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:	Ardbrae
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	28 June 2023
Centre ID:	OSV-0001700
Fieldwork ID:	MON-0032175

About the designated centre

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

Ardbrae is a designated centre operated by Sunbeam House Services CLG. The designated centre is located in a town in County Wicklow. It provides full-time residential service for up to four adults with an intellectual disability. The centre is a two-storey dwelling comprising of two joined houses which consists of a kitchen, living room, three individual living rooms for residents, staff sleepover room, office and two shared bathrooms. Each resident has their own personal bedroom (three of which have en-suites). There is a small garden to the rear of the building. The centre is staffed by a person in charge, (who is also employed as a person in charge for one other centre), social care workers, day facilitators and sleepover staff.

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
Wednesday 28 June 2023	09:30hrs to 18:10hrs	Jacqueline Joynt	Lead
Wednesday 28 June 2023	09:30hrs to 18:10hrs	Kieran McCullagh	Support

What residents told us and what inspectors observed

This inspection was a registration renewal inspection and it was announced. Throughout the inspection, the inspectors spoke with the deputy manager, staff members and three of the four residents living in the centre. In addition, a review of documentation, as well as observations, throughout the course of the inspection, were used to inform a judgment on residents' experience of living in the centre.

There had been significant improvements to the quality of care and support provided to residents living in the centre which overall, resulted in positive outcomes for residents. Although compatibility issues still remained in the house, there had been a notable decrease of notifiable safeguarding incidents submitted to HIQA. This was as a result of a combination of strategies the provider had put in place such as additional one-to-one staffing, change in layout of the environment and frequent reviews with positive behavioural supports specialists.

On the day of the inspection, the inspectors spoke with three of the residents. Two residents told the inspectors that they liked the house they were living in and wanted to continue living there. They said that they were happy with the specific spaces that were for provided for their use only. For example, both residents were provided their own sitting room. However, the residents expressed that they were not happy with who they were sharing their house with. In particular, they expressed their upset at the noise levels that sometimes occurred during the day and night. For example, banging of doors when other residents were upset, residents shouting at staff and the noise of the washing machine at night-time. The residents said that they could talk to staff if they were upset but felt it did not change anything.

On review of residents' monthly house meeting minutes, the inspectors saw that resident talked to their staff about their unhappiness or upset regarding some of their interactions with their peers. The minutes also demonstrated how staff endeavoured to provide reassurance to the residents. The complaints procedure, residents' rights, including discussions around bullying and respecting each other, was also discussed at these meetings. The meetings were held with each resident on a one-to-one basis, rather than in a group format. It had been noted on the minutes that this was to avoid negative interactions between residents during the meetings.

In advance of the inspection residents, and in some cases, residents' family members, completed a Health Information and Quality Authority (HIQA) questionnaire relating to the quality of care and support provided in the centre. For the most part, the feedback in the questionnaires was positive however, in relation to rights there were some negative comments. For example, one resident noted that they did not like arguments in the house. Another resident noted that they were unhappy with arguments or rude comments directed towards them by other

housemates.

Questionnaires also noted that residents were happy with the amount of choice and control they have in their daily life. Residents enjoyed a variety of activities such as crochet, sewing, pottery, jewellery making classes, knitting watching television, listening to music, spending time on their electronic devise (i.e. their tablet), rug making, drawing, making cards, spending time on their massage chair, playing bingo, going out with staff and looking up shows.

For the most part, residents provided positive feedback about the care and support provided by their staff. They noted that staff were easy to talk to and that staff listened to them and were familiar with their likes and dislikes. All residents were aware of who they could speak to if they were unhappy with something in their centre. One questionnaire noted that there was too many agency staff, but that they were nice. One resident noted that they got on well with most staff but felt that some staff did not listen to them. All residents noted that the knew who to go to if they were unhappy. Where residents had made a complaint, one resident noted that nothing was done about their complaint.

Overall, where residents' families had completed feedback forms, they expressed that they were satisfied with the quality of care and support provided to their family member. Some families said that they were happy with the level of communication between them and the staff, they were happy with the choice provided to their family member and felt their family member was being cared for in a respectful manner. However, not all family feedback provided the same level of positive responses. One family questionnaire noted that they did not feel their family member was always safe; that the front door was often left open and outside lights were not used in winter months. In addition, it was noted that it was a very noisy house. Families noted that they were aware of the complaints process, however, one family member noted that where they had made a complaint, said they were not happy with the way it was dealt with.

