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:	The Bay
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Short Notice Announced
Date of inspection:	10 September 2020
Centre ID:	OSV-0003434
Fieldwork ID:	MON-0030416

About the designated centre

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

The Bay is a designated centre operated by Autism Initiatives Ireland located in County Wicklow. The service provides a respite service for 10 adults with an intellectual disability on a rolling basis. A maximum of four service users can be accommodated at one time. The centre consists of a two storey house and a adjoining apartment. The house comprised of a sitting room, kitchen/dining room, office, three individual service user bedroom and shared bathrooms. The adjoining apartment comprised of a sitting room, kitchen/dining room, one bedroom, office and a bathroom. The designated centre is located close to the local town with access to local shops and transport links. The centre is staffed by a person in charge, social care worker and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 10 September 2020	10:15hrs to 16:35hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the three service users availing of the service at the time of the inspection. The inspector also observed elements of their daily lives at different times over the course of the inspection.

The service users who spoke with the inspector said they liked their time in the designated centre. The inspector observed service users engaging in activities of daily living including relaxing in the designated centre, listening to music, playing video games, accessing the community and spending time in their room. Overall, it was observed that service users appeared relaxed, comfortable and enjoyed being in the company of staff members.

Capacity and capability

Overall, the governance and management arrangements in place were monitoring the quality and safety of the care and support provided to service users. However, improvement was required in the effective governance and management of the centre, the centre's statement of purpose, policies and notification of incidents.

The designated centre had a defined governance and management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge also demonstrated a good knowledge of the service users and their support needs. There were arrangements in place to monitor the quality of care and support in the centre. The quality assurance audits included bi-monthly peer review audits, six-monthly unannounced provider visits and an annual review for 2019. These audits identified areas for improvement and action plans were developed in response. However, the annual review required improvement as it was not centre specific and did not include consultation with service users and their representatives as required by Regulation 23. This had been identified by the provider and the inspector viewed a draft template which had been developed for the next annual review. In addition, improvement was required in relation to the effective oversight of the designated centre. For example, the quality assurance audits did not identify areas for improvement in fire safety and the submission of quarterly notifications.

There was a planned and actual roster maintained by the person in charge. From a review of a sample of rosters, it was evident that there was sufficient levels of staffing to meet the assessed needs of the service users. The provider ensured continuity of care through covering gaps in the roster with members of the staff team and regular relief staff. At the time of the inspection, the centre was operating with two whole time equivalent (WTE) vacancies. The inspector was

informed that one vacancy had been filled and a staff member had been identified to began in October 2020. The provider was actively recruiting the fill the other vacancy. Throughout the day of inspection, positive interactions were observed between service users and the staff team.

There were systems in place for the training and development of the staff team. From a review of a sample of staff training records, the inspector found that, for the most part, the staff team had up-to-date mandatory training including medication management, fire safety and safeguarding vulnerable persons. There was evidence that refresher training was scheduled as required. This meant that the staff team had up to date knowledge and skills to support service users with their identified needs.

The provider prepared a Statement of Purpose for the designated centre dated September 2020. From a review of the statement of purpose, the inspector found that it did not accurately contain all of the information as set out in Schedule 1. For example, the statement of purpose did not contain all of the information as set out in the Certificate of Registration and the floor plans did not accurately reflect the floor plan of the centre. This meant service users and their representatives did not have access to a statement of purpose which accurately reflected the service delivered to service users.

The inspector reviewed a sample of incidents and accidents occurring in the designated centre and found that they were, for the most part, notified to the Chief Inspector as appropriate. However, improvement was required in the submission of quarterly notifications in relation to the use of restrictive practices.

Regulation 15: Staffing

There was a planned and actual roster maintained by the person in charge. The staffing levels in place were appropriate to meet the assessed needs of the service users and ensured continuity of care and support. Throughout the day of inspection, positive interactions were observed between service users and the staff team.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The staff team had up to date knowledge and skills to support service users with their identified needs.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a defined governance and management structure in place. There were arrangements in place to monitor the quality of care and support in the centre including bi-monthly peer review audits, six-monthly unannounced provider visits and an annual review for 2019. However, improvement was required in the provider's annual review of the centre and the effective oversight of the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The designated centre's Statement of Purpose did not accurately contain all of the information as set out in Schedule 1 of the Regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and accidents were notified as appropriate to the Chief Inspector. However, improvement was required in the submission of quarterly notifications as outlined in the report.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

A written policy and procedure on the use of CCTV was not in place on the day of inspection in line with Schedule 5.

Judgment: Not compliant

Quality and safety

Overall, the management systems were in place to monitor the service and the three service users the inspector met on the day of inspection appeared happy and spoke positively about the service. However, improvements were required in fire safety management, restrictive practices, risk management and premises.

The inspector completed a walk through of the designated centre accompanied by the person in charge. The centre consisted of a two storey house and an adjoining apartment. The house comprised of a sitting room, kitchen/dining room, office, three individual service user bedroom and shared bathrooms. The adjoining apartment comprised of a sitting room, kitchen/dining room, one bedroom, office and a bathroom. Overall, the designated centre was homely and well maintained. However, some areas of the centre required attention including areas of loose flooring and tiles.

The systems in a place for fire safety required improvement. For example, there was suitable fire safety equipment in place including an alarm, fire extinguishers and emergency lighting. However, on the day of inspection, there was no evidence of regular servicing of the alarm and emergency lighting. In addition, while there was evidence of fire drills taking place, they did not demonstrate that all of the service users could be safely evacuated. The inspector also observed a number of fire doors were wedged open on the day of inspection which negated the purpose of the fire door in the event of a fire. The inspector identified the wedges to the person in charge and they were removed on the day of the inspection.

