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:	Goldfinch 4
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Short Notice Announced
Date of inspection:	24 March 2021
Centre ID:	OSV-0004815
Fieldwork ID:	MON-0032143

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of four adults. In its stated objectives the provider strives to provide each resident with a safe home and with a service that promotes inclusion, independence and personal life satisfaction based on individual needs and requirements. All four residents attend off-site day services Monday to Friday; transport to and from these is provided. Residents present with a broad range of needs in the context of their disability and the service aims to meet the requirements of residents with physical, mobility and sensory needs.

The premises itself is a bungalow type residence with all facilities for residents provided at ground floor level. Each resident has their own bedroom and share communal, dining and bathroom facilities (one bedroom is en-suite). The house is located in a mature populated suburb of the city and a short commute from all services and amenities.

The model of care is social and the staff team is comprised of social care and care assistant staff under the guidance and direction of the person in charge. Ordinarily there is one staff on duty Monday to Friday with additional staff support hours provided at the weekend when residents do not have a day service.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 March 2021	10:00hrs to 16:30hrs	Cora McCarthy	Lead

What residents told us and what inspectors observed

On the day of inspection the inspector had the opportunity to meet with all four residents. The residents were receiving their COVID-19 vaccination that afternoon and were both excited and apprehensive. The staff on duty were very respectful of the residents and explained fully where they were going and why. The residents were fully informed of the details of the vaccine and had choice around it. During the course of the inspection the inspector observed the residents going about their daily activities, having lunch, and getting ready to go out for a drive and walk. The residents were very relaxed in their home and appeared comfortable in the presence of staff. The inspector spoke with one resident who explained that they would like to go out more and would like more staff to support them going out individually. The inspector noted that the residents had made a formal complaint previously to this affect. The resident said that they liked their home but wanted to be more independent and live on their own. They assured the inspector that managers were trying to to find them an appropriate house as they had mobility difficulties and not every house or apartment would be suitable.

The residents with whom the inspector spoke said they were happy in the centre and staff were very respectful and kind to them. This concurred with what the inspector observed, throughout te day. The centre was warm and homely and clean. The residents bedrooms were personalised with photographs of family and friends and were beautifully decorated in line with the residents personal tastes. One resident had a graduation photo in their bedroom from their graduation from Limerick Institute of Technology.

Capacity and capability

Based on the overall findings on this inspection the inspector found that the designated centre was not adequately resourced to ensure the effective delivery of care and support. There was a clearly defined management structure, which identified the lines of authority and accountability for all areas of service provision. The person in charge held the necessary skills and qualifications to carry out the role and the day-to-day management of the centre and was effective in the role.

The inspector reviewed the actual and planned staff rota which indicated that the provider had not ensured that the number of staff was appropriate to the assessed needs of the residents. One resident had significant mobility issues as they were diagnosed with progressive multiple sclerosis and required a lot of support both in the centre and while out in the community. Another resident was visually and hearing impaired and therefore required staff support also. There was evidence to show that the inadequate staffing numbers had an impact on the other residents

socially engaging in their community. The residents also told the inspector that it impacted their outings for example going bowling. The staff members whom the inspector spoke with were very knowledgeable around the residents' assessed needs and their abilities.

The person in charge had a training matrix for review and the inspector noted that all staff had received mandatory training. It was noted that some mandatory training had been cancelled due to the COVID-19 pandemic, however, the person in charge had ensured that staff members were scheduled to access appropriate online trainings until face-to-face training could recommence. Discussions with staff demonstrated that staff were supported to access mandatory training in line with the provider's policies and procedures in areas such as safeguarding, medication management, fire safety and infection control.

Clear management structures were in place. The provider had also undertaken unannounced inspections of the service and an annual review of the quality and safety of service was carried out for 2020. This annual review included a review of staffing, restrictive practices, quality and safety and safeguarding. However some areas that were identified in the audit process had not been progressed. For example an action around a business case to increase staffing had not been progressed. This required to be progressed in line with the providers own audit process time line. Given the non compliance on this inspection and the urgent action issued on the day of inspection, governance and management systems required review in this designated centre.