After reviewing minutes' of residents meetings, and other documents, including speaking with some residents, the inspectors spoke with management about a number of the issues raised. For example, residents' comments regarding not liking who they were sharing their house with, not feeling they were listened to and their upset at the banging noises in the house.

The person in charge advised that there had been a lot of supports and initiatives implemented in an effort to reduce the compatibility issues in the house and to better ensure a positive lived experience for residents. Details of the supports and initiatives are expanded on further in the quality and support section of report.

The inspectors observed the physical environment of the house to be clean and for the most part, in good decorative and structural repair. The house was homely and welcoming. Through-out communal and private sitting rooms there were photographs, pictures, ornaments and memorabilia that was important and meaningful to residents. Many of the residents' rooms had been recently decorated. Residents had been consulted and participated in choosing the décor, paint colours,

wallpaper and items for their room that they liked and were in line with their wishes and preferences.

In addition to the residents’ own individual spaces, there was a communal dining area, sitting room and kitchen downstairs. To support compatibility issues, meal times were often staggered to avoid all four residents having using the kitchen at the same time. Improvements were needed to the layout of the kitchen so that it met the assessed needs of all residents. In addition, a number of upkeep and repair works were needed in the kitchen to ensure that the infection, prevention and control measures in place were effective, at all times.

There was a garden space to the rear of the house that included a rockery with plants, painted ornaments and garden items. The inspectors were informed that some of the residents were supported to create and develop the garden area and enjoyed spending time in it with staff. At the front of the house there were two garden seating areas. The inspectors were informed that residents liked to sit out in the front garden at the table under the sun umbrella on a sunny day.

Throughout the day, the inspectors observed that the residents seemed relaxed and happy in the company of staff and that staff were respectful towards the residents through positive, mindful and caring interactions.

In summary, from speaking with the deputy manager and staff and from observations and a review of documentation, it was evident that they were striving to ensure that residents lived in a supportive and caring environment. Initiatives and supports had been implemented to reduce the number of safeguarding incidents occurring in the house.

While there continued to be compatibility issues in the house, overall, the initiative and strategies had resulted in positive outcomes for some residents. The provider had made some changes to the layout of the premises which had also resulted in positive outcomes for some residents, however, due to the unsatisfactory timeliness of completing upgrades to the centre's kitchen, not all residents were living in a home that meet all of their assessed needs.

The next two sections of the report 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 to each resident living in the centre.

Capacity and capability

The inspectors found that the provider and person in charge were striving to ensure that the governance and management arrangements in place provided a safe and good quality service to residents. There was a clearly defined management structure in place. The service was led by a capable person in charge, supported by a deputy

manager and person participating in management, who were knowledgeable about the support needs of residents. On the day of the inspection, the person in charge was absent and the deputy manager supported the inspection.

Since the last inspection, there had been a significant reduction in the number of peer-to-peer safeguarding incidents occurring in the house. The inspectors found that the provider and person in charge had implemented a number of environmental and individual strategies and initiatives to reduce the risk of safeguarding incidents occurring in the house. Overall, this had resulted in a number of positive outcomes for residents. However, the timeliness of the provider to complete some of the outstanding premises works, meant that not all residents were living in a centre that met all of their assessed needs. As a result, there was a potential risk of the continuance of non-serious injury occurring due to the layout of the centre's kitchen.

In an effort to reduce compatibility issues in the house and in particular, to reduction the risk of peer-to-peer safeguarding incidents continuing, the provider changed the layout of the upstairs section of the house. The change meant that there were now three individual sitting rooms provided to three of the residents, in addition to the communal sitting room. The provider had also increased staffing levels with the addition of a personal assistant for one resident. Behavioural support input had also been increased and included a day service staff member who provided positive behavioural support input on a part-time basis.

