



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

## Issued by the Chief Inspector

Name of designated centre:	Kinvara Avenue
Name of provider:	Avista CLG
Address of centre:	Dublin 7
Type of inspection:	Unannounced
Date of inspection:	07 April 2022
Centre ID:	OSV-0005729
Fieldwork ID:	MON-0036070

## About the designated centre

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

Kinvara Avenue is located in a suburban area of North Dublin City and provides 24 hour residential services for up to four individuals with intellectual disabilities, medical needs, mental health needs and age associated conditions. The centre is comprised of one terraced house and consists of an entrance hallway, a living room, an open plan kitchen and dining room, an accessible toilet and shower room, four resident bedrooms, a first floor bathroom, a laundry room, a store room and an enclosed garden space to the rear of the property. Residents who avail of the services of this centre are supported by a staff team made up of a person in charge, social care workers, and health care assistants. There is a total staff compliment of 10.10 full-time equivalents.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	4
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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
Thursday 7 April 2022	09:15hrs to 15:30hrs	Sarah Cronin	Lead

## What residents told us and what inspectors observed

This unannounced inspection was carried out to assess the arrangements in place for the prevention and control of infection and compliance with Regulation 27: Protection against infection and the associated National Standards for Infection Prevention and Control (IPC) in Community Services (HIQA, 2018). The inspector found this service gave good quality support to the residents. Residents appeared happy and comfortable in their homes. Staff interactions were supportive and kind. While the inspector found some good infection prevention and control practices, some improvements were required to ensure that there was adequate oversight of IPC practices and procedures in place to meet the required standards.

This centre is a home to four older adults with changing health and social care needs due to ageing. The house is a four bedroom terraced house. Upstairs, there is three bedrooms and a bathroom. This bathroom was noted to have a bath only which was inaccessible to the majority of residents. Downstairs consisted of a sitting room, a bedroom, a wet room, a small laundry room and a large kitchen/dining area. There was a large garden to the rear which required maintenance work to ensure it was accessible for residents. The house did not have adequate storage space which meant that items such as walkers, PPE and boxes for archiving were stored in the sitting room. Additionally, staff did not have any office space and were required to work from the kitchen table. Files were stored in a large cupboard in the kitchen.

Both the person in charge and the person participating in management for this centre was on an unexpected absence on the day of the inspection. The inspection was facilitated by a staff member who was a qualified social care worker. The inspector spoke with all of the residents, two staff members and a person participating in management during the inspection. The inspector spent time observing the physical environment and reviewing documentation. In addition to speaking with residents and staff, the inspector observed residents' daily interactions and routines.

On arrival to the centre, the inspector was greeted by a staff member. The inspector noted there to be hand gel and appropriate documentation for visitors at the front door. One of the residents was having their breakfast and a cup of tea in the sitting room. They greeted the inspector and told them about a piece of research they had been involved in. They showed the inspector a copy of the report which they had received in the post that morning. The research was about the impact of COVID-19 on residents with disabilities. The resident told the inspector that they washed their hands and wore their mask when they were out. A second resident greeted the inspector and was bringing down their washing in a basket. This resident had previously worked as a cleaner and missed their work. They continued to engage in some light housework in line with their wishes. The resident went out on the bus with staff and another resident later in the morning. The third resident was colouring and enjoying breakfast at the kitchen table. They had recently had a

birthday party in a local bar which they had enjoyed with friends. The fourth resident rose later in the morning and greeted the inspector. They were going out to get their hair done. They told the inspector they had to wear their mask and they knew that they had to wash their hands.

The inspector viewed a sample of the minutes from weekly residents meetings. COVID was on this agenda each week and this included giving consistent information to residents about social distancing, hand hygiene and wearing masks. There were clear processes in place to obtain consent for the vaccine and consent for PCR testing which was done within the service. There was easy to read information for residents about COVID-19, about isolation and why other residents may be isolating outside the house. This supported staff to have discussions with residents in a consistent way.

The inspector found that overall, the centre was operating at a good standard of infection prevention and control practice and that the provider was ensuring that residents were appropriately protected from health care -associated infections. The next two sections of the report will outline the findings in relation to governance and management and how these arrangements impacted on the quality and safety of infection prevention and control. The findings will be presented under Capacity and Capability and Quality and Safety and an overall judgment on compliance with regulation 27.

## Capacity and capability

At provider level there were a number of systems and structures in place to govern infection prevention and control in the organisation. The provider had an Infection Prevention Control Committee at regional and national levels. Membership of this committee included a nominated centre nurse and liaison nurses for IPC, the director of nursing, quality and risk and a senior pharmacist. The committee met on a quarterly basis. The committee monitored health care acquired infections, hygiene and IPC audits and compiled an annual review for the CEO. There were clear reporting structures in place and the provider had access to a Clinical Nurse Specialist in Infection Prevention and Control and Public Health. The provider had a serious incident management team who met weekly. Local outbreak meetings took place between public health, the HSE, the attending GP and nursing management where required. Local management meetings took place between the persons in charge and persons participating in management and IPC information and updates formed part of the agenda for these meetings.