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations.

During the inspection incidents were reviewed and it was noted that the person in charge had notified the Chief Inspector of incidents that occurred in the designated centre.

Regulation 14: Persons in charge

The person in charge demonstrated the relevant experience in management and was effective in the role.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that the number of staff was appropriate to the assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had a training matrix for review and the inspector noted that all staff received mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

The centre was not resourced to ensure the effective delivery of care and support.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a written statement of purpose in place for the centre, which contained all information required under Schedule 1 of the regulations

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge notified the Chief Inspector of incidents that occurred in the designated centre.

Judgment: Compliant

Quality and safety

The findings on the day of this inspection found that the provider had failed to make adequate arrangements for the containment of fire in the centre and had not progressed their compliance plan from the last inspection in relation to a fire

engineer's report. Also the provider had not ensured that the residents had the freedom to exercise choice and control in their lives in relation social engagement in their community.

On the day of inspection and urgent action was issued in relation to fire safety. The provider had stated in a compliance plan October 2019 that a fire review would be completed and in November 2020 as part of an update on the compliance plan the provider stated that a fire engineer's inspection report would be completed. On the day of inspection on the 24th March 2021 these had not been actioned. The works required included additional measures to contain fire such as fire doors and ceiling compartmentalisation. It was noted by the inspector that there was good control measures in place to mitigate against fire such as fire drills, personal egress plans, emergency lighting and an L1 alarm system. The fire works required had originally been proposed to be completed by 2021 however the provider stated in the updated compliance plan that it would be 2022 before works would be complete however a time bound plan in relation to the work was not received.

In relation to the rights of the residents the provider had not ensured that the residents had the freedom to exercise choice and control in their lives. Due to the number of staff not being adequate for social engagement in the residents local community the residents did not have the opportunity to choose to go out independently of the other residents. The provider had input a second staff member at the weekends however this still meant that the residents would have to go out in couples or as an entire group. There was only one staff member on duty midweek evening so the residents could not go out on a one to one with staff. The residents had previously made a complaint to this effect and a business case was submitted for funding however this had not been approved.

The inspector noted that the provider had implemented the necessary protocols and guidelines in relation to good infection prevention and control to ensure the safety of all residents during the COVID-19 pandemic. These guidelines were in line with the national public health guidelines and were reviewed regularly with information and protocols updated as necessary. For example, when staff were coming into the centre they had to adhere to COVID-19 protocols such as temperature checks, a COVID-19 questionnaire and wear appropriate personal protective equipment (PPE).

The person in charge had ensured an assessment of need was completed for the residents. For example the provider had ensured that a assessment by an occupational therapist was carried out for one resident. This assessment was sought as a result of residents mobility issues. The residents mobility was assessed and appropriate equipment was provided for the resident such as handrails and a walking frame for support. The resident was encouraged to use the walking frame however mostly declined to use it. This was risk assessed for the potential risk of falling for the resident. The occupational therapy assessment was comprehensive and the actions addressed.

The assessment of needs included review of residents behaviour support needs. There was a behaviour functional analysis completed for one resident which gave a overview of the function of the resident's behavior. This meant that there was clear

guidance for staff on how to support the resident when the resident exhibited behaviours that challenge.

Staff demonstrated a good knowledge of the residents' health care needs and how to support them. For example staff members with whom the inspector spoke were knowledgeable about the residents needs and were aware of one residents dental care needs. The resident recently had extensive dental work completed under general anaesthetic. Another resident was having chiropody treatment for an ongoing issue. The residents had access to a GP and other health care professionals.

Residents were supported to achieve their personal goals although these had been subject to changes due to the effects of COVID-19 public health restrictions. For example where residents had aspired to go to particular events such as a music concert this had to be postponed due to COVID 19.