The inspector reviewed a sample of personal plans. Each service users' needs were assessed through an 'about me' assessment and healthcare pathway assessment. These assessments informed the service users' personal plans which were found to be up-to-date and appropriately guided the staff team in supporting service users with identified needs and goals while attending the service. Service users were supported to manage their health care while availing of the service and there was evidence that service users were supported to have regular access to allied health professionals, as appropriate.

Service users were supported to manage their behaviours and there were positive behaviour support plans in place as required. The inspector reviewed a sample of behaviour support plans and found that they were up to date and contained appropriate information to guide the staff team. There was evidence that service users were supported to access psychiatry and psychology supports where required.

There were some restrictive practices in use in the designated centre. There was evidence that restrictive practices were identified and regularly reviewed. However, the inspector was concerned about the management of visual monitors for observation of a service user during a period of decline in their mental state. At the time of the previous inspection, an immediate action was issued to introduce a method of observation to address the immediate risk posed to the safety of the

service user and the staff team. In response, the provider put visual monitors in place and an emergency meeting was scheduled for the following day to review the service users care needs. This practice had a significant impact on the resident's right to privacy and dignity.

On the day of this inspection, the inspector observed a visual monitor, which was not in use, in situ in the service user's bathroom. The inspector was informed that the visual monitors had not been utilised for over a year. The inspector reviewed the protocols and plans in place on the use of visual monitors, which were agreed by the service user's multi-disciplinary team, and found that they were unclear as they referred to the use of audio monitors in places rather than the use of visual monitors. While there was evidence of regular review of the restrictive practice, it was not evident that this practice was the least restrictive. For example, the visual monitors were introduced to address an immediate risk to safety of the service user and other people. However, it was not evident that after the service user's mental health improved and the risk to safety reduced, that alternative restrictive interventions were explored. In addition, the provider had received consent from the service user's representatives for the use of the restrictive practice. However, it was not evident that the service user had been consulted regarding the restrictive practice or their informed consent sought.

There were systems in place to safeguard service users. The inspector reviewed a sample of incidents occurring in the centre which demonstrated that incidents were appropriately managed and responded to. Service users were observed to appear comfortable and content in the designated centre throughout the inspection. There was evidence that respite bookings considered the preferences, compatibility and safety of service users.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre specific risks and the measures in place to manage the identified risks. In addition, individual risk assessments were also in place for identified risks including behaviour and restrictions.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19. For example, the provider had reduced capacity, developed contingency plans for staffing and the isolation of service users if required. There was a folder with information about COVID-19 and infection control guidance and protocols for staff to implement while working in the centre. The inspector observed that personal protective equipment including hand sanitizers and masks were available in the centre.

Regulation 17: Premises

The centre was well maintained and decorated in a homely manner. However, there

were areas of flooring in need of attention.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and control of infection.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place. However, improvements were required in:

- the servicing of fire safety equipment,
- the arrangements for reviewing fire precautions,
- and the containment of fire (fire doors wedged open).

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need in place which consisted of an 'about me' assessment and a heathcare pathway plan. The personal plans in place were up to date and guided staff to support service users with identified needs.

Judgment: Compliant

Regulation 6: Health care

Service users were supported to manage their health care conditions and had access relevant allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and there were positive behaviour support plans in place as required.

Restrictive practices in use in the centre were identified and there was evidence of regular review. However, improvement was required to:

- ensure that a restrictive practice was the least restrictive and used for the shortest duration necessary,
- restrictive interventions are implemented with the informed consent of service users,
- and, restrictive procedures are applied in accordance with national policy and evidence based practice.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to safeguard service users. Incidents occurring in the centre were appropriately managed and responded to. Service users were observed to appear comfortable and content in their home throughout the inspection.

Judgment: 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially 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	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Bay OSV-0003434

Inspection ID: MON-0030416

Date of inspection: 10/09/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Operational team has devised new template for Annual Quality report to be introduced in 2021. This Annual Quality Report will be personalized for The Bay. This new template will include feedback from families and Service Users. This will be done by devising and circulating a questionnaire to the Bay service users and their families in Nov 2020 for return in Dec 2020.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Include all information from HIQA certificate – to include the three conditions of registration - The room sizes included - The floor plan updated	
Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Include all restrictive practices in NF39 report – due 31-10-20 and ongoing thereafter

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Policy for CCTV to be devised and implemented by Operational team - Meeting to review first draft on 5th Nov 2020 - Expected to role-out by 30-12-20

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Maintenance on the following areas: - Tiles in upstairs bathroom – replaced 1-10-20 - floorboards in sitting – fixed 1-10-20

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Servicing of fire safety equipment - fire panel and emergency lighting to be serviced and inspected annually – currently awaiting date for technician to complete service - Updates to be added to internal quality audits to ensure fire procedures are reviewed in more detail eg. To be implemented in upcoming internal inspections - Fire drills for each service user underway, expected to be completed by 16-11-20. - Fire wedges removed immediately – order placed for new firestops.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
- Psychologist has met with service user to review mental health plan and check service users understanding of same on 6-10-20. Mental health plan including consent to be completed by 16-11-20.

- Restrictive interventions to be reviewed at annual Future Planning Meeting (with service user and family) – 10-12-20

- Policy and Guidance for use of CCTV to be implemented by 30-12-20.

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(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/10/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation	Substantially Compliant	Yellow	30/12/2020

	with residents and their representatives.			
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.	Not Compliant	Orange	16/11/2020
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	16/11/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/11/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	16/11/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure	Substantially Compliant	Yellow	31/10/2020

	including physical, chemical or environmental restraint was used.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/12/2020
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	16/11/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/12/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Not Compliant	Orange	10/12/2020

	this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			