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:	Abbey View Residences
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	24 January 2024
Centre ID:	OSV-0003453
Fieldwork ID:	MON-0040308

About the designated centre

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

Abbey View Residences provides accommodation and support in a purpose-built facility of self-contained apartments to 10 adults with physical disabilities and neurological conditions. Residents may also have secondary disabilities which could include an intellectual disability, mental health difficulties or medical complications such as diabetes. Support is provided 24 hours per day, seven days per week and may include respite care. People living within Abbey View Residences direct and participate in their own care. Residents at Abbey View Residences are supported by a staff team which includes a full-time person in charge, nursing staff, and care staff as well as maintenance and administrative support. Staff are based in the centre when residents are present including at night. All residents also have personal assistants for social support.

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 24 January 2024	10:10hrs to 16:15hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

This was an unannounced risk inspection to review the provider's implementation of their compliance plan following a previous inspection by the Health Information and Quality Authority (HIQA) in April 2023. On the previous inspection, improvement was required in relation to the staffing arrangements in the centre as well as the premises to meet the needs of residents. This inspection found that although improvements had been made at the centre and residents' needs were meet, further improvements were required in relation to fire precautions and the safe evacuation of residents in the event of an emergency.

The centre was registered to accommodate 10 residents. One the day of inspection, only four of the apartments were occupied. The person in charge reported that some apartments were used occasionally for respite. Two individuals had been identified as possibly moving to the centre in the future and the person in charge said that assessments with these individuals were planned for the coming weeks.

The centre was located in a town near shops, hotels, restaurants and other local amenities. The centre was a large single-storey building with 10 individual apartments. Each apartment had its own entrance from the outside of the building. In addition, the apartments each had a door that led onto a central corridor. The doors into the central corridor were fire doors. All apartments had one large room that contained the resident's bed, a living space and a kitchen. Each apartment had its own bathroom with a level-access shower. A call-bell system was in each apartment. Residents could ring a bell that they kept on their person and it activated an intercom system. Staff could speak with the residents from a central location. The apartments were decorated in line with the residents' tastes and personalised with their own pieces of furniture and belongings.

The communal areas of the building consisted of a large sitting room, two shared bathrooms, a laundry room, a sluice room, four staff offices, staff kitchen and store rooms. The building was divided into three separate compartments for the purposes of fire containment. The fire compartments were separated by two sets of double doors. There was tape and paint on the intumescent strip of one set of fire doors. This meant that in the event of fire, the seal on the door would not function as intended. A member of staff removed the tape and paint before the end of the inspection.

In response to the last inspection, the provider had outlined in their compliance plan that they would refurbish two bathrooms. This was to provide a more appropriate place for residents to shower and would ensure that residents did not have to travel through communal areas to access the shared bathroom. On the day of inspection, one bathroom had been fully refurbished and was used by the resident in their apartment. The provider had a plan to refurbish the second bathroom in the near future. The second bathroom was located in a vacant apartment. On the day of inspection, all residents could shower in their own bathrooms and no longer needed

to access the shared bathroom.

The provider had also recently refitted two kitchens. These kitchens were designed to ensure that they were accessible to residents by changing the height of the countertops and making space underneath to accommodate the residents' wheelchairs. This meant that residents could now access and use ovens, hobs and sinks. The provider had also recently installed an automatic door opener in one resident's apartment. This meant that the resident could independently open the door to enter or exit their apartment. Outside, the patio area had recently been covered and a heater installed. The patio was accessed through double doors that were opened automatically. Further maintenance and upgrade works were planned and will be discussed later in the report.

The inspector met with three residents on the day. One resident was leaving the centre and greeted the inspector. The other two residents met with the inspector individually in their apartments. Residents reported that they were happy with the service they received and the increase in the number of staff in the centre. One resident said that the increase in staff numbers meant that they could request their personal care be completed at a time that suited them rather than waiting for agency staff to arrive at the centre. Residents said that staff were helpful and caring. They said that staff responded quickly when the residents called for help. They spoke about the support that staff gave residents with daily tasks while respecting the residents' independence and privacy. They talked about plans they had made with staff for social events. A resident said that they had chosen tiles for their new kitchen and they were looking forward to having them fitted soon. However, they also expressed frustration at the time it took for the provider to process the funding for this project. They spoke about the difficulty that they had exiting the apartment as their doors had to be opened manually. They said that they had discussed this with the person in charge and that they hoped an automatic door opener would be installed. The person in charge reported that there were plans to submit an application for a grant to fund this. In relation to fire safety, one resident discussed the most recent fire drill that had taken place but said that they were unsure what the procedure would be in the event of an evacuation at night.

