection, prevention and control practices – completed 5.01.2022 • The LSM has ensured that all Staff have the training and support to meet the Services IPC control needs. • IPC audits are completed by the LSM.	

• IPC is part of handovers everyday and part of team meetings.
• There is sufficient staff on everyday to ensure good quality IPC controls within the service.
• There is a local risk register to reflect IPC risks and the control measures.
• A new local cleaning checklist has been completed for staff, this will be monitored by the IPC Staff Member and the PIC as part of governance and management systems.
• Stains on cupboards and in drawers have been cleaned and this will continue on a daily basis.
• The wet bin has been removed from the kitchen to an outside area and the stains on the wall behind the bin has been cleaned.
• Information is available to Residents during meetings about IPC and how best staff can support them.
• The LSM has ensured there is a two week supply of FPP2 masks at any one time.
• The LSM has ensured that there is sufficient cleaning products in the Service to meet the IPC requirements.
• Enhanced cleaning around workstations – cleaning products/wipes beside all computers and telephone systems.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• During handover the cleaning tasks are assigned to each staff member.
• The Cleaning schedule has included date, time and staff signature.
• In areas of high activity, there is a touch cleaning schedule in place to be completed every 4hrs with staff signature, time and date (i.e handles, doors on cupboards, bins, tables, office area). This is risk assessed on a regular basis and monitored by the LSM.
• The LSM has supported all staff with IPC management and has a designated covid lead person on the team.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Local Risk Register will include all risks that relate to staffing and infection, prevention control.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Senior Management have reviewed the use of masks and PPE within the Organisation and issued guidance for all staff to ensure clarity.
• There is a nominated Staff member in place with support of the LSM to ensure good infection, prevention and control practices – completed 5.01.2022
• The LSM has ensured that all Staff have the training and support to meet the Services IPC control needs.
• IPC audits are completed by the LSM.
• IPC is part of handovers everyday and part of team meetings.
• There is sufficient staff on everyday to ensure good quality IPC controls within the service.
• There is a local risk register to reflect IPC risks and the control measures.
• A new local cleaning checklist has been completed for staff, this will be monitored by the IPC Staff Member and the PIC as part of governance and management systems.
• Stains on cupboards and in drawers have been cleaned and this will continue on a daily basis.
• The wet bin has been removed from the kitchen to an outside area and the stains on the wall behind the bin has been cleaned.
• Information is available to Residents during meetings about IPC and how best staff can support them.
• The LSM has ensured there is a two week supply of FPP2 masks at any one time.
• The LSM has ensured that there is sufficient cleaning products in the Service to meet the IPC requirements.
• Enhanced cleaning around workstations – cleaning products/wipes beside all computers and telephone systems.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• There is a nominated Staff member in place with support of the LSM to ensure good infection, prevention and control practices – completed 5.01.2022
• The LSM has ensured that all Staff have the training and support to meet the Services IPC control needs.
• IPC audits are completed by the LSM.
• IPC is part of handovers everyday and part of team meetings.
• There is sufficient staff on everyday to ensure good quality IPC controls within the service.

• There is a local risk register to reflect IPC risks and the control measures.
• A new local cleaning checklist has been completed for staff, this will be monitored by the IPC Staff Member and the LSM as part of governance and management systems.
• Stains on cupboards and in drawers have been cleaned and this will continue on a daily basis.
• The wet bin has been removed from the kitchen to an outside area and the stains on the wall behind the bin has been cleaned.
• Information is available to Residents during meetings about IPC and how best staff can support them.
• The LSM has ensured there is a two week supply of FPP2 masks at any one time.
• The LSM has ensured that there is sufficient cleaning products in the Service to meet the IPC requirements.
• Enhanced cleaning around workstations – cleaning products/wipes beside all computers and telephone systems.

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	07/01/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	07/01/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with	Not Compliant	Orange	07/01/2022

	the statement of purpose.			
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	07/01/2022
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/03/2022
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 control of healthcare associated infections published by the	Not Compliant	Orange	07/01/2022

	Authority.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	07/01/2022