While some premises works had been completed, overall that the provider was not operating in a manner that ensured residents were residing in a suitable environment to meet their assessed needs, at all times. On the day of the inspection, while a new contractor had been sourced, they had yet to provide a quote and timescale. The timeliness of the provider to complete the change in layout of the kitchen was not satisfactory and meant that there was a continued risk of non-serious injuries occurring in this area of the house.

The provider had completed an annual review of the quality and safety of care and support in the designated centre and there was evidence to demonstrate that the residents and their families were consulted about the review. A six monthly unannounced visit had taken place in June 2023 to review the quality and safety of care and support provided to residents and an action plan with allocated actions and time scales was in place. In addition, the provider had made arrangements for an infection, prevention control audit to be completed by an external contractor in May 2023, a meditation audit in May 2023 and a health and safety audit in June 2023. Overall, the audits were found to be effective and were part of the overall quality improvement systems in the centre.

The person participating in management met with the person in charge on a regular basis to monitor any issues that were arising and track actions that were completed or required completion or escalating. Furthermore, there was a local auditing system in place that was carried out on a monthly basis by the person in charge to evaluate and improve the provision of service and to achieve better outcomes for residents. During the period the person in charge had been absent, the deputy manager had

ensured that the audits had been completed and were up-to-date.

The inspectors reviewed a sample of staff rosters and found that, on the day, the staffing arrangements included enough staff to meet the needs of the residents. There were two staff vacancies in the centre. There were agency and relief staff employed to cover the vacancies and other leave. Overall, while the person in charge and local management were endeavouring to ensure continuity of staffing so that support and maintenance of relationships were promoted, there was a high usage of agency staff in the centre. In addition, improvements were needed to ensure that agency staff had access, at all times, to information that supported them in their role and to systems where they could appropriately record updates on residents care and supports.

There was a training matrix in place that supported the person in charge to monitor, review and address the training needs of staff to ensure the delivery of quality, safe and effective service for the residents. Overall, staff training was up-to-date including refresher training. Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability.

The inspectors found that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements. The person in charge had ensured that quarterly and six-monthly notifications were being submitted as set out in the regulations.

There was an effective complaint's procedure that was in an appropriate format which included access to a complaints officer when making a complaint or raising a concern. The complaint procedure was monitored for effectiveness on the provider's internal system and endeavoured to ensure that residents received a good quality, safe and effective service.

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents including, guiding staff in delivering safe and appropriate care.

In relation to the review and update of centre's Schedule 5 policies, there had been shared learning and progress on actions from a recent inspection of another designated centre run by the provider. A number of policies and procedures had since been updated. These improvements meant that the register provider was ensured that the majority of its policies and procedures were consistent with relevant legislation, professional guidance and international best practice relating to delivering a safe and quality service.

Regulation 14: Persons in charge

On a review of documentation in advance of the inspection, the inspectors found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

The person in charge had been absent for most of the previous four weeks. During this time the arrangements in place where the deputy manager, with the support of the person participating in management covered, was found to be satisfactory.

The deputy manager was familiar with the residents' needs and was endeavouring to ensure that they were met in practice. They were also familiar with the local systems in place that ensured the governance, operational management and administration of the centre, were effective.

Judgment: Compliant

Regulation 15: Staffing

There were two vacancies for community support workers required. A 140 hour contract and a 100 hour contract. Alongside the core staff team working additional shifts, agency staff were employed to cover the vacancies, maternity leave (140 hours), annual leave and sick leave. The person in charge and deputy manager endeavoured to employ the same four agency staff as much as possible however, overall there was a high usage of agency staff.

The organisational arrangements that supported agency staff avail of the computerised system in the centre, which provided up-to-date details of the care and support needs of residents as well and policies and procedure, were not in place in this centre and required addressing.

Throughout the day, staff who spoke with the inspectors demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a training schedule in place for all staff working in the centre. The inspector found that for the most part, staff had been provided with the organisation’s mandatory training and that the majority of this training was up-to-date. For example, staff were provided training in fire safety, human rights, safe

medicine practices, infection control, and food hygiene but to mention a few.

While staff had been provided with some infection, prevention and control training, overall improvements were needed to ensure that they extended beyond COVID-19 related training (this is addressed under regulation 27).