Staff were knowledgeable on the needs of residents. They talked about the support they provided to residents while promoting their independence. They were respectful when they spoke about residents. In relation to fire safety, staff spoke about the actions that should be taken in the event of the fire alarm sounding. They spoke about the role of fire warden in the event of a fire and the support that residents needed to evacuate the building.

Overall, the inspector noted that residents were supported by staff in the centre to meet their assessed needs. There had been an improvement to the premises that met the needs of residents. However, fire precautions in the centre required review. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of the service being delivered to residents.

Capacity and capability

The quality of the service had improved in the centre due to new staffing arrangements. The governance arrangements supported staff to deliver a good service to residents. Oversight was maintained through the use of supervision and audit. However, improvement was required in relation to audit to ensure that all risks were identified and addressed.

The number of staff employed in the centre had increased since the previous inspection. The provider had secured additional funding for staffing and the centre had a full complement of staff on the day of inspection. This increased the number of staff available to support residents during the day. The night-time staffing arrangements had also increased. This had a positive impact on the lives of residents. When residents asked for help, staff were able to respond promptly. Residents had more flexibility in their day as staff were available throughout the day to support residents with personal care and daily activities. The increase in staff also meant that residents had more opportunities to engage in social activities with the support of staff from the centre.

There were clear lines of management and accountability within the service. Staff were clear on who to contact if they had questions or concerns. Staff induction and training were monitored by the person in charge. The clinical nurse manager had oversight of the medical needs of residents. They provided clinical supervision and assessed the competencies of staff in certain areas, for example, gastrostomy feeding.

The provider had completed unannounced audits every six months as outlined in the regulations. The most recent of these had been conducted the day before this inspection. Actions identified from these audits were discussed at monthly local governance meetings. However, audits and checks had not identified improvements that were needed in relation to the management of the risk of fire. This will be discussed in the next section of the report.

Overall, the residents in the centre received a good service that was responsive to their assessed needs. The provider maintained oversight of the service through supervision and audit. However, not all audit systems were adequate to identify all areas of risk.

Regulation 15: Staffing

The staffing arrangements in the centre were suited to meet the assessed needs of residents. The number and skill mix of staff was appropriate to support residents

meet their needs.

Judgment: Compliant

Regulation 23: Governance and management

The provider had clearly defined management structures and lines of accountability. The systems in place ensured that staff received supervision and support to meet the needs of residents. The provider had completed an annual review and six-monthly unannounced audits into the quality and safety of care and support in the centre. Systems were in place to to monitor the service. However, not all systems were adequate to identify all risks. For example, the fire safety audits in the centre had failed to identify that the the intumescent strip of one compartment fire door had been covered since painting works were completed four months previously.

Judgment: Substantially compliant

Quality and safety

The provider had addressed the issues relating to the premises that had been identified on the last inspection. However, plans to improve the accessibility for one resident did not have a timeframe. In relation to fire safety, significant improvement was required in order to ensure that effective fire safety systems were in place.

The provider had completed refurbishments in parts of the centre that had a positive impact on the lives of residents. The completed projects protected the residents' privacy and dignity, for example, all residents were now able to shower in their own apartments. The refurbishments also supported residents to be more independent, for example, the installation of automatic door openers. In addition, the provider had identified key refurbishment projects for the year ahead. The person in charge reported that funding had been secured for these projects. The projects would directly benefit the residents, for example, the provider planned to upgrade the existing call-bell system. However, though the person in charge had identified that an automatic door opener was required by one resident and had planned to apply for a grant, there was no timeline or definite plan as to when this would occur.

The provider had taken steps to protect residents from the risk of fire. The centre was fitted with a fire alarm system, emergency lighting, and fire-fighting equipment. These were routinely checked and serviced by an external fire company. However, significant improvement was required in relation to the governance and oversight of fire safety systems in the centre. Risks identified by the inspector had not been detected on audit. Record keeping in relation to fire drills and evacuation plans did

not provide assurances that staff were given adequate guidance on what to do in the event of an emergency evacuation of residents. Control measures that were included in fire safety risk assessments were not reflective of the staffing situation in the centre.

Overall, the premises had been improved and refurbishments promoted the independence of residents. However, further improvement in relation to the accessibility of the building for one resident was required. In addition, significant improvement was required in relation to the audit of fire safety, risk assessments relating to fire, documentation to guide staff on evacuations, and fire drills.