The annual review report for 2020 and six monthly unannounced visits in 2021 were reviewed. Consideration was given to IPC in some of these reports (for example, maintenance was noted to have a negative impact on IPC in June 2021). However, it was unclear on the day of the inspection what actions had been taken to rectify these issues. The provider carried out an annual IPC audit. This had taken place in

December 2021 and had identified a number of areas requiring improvement. Again, it was not evident that actions identified had been completed in order to continue to drive quality improvement.

Day- to -day management arrangements in the centre required improvement to monitor and oversee practices within the centre and ensure that these were in line with organisational policies and guidance. There were a number of policies and procedures in place relating to IPC which included infection prevention and control, guidance on cleaning and decontamination of goggles, the use of surgical masks and wearing personal protective equipment. There were additional guidelines developed by the provider on cleaning standards and checklists, IPC local audits and hand hygiene audits. However, staff were not familiar with some of these guidance documents such as the guidance on cleaning and disinfection. This was particularly relevant to ensure that staff were familiar with required cleaning methods and products to use in the event of a suspected or positive case of infection.

Furthermore, the contingency plan and HIQA self -assessment were not readily available to the inspector on the day of the inspection. Staff on duty were not familiar with these documents. They were submitted to the inspector following the inspection by a person participating in management. Auditing within the centre was found to be limited in bringing about required changes. Weekly health and safety walk arounds were taking place in addition to hand hygiene audits. It was noted that audits were not self-identifying areas in the centre which needed improvement (for example, storage of equipment and cleaning products). Staff meetings were taking place every two months. While the provider's guidance indicated that IPC should be a standing item on staff meeting agendas, the records viewed by the inspector indicated that IPC had not been a standing item for the previous two meetings. At a recent staff meeting in March 2022, two staff members had been identified as IPC leads. It was unclear from the documentation reviewed what additional responsibilities and/ or training these staff members had received.

On the day of the inspection, there were 2 staff vacancies and the person in charge was on an unexpected absence for a number of months. The person participating in management who was a Clinical Nurse Manager (CNM3) was deputising for the person in charge for a number of months. They were on leave on the day of the inspection. The person participating in management had responsibility over a large number of centres. There was not a nominated or named staff member /leader in the house. Staff spoke about staffing difficulties and how they were managing it through staff filling relief hours and use of regular relief and regular agency staff. This was done with input from the person participating in management. Staff reported that they were taking responsibility for doing the roster themselves. A review of the planned and actual rosters indicated that while there was use of relief staff, these were regular relief staff which enabled good continuity of care for the residents. Shift leaders were not identified on rosters.

Staff had completed training in hand hygiene, infection prevention and control, recognising COVID-19 and donning and doffing of PPE. However, these courses had been completed online and it was not clear how practices were being monitored. In addition, the provider had listed training for staff on cleaning and disinfection, the use of chlorine based disinfectants and terminal and environmental cleaning as a

control measure. However, staff training records and staff report indicated that this had not taken place.

The centre's risk register had a number of risk assessments in relation to COVID-19. However, many of these were not up to date and not in keeping with current guidance. For example, the risk assessment on supporting residents to receive visitors was done in September 2021. In addition to this, some of the control measures did not correlate with practice. For example, in the risk assessment relating to laundry and the management of body spillages stated that soiled linen should be placed in alginate bags. However, staff did not have access to these bags. The manager who facilitated the inspection informed the inspector that alginate bags had caused damage to machines. For that reason, the practice was that if linen was badly damaged that they would be disposed of and replaced. Since the beginning of the COVID-19 pandemic, the centre had one outbreak. The provider had developed systems to ensure each outbreak was reviewed with the person in charge and the staff team and that learning was identified and shared at meetings with all persons in charge.

## Quality and safety

While the inspector found most of the house to be clean and in a good state of repair, some areas required improvement. On arrival, the house was noted to be warm and there was a homely atmosphere, with residents engaging in their morning routines. The house had three bedrooms upstairs and a bathroom. The bathroom had a bath only which was inaccessible to most of the residents. This had been noted on a previous inspection of the centre in March 2021, with the provider committing to works being completed by December 2021. Bedrooms were nicely furnished and residents had space for their personal belongings. One room had a significant amount of bags and clutter on the floor and staff were working with that resident to reduce the amount of bags stored on the floor in line with their needs. Downstairs there was a sitting room, a bedroom, a wet room, a small utility space, a storage cupboard and a large kitchen/ dining area. Due to a lack of storage space, there was PPE, boxes of documents for archiving and two walkers stored in the sitting room. The wet room was in a good state of repair. However, the shower chair was noted to be rusted. Due to lack of storage, there was a requirement for a specifically adapted shower chair and commode to be stored in the bathroom when it was not in use. The laundry room was found to be in a poor state of repair. There was no ventilation and there was a build up of mould on the walls and one of the cupboards had paint peeling off the front of it. There was a very small cupboard where cleaning equipment such as mops, buckets and cloths were stored. Clean cloths were stored on top of a dirty mop bucket. These maintenance and storage issues posed significant challenges in infection prevention and control.