Staff were provided with one to one supervision meetings by the person in charge and deputy manager. These meetings were provided to assist staff perform their duties to the best of their ability when supporting residents.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured information and documentation on matters set out in Schedule 2 were maintained and were made available for inspectors to view. Inspectors reviewed a sample of staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

There were good governance and management arrangements in place in the centre and this included appropriate arrangements when the person in charge was absent. The deputy manager had ensured that during a period of absence that the local monitoring systems in place had been kept up-to-date and overall, were effective in ensuring positive outcomes for residents.

The provider had implemented a number of environmental and individual strategies which had resulted in the reduction of safeguarding incidents occurring in the house.

However, the untimely response to recommendations of a allied health professional meant that for the last two years, not all areas of the centre were meeting the assessed needs of all residents,. This was at times, resulting in continuance of non-serious injuries. Previous to a HIQA inspection in February 2022, the provider had organised an environmental assessment of the location to determine the cause of non-serious injuries for one residents. The report recommended structural changes to the layout of the kitchen. On review of the centre's annual report, updated compliance plans and other tracking systems, the inspectors saw that the completion date for the work had been pushed out on several occasions.

Funding was secured in May 2023 and in June 2023 a new contractor was secured to provide a quote and timeline. On the day of the inspection, inspectors were

advised of a possible commencement date in quarter four of 2023. Overall, the timeliness to complete the required work was not satisfactory and meant that there was a continued risk of non-serious injuries occurring due to the layout of the kitchen.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.The statement of purpose clearly described the model of care and support delivered to residents in the service. It reflected the day-to-day operation of the designated centre. In addition, a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room size and function.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. It was evident that the centre strived for excellence through shared learning and reflective practices. There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors found that the residents were aware of the complaints process and it was available in an easy-to-read format displayed in the hallway for residents' review. Complaints were discussed weekly at the centres residents meetings. There was access and information available to residents in relation to advocacy services.

While, there were two negative feedback comments regarding the complaints process, overall the inspectors found the that where complaints had been made they were recorded, investigated and addressed in accordance with the provider’s policy.

Through a review of the documentation in place, the inspectors were assured that

the registered provider demonstrated that the complaints procedure was monitored for effectiveness, including outcomes for residents.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured policies and procedures on matters set out in Schedule 5 had been implemented. For the most part, the policies had also been reviewed within the prescribed time frame. There had been improvements since the inspection of another centre run by the provider, where a number of policies and procedures had not been reviewed in line with regulation requirements. For example, seven of the nine outstanding policies had been updated. In relation to the centre's safeguarding policy, this is addressed under regulation 8.

Judgment: Compliant

Quality and safety

The provider and person in charge were endeavouring to ensure that residents' well-being and welfare was maintained to a good standard. There was a strong and visible person-centred culture within the centre. The person in charge and staff were striving to ensure that residents lived in a supportive environment where they were encouraged to live as independently as they were capable of.

Since the previous inspection, there had been a number of improvements in the centre which had resulted in positive outcomes for residents, however, further improvements were required to ensure outstanding actions relating to premises were completed and in a timely manner.

There had been improvements to the change in layout of the environment upstairs to support a residents preference to have their own living area. The new layout included the conversion of two rooms into one large relaxing sitting room for a resident to enjoy. This meant that most residents now had the choice of using the communal sitting room or their own individual sitting room. As a result, while compatibly issues remained in the house, overall (and in addition to other strategies), the change in layout of the upstairs environment had seen a reduction in peer-to-peer safeguarding incidents.

However, the layout of the kitchen meant there was a continued risk of non-serious injuries occurring for a resident. There was a planned reconfiguration of the centre's kitchen, which was part of an allied health professional recommendation made in November 2021 and had been identified as a non compliance finding on during an

inspection in February 2022. At the time of this inspection, the work had not yet been completed and the commencement date for the work had been moved on several occasions.

In addition to the required change in layout of the kitchen, there were a number of upkeep and repair works needed to the kitchen. Overall, this meant that some areas of the room could not be effectively cleaned and posed the risk of spread of healthcare-associated infection.