Appropriate user friendly information with visuals was provided to the residents to support their understanding of COVID-19 and the restrictions in place. Other visuals in place included how to make a complaint or report alleged abuse.

The provider ensured that each resident received appropriate care and support, having regard to the nature and extent of the residents' disability, assessed needs and their wishes. There was evidence of access to facilities for occupation and recreation prior to COVID-19. Prior to the COVID-19 restrictions the residents were noted to have been active in their community and were regulars in the local cafes and restaurants.

The provider had a risk management policy in place and all identified risks had a risk management plan in place including the risks attached to COVID-19. The provider ensured that there was a system in place in the centre for responding to emergencies.The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control. The person in charge had ensured that the risk control measures were proportional to the risk. In this sense residents were still able to engage in activities such as walks and drives. Staff were observed to wear masks and practice appropriate hand hygiene during the inspection. There was adequate supply of PPE in the centre and hand sanitiser while all staff were trained in infection prevention and control.

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. The inspector spoke with one staff member regarding safeguarding of residents. The staff member was able to clearly outline the process of recording and reporting safeguarding concerns.

Regulation 13: General welfare and development

The provider ensured that each resident received appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and their wishes.

Judgment: Compliant

Regulation 17: Premises

The premises were laid out to meet the needs of the residents.

Judgment: Compliant

Regulation 20: Information for residents

Appropriate user friendly information with visuals was provided to the residents to support their understanding of COVID-19 and the restrictions in place. Other visuals in place included how to make a complaint or report alleged abuse.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and all identified risks had a risk management plan in place including the risks attached to COVID-19. The provider ensured that there was a system in place in the centre for responding to emergencies.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that residents who may be at risk of an infection such as COVID-19 were protected by adopting procedures consistent with the standards for infection prevention and control.

Judgment: Compliant

Regulation 28: Fire precautions

The registered Provider had not made adequate arrangements for containing fires.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensure an assessment of need was completed for the residents.

Judgment: Compliant

Regulation 6: Health care

The person in charge had ensured each resident received appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured every effort was made to identify the function of behaviours that challenge and supports were provided where necessary.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured there were systems in place to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that the residents had the freedom to exercise choice and control in their lives.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Goldfinch 4 OSV-0004815

Inspection ID: MON-0032143

Date of inspection: 24/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The staffing in the designated centre is funded in line with the service arrangement signed between the BOCSILR and the HSE. • These funded staffing levels include additional hours at the weekend. • However additional support hours are required in the evening to meet the support needs of residents. • On call support hours, which are available every evening, are allocated to the designated center where possible. However these hours may be redirected at short notice to cover other priorities. • An updated business case for additional staffing has been submitted to HSE following the inspection. This business case was discussed at the business case meeting on 26th April 2021. • The HSE are actively working with the Services in order to provide consistent support hours that will support choice for residents. We are currently awaiting approval from the HSE on the proposal. • Another business case will be considered once Day Services resumes in the future given the changing needs of the residents. The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
• The staffing in the designated centre is funded in line with the serviced arrangement signed between the BOCSILR and the HSE.
• These funded staffing levels include additional hours at the weekend.
• However additional support hours are required in the evening to meet the support needs of residents.
• On call support hours, which are available every evening, are allocated to the designated center where possible. However these hours may be redirected at short notice to cover other priorities.
• An updated business case for additional staffing has been submitted to HSE following the inspection. This business case was discussed at the business case meeting on 26th April 2021.
• The HSE are actively working with the Services in order to provide consistent support hours that will support choice for residents. We are currently awaiting approval from the HSE on the proposal.
• Another business case will be considered once Day Services resumes in the future given the changing needs of the residents.
• The status of the business case will be communicated to the Area Manager and the Person in Charge.
• The Area Manager and Person in Charge meet on a weekly basis. The status of the business case will be on the weekly meeting agenda.
• Residents will be kept up to date on the status of the business case and the request for funding. The status of the business case will be communicated to residents on a monthly basis as part of the monthly meetings with residents, staff and Person in Charge.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A letter from a fire safety engineer outlining the adequacy of the current fire safety systems was forwarded to HIQA 29/03/2021.
• An L1 fire panel and emergency lighting are in place.
• Fire safety systems are serviced and maintained by a qualified contractor on a quarterly basis.
• A fire register is in place in the centre. All staff are required to familiarise themselves with the fire register and to sign the register to indicate they are familiar with its contents.
• The fire panel is checked for faults daily by staff. Any faults are reported.
• The fire exits are checked daily by staff to ensure that they are clear of obstructions.
• The emergency lighting is visually checked by staff on weekly basis. Any faults are reported.