Cleaning was the responsibility of all staff. There was a detailed cleaning schedule in place which included equipment in the centre. Touch points were cleaned four times

a day. Staff were using normal household products to clean each day. They had not had clear training on what products to use to disinfect surfaces. Staff who the inspector spoke with were unclear on what products and protocols they would use for cleaning during an outbreak of infection. There was a colour coded system in place for cleaning cloth mops. When managing body fluid spillages, staff spoke about how they managed these but did not know about spill kits. Documentation indicated that they had access to these as required. The provider engaged an external cleaning company to do a deep clean of premises in the organisation following an outbreak or a case of infection.

Laundry management required improvement. All of the residents' laundry was done in one wash each day. Where residents linen was soiled/ contaminated, staff did not have access to alginate bags. However, this was listed as a control measure on the risk assessment on the management of linen. The person participating in management reported to the inspector that the process was that clothing was to be thrown out and replaced if badly damaged due to bags damaging machines. The inspector found that there were appropriate systems in place for waste management. Waste was collected by an external contractor. Staff had access to clinical waste bags where required.

There was evidence that staff were engaging with residents to educate and inform them about COVID-19 and precautions such as hand hygiene, using masks and having visitors. Consent was sought for vaccinations and for having PCR tests carried out. Staff were knowledgeable about standard and transmission based precautions and appropriate levels of PPE. One of the staff members was noted to wear an FFP2 mask while another had a surgical mask. However, the staff member with the surgical mask was noted to have a medical reason for doing so. Symptom checks were carried out by staff on both themselves and residents twice a day. There had been one outbreak in this centre since the beginning of the COVID-19 pandemic. At that point, the provider did not carry out reviews of outbreaks to identify learning points.

## Regulation 27: Protection against infection

It was evident to the inspector that the provider had developed a number of governance structures, policies and guidance for staff in order to inform and guide IPC practices in the centre.

Improvement was required in the following areas:

- Day to day oversight and monitoring of IPC practices was required with clearer deputising arrangements in the centre.
- Audits relevant to IPC were conducted but these required review to ensure that key issues were identified and actioned quickly.
- Training for staff was generally completed in relevant areas. However, training and guidance on cleaning and disinfection required improvement to

ensure consistent practices among staff, particularly where there was a suspected or positive case of infection.

- Laundry management arrangements required improvement to minimise the likelihood of transmission of infection. Clarity was required for staff on the use of alginate bags.
- Management of spills of body fluids required clarity for staff to ensure that they were familiar with the protocols to be followed in addition to accessing spill kits.
- Risk assessments required an update to ensure they were in line with current guidance and that staff were knowledgeable about control measures required.
- The centre's contingency plan and self -assessment documents were not readily available in the centre on the day of the inspection and staff were not familiar with the contents of these documents.
- The laundry room required immediate works to remove mould and repair damaged surfaces.
- Storage of cleaning equipment required review to ensure the segregation of clean and dirty items and of colour coded items.

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
<b>Capacity and capability</b>	
<b>Quality and safety</b>	
Regulation 27: Protection against infection	Not compliant

# Compliance Plan for Kinvara Avenue OSV-0005729

Inspection ID: MON-0036070

Date of inspection: 07/04/2022

## Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

## Section 1

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

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 27: Protection against infection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Protection against infection:</p> <p>The Provider and PPIM are committed to addressing and resolving the issues.</p> <ul style="list-style-type: none"> <li>• The Provider is aware that the P.I.C is absent for a prolonged period and has increased site visits by PPIM to the Designated Centre.</li> <li>• The Service Manager and CNM3 has completed a six monthly provider visit .All actions from this will be addressed.</li> <li>• The Provider will look at Alternate arrangements for a more suitable Laundry..</li> <li>• All mops and clothes are now replaced and mould removed .</li> <li>• Risk Assessments ,Contingency plan and HIQA self assessments are all up to date and on file.</li> <li>• IPC is now on the Agenda for all staff meetings.</li> <li>• Infection control Committee will discuss extra training for staff and the sourcing of new alginate bags.</li> </ul>	

**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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	05/06/2022