There had been significant improvements to the arrangements and systems in place that ensured infection, prevention and control measures were effective at all times. The house was observed to be clean and tidy. There were numerous cleaning schedules in place which ensured the centre was kept clean and for the most part, conducive to a hygienic environment. The person in charge and deputy manager monitored the cleaning checklist on a regular basis for their effectiveness. On a review of a sample of cleaning lists, it was clear staff were adhering to them.

There were satisfactory contingency arrangements in place in the event of an outbreak of infectious decease in the centre. The centre's outbreak plan included appropriate precautions to be in place for residents and staff, how to deal with suspected cases of infections, the required PPE and the safe disposal of waste. The plan also included, self-isolation plans for residents. However, an improvement was required in relation to staff training to ensure that it encompassed all areas of infection prevention and control.

Staff had been provided with training in safe administration of medicine and overall, were knowledgeable of the associated policy and procedures in place. For the most part, the processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. Medication was administered and monitored according to best practice as individually and clinically indicated to increase the quality of each person’s life. There were regular local and organisational audits of the practices in place. Where there had been a trend of medical errors, the provider, person in charge and staff were innovative in finding strategies and initiative to reduce the risk of re-occurrence.

The pharmacy used by the residents was acceptable to them and a positive relationship had been built between the pharmacy staff and the residents. On review of residents medical documents, the inspectors found that some improvements were needed to maintenance and upkeep of residents' medical administration records to ensure they were clear and legible at all times. In addition, in line with the provider's safe medication policy, improvements were needed to ensure that the oversight of PRN protocols by an appropriate health professional was clearly documented.

The residents were protected by practices that promoted their safety. Staff were provided with appropriate training relating to keeping residents safe. Safeguarding measures were in place to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected the resident's dignity and bodily integrity. The provider had systems in place to ensure residents were safeguarded from financial

abuse. The person in charge carried out a monthly audit of the residents' finances to ensure each resident's money was maintained appropriately.

The inspectors found that the provider's safeguarding policy required review. The safeguarding policy in place did not contain sufficient information within the document to demonstrate that it was consistent with relevant legislation, professional guidance and international best practice and overall, that it contained adequate information to provide clear guidance to staff.

Regulation 17: Premises

There had being a reconfiguration of two rooms upstairs which resulted in a resident having their own living space that including a large sitting room where they could take time out and relax and spend time on their own if they so wished. Another resident was supported to move bedrooms so that they were closer to their own separate sitting room including an additional wardrobe and storage space that was in the room.

The completion date for the upgrade of the centre's kitchen had been changed and pushed out on numerous occasions and was not in line with the previous inspection's compliance plan's completion date. The funding for the works had been secured in May 2023. On the day of the inspection, a new contractor had been sourced. The contractor was putting together a quote and timeline for the works to be completed. However, this was in the very early staged of progress. For example, the quote and timeline had yet to be submitted to the provider and agreed upon.

The layout of the kitchen meant that their was a risk of a resident bumping into some of units in the room resulting in bruising. There was a risk assessment in place which addressed these risks and control measures were in place to reduce the risk. However, until the kitchen works were completed, the risk of non-serious injury remained. This was evident through information submitted through the quarterly notifications where non-serious injuries were recorded.

In addition to the required change in layout of the kitchen there were a number of required upkeep and repair works needed to the kitchen, such as raw timber on open cabinets, chipped and peeling plaster and rust on the radiator. Overall, this meant that they could not be effectively cleaned and posed the risk of spread of healthcare-associated infection.

The entrance to the front and back door to the house included a step down. While there was a visible yellow line to draw attention to the step, a recent allied health professional environmental assessment recommended for a ramp to be installed to support the assessed needs of two residents who, on occasions, used mobility equipment. There was no plan or completion date in place for the ramps to be installed.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. The provider maintained a risk register for the designated centre which identified the active risks in the house and the respective measures in place to mitigate the impact of same.

The risk register was regularly reviewed and updated when required.

There were individual risk assessment in residents' personal plans, and where a new risk occurred or was reduced, the assessment were updated on the risk register and in residents' personal plans.

Judgment: Compliant

Regulation 27: Protection against infection

For the most part, the inspector found that the infection, prevention and control, (IPC), measures were effective and efficiently managed to ensure the safety of residents living in the centre. Improvements were needed to the upkeep and repair of a number of areas of the centre's kitchen which were potentially impacting on the IPC measures in place. (These have been addressed under regulation 17).