• The fire alarm system, emergency call points and firefighting appliances are checked on a weekly basis. Any faults are reported.
• Daily and weekly checks of fire safety systems are recorded in the fire register.
• Fire extinguishers are in place across the centre. They are serviced annually.
• A nightly checklist is completed to confirm that all electrical appliances in communal areas are unplugged. This includes all appliances the kitchen (where there is access to the plug and where it is reasonable to plug the appliance out), the living room and the utility room.
• Fire drills are conducted on a quarterly basis. Fire drills are conducted by all staff working in the centre and with all residents of the centre.
• Where required, electrical equipment is cleaned on a regular basis e.g. extractor hood, toaster etc. – Cleaning of the toaster will be included on the cleaning checklist. The extractor fan in the kitchen will be checked quarterly by an electrician and it will be changed when required.
• The tumble dryer is checked daily to ensure the lint compartment is emptied, the water compartment is emptied and it is unplugged when not in use. Checks are recorded.
• New staff participate in fire drills during the shadowing period of induction.
• Personal Emergency Egress Plans (PEEP) are in place for all residents across the centre and are reviewed in line with residents' needs.
• The importance with residents of unplugging their appliances in their bedrooms before they go to sleep each night will be discussed at house meetings, while remaining cognisant of the residents' right to privacy. This will be added to the agenda of the weekly house meetings with the all residents of the centre.
• A risk assessment in relation to fire safety is in place for the designated centre. It is monitored on a quarterly basis.
• An annual safety inspection is completed by Person in Charge.
• There is an emergency assembly point identified at the front of the premises.
• Fire safety is discussed at house meetings and staff meetings.
• Assistive fire safety equipment is in place for a resident with a profound hearing impairment.
• The installation of fire rated doors and the provision of protected corridors etc. will be planned during 2022 as part of an ongoing programme of works.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The staffing in the designated centre is funded in line with the serviced arrangement signed between the BOCSILR and the HSE.
• These funded staffing levels include additional hours at the weekend.
• However additional support hours are required in the evening to meet the support needs of residents.
• On call support hours, which are available every evening, are allocated to the designated center where possible. However these hours may be redirected at short notice to cover other priorities.

• An updated business case for additional staffing has been submitted to HSE following the inspection. This business case was discussed at the business case meeting on 26th April 2021.
• The HSE are actively working with the Services in order to provide consistent support hours that will support choice for residents. We are currently awaiting approval from the HSE on the proposal.
• Another business case will be considered once Day Services resumes in the future given the changing needs of the residents.
• Residents are aware of the complaints procedure and can make a complaint if they are unhappy about the level of staffing or the level of activities they are receiving
• Residents attend local advocacy meetings monthly to discuss any issues that may arise for them and the Director of Services is invited to these meetings to answer questions the Regional Advocacy Council has. These engagement is communicated to all residents in the internal Advocacy magazine.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the chief inspector that the action will result in compliance with the regulations

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	30/09/2021
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 the statement of purpose.	Not Compliant	Orange	30/09/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	31/12/2022

	containing and extinguishing fires.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	30/09/2021