Regulation 17: Premises

The registered provider had made upgrades to the centre to address the issues identified on the previous inspection. This had positively impacted the lives of residents. The provider had also made upgrades to improve the accessibility of the centre. However, although the person in charge planned to apply for a grant to upgrade a door opener in one apartment, there was no timeline in place for this to be completed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a risk register that identified risks to residents, staff and visitors to the centre. Individual residents also had risk assessments relating to their individual assessed needs. The risk assessments identified control measures to guide staff on how to reduce these risks. However, not all risk assessments were reflective of the actual situation in the centre. For example, the centre's risk assessment in relation to fire outlined that all staff had fire warden training. However, on the day of inspection, three members of staff had not yet received fire safety training.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Significant improvement was required to ensure that effective fire safety management systems were in place. On inspection, it was found that:

- A number of staff had not yet taken part in a fire drill.
- Residents were unsure of the fire evacuation procedure for a night-time

evacuation.

- Records of fire drills did not adequately outline the scenarios that were simulated during each drill. The simulated location of the fire was not recorded. The simulated staffing arrangements were not recorded. Therefore, it was difficult to ascertain if the drills had been completed in line with best practice. For example, on the most recent fire drill, records indicated that a resident had been evacuated through the building towards the path of fire rather than to an external exit.
- Fire drills did not simulate night-time scenarios when staffing numbers were lowest and each resident required two members of staff to assist with hoisting out of bed.
- Repeated issues were identified on a number of fire drills but had not been addressed by the provider. For example, it was noted that staff needed refresher training on using two-way radios. However, refresher training in this area had not been arranged.
- The centre's emergency evacuation plan did not provide adequate guidance to staff on how to safely evacuate the centre. The plan gave detail on how to check for fire and alert emergency services but did not clearly outline the fire evacuation procedure. For example, the person in charge reported that in the event of a fire occurring in the attic, all residents should evacuate through the nearest external exit rather than horizontal evacuation to another fire compartment. This was not outlined in the centre's evacuation plan.

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	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Abbey View Residences OSV-0003453

Inspection ID: MON-0040308

Date of inspection: 24/01/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Provider and Management team of the Designated Centre have reviewed the content and practice of Fire Safety Walks in the centre to ensure full inspection of fire doors • The Provider has contacted the company who conduct quarterly inspections of all life safety equipment in the Designated Centre and asked them to ensure that fires safety doors are fully reviewed on all future inspections • Fire safety, specifically equipment, actions required following drills, and training required will be a standing agenda item on all future Monthly Local Governance Meetings held in the Designated Centre and on Regional Service Support Team Meetings (These are quarterly meetings involving the Provider, support Functions and local management team.)	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: An apartment door opener will be installed in the identified apartment by 30 June 2024.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Fire Risk Assessment for the Designated Centre has been reviewed and updated by the Provider's National Health and Safety Lead and the Local Management Team.	

The Fire Risk Assessment will be reviewed in 6 months by the Provider and local Management team and further reviews planned according to the risk rating

Every new staff member will receive a local fire safety induction before commencement in the role. This will be recorded and kept on file on the premises.

Fire Warden staff training has been scheduled for 1st March 2024 for 3 staff who require it.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A list of staff yet to participate in a fire drill has been identified and extra fire drills scheduled. All staff will have participated in a fire drill by 20th March 2024.

A nighttime simulation was conducted with residents on 7th February. All residents participated. A review of the simulation was completed with all staff and all residents after this evacuation.

The PIC (Person in Charge) has explained the purpose and schedule of a nighttime simulation at a residents meeting on 15th February 2024.
The PIC and Service Coordinator have gone through each residents Personal Evacuation Plan with them to ensure their understanding. This was completed on 7th February

The Service Co-Ordinator is conducting small group refresher training with all staff members on using 2-way radios. This will be completed by 23 February 2024.

The local Management team's monthly Governance meeting will have fire safety on the agenda to ensure that any re-training or other actions required following fire drills have been actioned.
Fire Evacuations and required follow up will be included on the Provider's Regional Service Support Team Meetings agenda to ensure external support and governance.

The center's evacuation plan has been reviewed and updated by the PIC, Regional Manager and National Risk Manager on 16th February 2024

The Fire Risk Assessment for the Designated Centre has been reviewed and updated by the Provider's National Health and Safety Lead and the Local Management Team.

The Fire Risk Assessment will be reviewed in 6 months by the Provider and local Management team and further reviews planned according to the risk rating of the assessment.

Every new staff member will receive a local fire safety induction before commencement in the role. This will be recorded and kept on file on the premises.

Fire Warden staff training has been scheduled for 1st March 2024 for 3 staff who require it.

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 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.	Substantially Compliant	Yellow	30/06/2024
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	Substantially Compliant	Yellow	22/02/2024

	to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	22/02/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	22/02/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	22/02/2024
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	Not Compliant	Orange	20/03/2024

	followed in the case of fire.			