Cleaning equipment such as mops and bucket sets were appropriately stored in the laundry room which was a separated building located to the back of the house.

Overall, cleaning schedules in place were being adhered to. Where there had been gaps, this had been addressed at staff meetings.

There were satisfactory contingency arrangements in place for the centre in the event of an outbreak of infectious decease as well as self-isolation plans for residents. Policies and procedures and guidelines in place in the centre in relation to infection prevention and control clearly guided staff in preventing and minimising the occurrence of healthcare-associated infections.

However, improvements were needed to ensure that suitable and sufficient training in infection prevention and control was provided to staff to enable them to carry out their tasks in line with infection prevention and control best practices. For example, training records demonstrated that staff were provided with hand-hygiene and organisation specific COVID-19 training only.

Judgment: Compliant

Regulation 28: Fire precautions

The provider was found to have good measures in place to protect residents and staff in the event of a fire, however some improvements were required. Inspectors viewed a sample of the servicing records in the centre, and found that the fire extinguishers, alarms, emergency lights, and fire blankets were up to date with their servicing. Staff in the centre were also completing daily, weekly, and monthly fire safety checks.

The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own evacuation plan which outlined the supports they may require in evacuating. Regular fire drills were completed, and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances. However, the overall, fire prevention and emergency evacuation plan required review so that it was in line with practice. For example, the plan noted that fire drills were to take place monthly, however, in practice they were taking place bi-monthly.

All staff had received suitable training in fire prevention and emergency procedures. For the most part, there were adequate means of escape, including emergency lighting. However, some improvements were needed. For example, during a walk-through of the centre, inspectors observed that the fire escape stairs at the rear of the centre to require a deep clean.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Some residents, through the support of an appropriate assessment, were supported by staff to administer their own medications. Where residents required staff to administer their medication, the provider and person in charge ensured that residents received effective and safe care and support to manage their medicines.

Overall, residents' medicines was administered and monitored according to best practice as individually and clinically indicated to increase the quality of the residents life. Staff had been provided with appropriate training in safe medication management.

A recent medication audit demonstrated that a number of medication errors had occurred. In response, the person in charge, deputy manager and staff made a number of changes to reduce the risk of the errors reoccurring. For example, the location of the medication cabinet was moved to a quieter room in the house. A 'do

not disturb' notice was put on the door when the medicines were being prepared. Additional visual information regarding the medicines was included in the medication folder and staff had been provided with additional refresher safe medication training.

However, improvements were needed to a number of residents' medication administration records. The inspector observed that a number of the records had several 'no longer in use' medications crossed out by pen. There were records were additional medications had been hand-written on the record. As a result, the records were difficult to read. On speaking with staff, the inspectors were informed that that sometimes, due to the current layout of the records, they were difficult to read. While the person in charge and local management had requested a new medication administration record from the pharmacist, copies that had been sent to the centre had to be returned on numerous occasions due to incorrect information. This had been ongoing for almost two months and required escalating at senior management level for a speedier outcome.

Improvements were also needed to PRN protocol forms to demonstrate that they had oversight by an appropriate health professional. The inspector was advised that, in line with the organisation's policy, the medical auditor had oversight over any PRN protocols when they were written up. However, on review of the protocols, the inspector saw that there was no documented evidence on the protocols to demonstrate this had taken place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed a sample of residents' personal plans. The person in charge ensured that there was a comprehensive assessment for each resident, taking into account their changing needs. The assessment informed the residents' personal plans which guided the staff team in supporting residents with identified needs and supports.

There was evidence of goals set by the resident and staff supporting same. The plans were under regular review and contained clear guidance on how staff members could maximise each resident's personal development in accordance with their wishes. Key working sessions were completed regularly. These sessions were carried out using a person-centred approach where the input and decision-making of residents was prioritised as much as possible. Recommendations from the personal plan reviews, included proposed changes, reasons for changes and names of those responsible for pursuing objectives.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall, the provider and person in charge promoted a positive approach in responding to behaviours that challenge. The inspector found that staff had been provided with specific training relating to behaviours that challenge that enabled them to provide care that reflected evidence-based practice.

There were systems in place to ensure that where behavioural support practices were being used that they were clearly documented and reviewed by the appropriate professionals on a regular basis. However, not all residents' positive behavioural support plans had received an timely review and update. While one residents' plan was in progress, it had been over two years since the plan had underwent a review by an appropriate professional.

There were a number of restrictive practices in place in the centre. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals. The restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis.

Judgment: Substantially compliant

Regulation 8: Protection

While, compatibility issues remained in the centre, there had been a significant reduction in the number of notification submitted to HIQA regarding peer to peer safeguarding incidents.

The provider and person in charge had implemented a number of strategies and initiative to support the reduction in safeguarding incidents occurring. For example, an upstairs section of the house had been reconfigured to support a residents have their own sitting room so that they could have time out and relax in an environment that was specifically for them. Additional staff had been employed to support one to one support and care for some residents. A personal assistant was supporting a residents to attend more community activities of their choice and preference which resulted in them spending less time in the house with other residents.

Resident were provided with safeguarding plans which provided adequate guidance for staff to support the reduction of safeguarding incidents. Safeguarding plans were regularly reviewed and updated and the person in charge and staff were continuously looking for ways to reduce the chance of further SG incidents occurring. In addition, residents were regularly supported by positive behavioural supports and plans.

There was a safeguarding policy and procedure document in place on the organisation's computerised shared space service. As such it was not accessible to

all staff. For example, it was not available to agency staff who did not have access to the shared space. In addition, the online copy only included three pages. Overall, the policy did not contain sufficient detail to demonstrate that it was consistent with relevant legislation, professional guidance and internal best practice.
Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Ardbrae OSV-0001700

Inspection ID: MON-0032175

Date of inspection: 28/06/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment for two vacancies in process. Staff who is currently on maternity leave is due to be back September 2023. The organizational arrangements that support agency staff have been updated. Agency staff can now access CID and eLearning, this is part of induction process for all agency staff. This has also now added to the location induction folder.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC discussed the kitchen works with the maintenance department. The plans for the kitchen have been received and the proposed start date for the kitchen works is 20th August 2023. The proposed plans include OT recommendations to meet the clients individual needs.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: PIC discussed the kitchen works with the maintenance department. The plans for the kitchen have been received and the proposed start date for the kitchen works is 20th August 2023. The proposed plans include OT recommendations to meet the clients individual needs. Other upkeep and repair works required in the kitchen area had been logged to Flexmaint and will be addressed as part of the kitchen works by August 2023. Ramp is required for the front door, and grab rails for the back garden to support clients with their mobility needs. This is now logged on flexmaint.PIC also discussed action plan with the maintenance department and this work is due to be completed by 30th November 2023.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:	

Overall fire prevention and emergency evacuation plan has been updated to specify that the evacuations are now completed every second month.

Monthly health & safety checklist is also updated to add that the fire escape stairs at the rear of center are checked monthly. Any issues with the stairs are to be logged on flexmaint, this includes cleaning of the stairs.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Residents medication administration records have been updated by pharmacy and are now in place.

PRN protocols will be signed and dated by medication auditors. As a part of the medication audits the current practice is to document that they have been reviewed, and this is contained in the medication audit report. All PRN protocols have been recently received and are now signed by medication auditor.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behavior Support Plan for one of the residents still in process. This will be completed by 30th September 2023.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Safeguarding policy was reviewed and updated on 25.07.2023

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.	Substantially Compliant	Yellow	30/12/2023
Regulation 17(1)(a)	The registered provider shall 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.	Not Compliant	Orange	30/11/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/11/2023

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2023
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	03/08/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	03/08/2023
Regulation 29(3)	The person in charge shall ensure that, where a pharmacist	Substantially Compliant	Yellow	03/08/2023

	provides a record of a medication-related intervention in respect of a resident, such record is kept in a safe and accessible place in the designated centre.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	03/08/2023
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.	Substantially Compliant	Yellow	30/09/2023
Regulation 08(2)	The registered provider shall	Substantially Compliant	Yellow	25/07/2023

	protect residents from all forms of abuse.			