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

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| Name of designated centre: | Holly Services |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Roscommon |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 27 February 2023 |
| Centre ID: | OSV-0004694 |
| Fieldwork ID: | MON-0038483 |

## About the designated centre

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

Holly Services is a residential service which is run by Brothers of Charity Services, Ireland. The centre caters for the needs of five female and male adults who have an intellectual disability. The centre comprises of two houses, one of which is located on the outskirts of a town in Co. Roscommon, and the other house is located in a village in Co. Roscommon. Both houses are within easy access to all local amenities and the community. The houses are comfortable and suitable for purpose with two residents living in one house and three residents in the second house. Staff are on duty both night and day to support residents living in this centre
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**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 5 |

## 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 |
|---|---|---|---|
| Monday 27 February 2023 | 12:30hrs to 17:30hrs | Catherine Glynn | Lead |
| Monday 27 February 2023 | 12:30hrs to 17:30hrs | Eilish Browne | Support |

## What residents told us and what inspectors observed

This was an short notice announced inspection to monitor and review the arrangements the provider had put in place in relation to infection prevention and control (IPC). During the course of the inspection, inspectors visited throughout the centre, met with residents and staff and had an opportunity to observe the everyday lives of residents in the centre. Inspectors found that significant improvements were required in relation to the management of risk of IPC in this centre. While the provider was aware of the improvements required, they had not established or commenced a quality improvement plan to address the significant gaps evident.Therefore, the IPC measures in this centre were compromised as a result of the numerous gaps evident.

This is a centre that very much ensured residents were provided with the care and support that they require. All efforts were made by staff to ensure residents had multiple opportunities to engage in activities of interest to them, in accordance with their capacities and assessed needs. Overall, this is a centre that prioritises the needs of residents in all aspects of the service delivered to them. Inspectors met and spoke with five residents during the inspection, and they all reported they felt safe, supported and spoke about their lives in the centre and their local community.

The centre comprised of two houses which were spacious and laid out to meet the needs of residents, each of who had their own bedroom. The houses were nicely furnished and equipped, and had large garden areas to facilitate residents outdoor activities, such as gardening, minding pets and hens. It was evident that residents were being supported to engage in activities according to their preferences, and that there were sufficient and familiar staff on duty to support them.

On arrival to the centre, it was observed hand sanitising equipment and face masks were readily available in the centre. Staff were observed wearing masks when residents were present in the centre and visitors were reminded and offered the choice to wear masks when attending the centre. Inspectors were asked to complete a checklist to enable the provider to maintain an effective record for persons attending the centre.

Inspectors conducted a 'walk around' of the centre. The centre appeared initially to be visibly clean, however on closer inspection it was apparent that some areas required attention, and these will be discussed later in the report. There were various communal areas, including large kitchens and dining areas, sitting rooms, office area and various activities rooms in both houses, which included a music room and additional seating areas. All residents communicated verbally with the inspectors. The inspector spent time with these residents and chatted about their lives and experiences. Inspectors observed interactions between staff and residents which indicated that staff were very familiar in both houses, with their way of communicating.

Residents told inspectors that they were very happy in their home, and they enjoyed living there. While the residents were busy interacting with staff, or participating in their day services, inspectors completed a walk around of the centre. During the walk around the inspector noted that five rooms in one house had mould evident on the ceilings and walls. In four rooms this was a small area, but in the utility room there was significant evidence and damage as a result of the mould, which included discolouration, bulging of the plasterwork and cracked paint. The provider was aware of this issue which was highlighted in a recent announced visit prior the the inspection. At the time of the inspection, the provider required funding to address the remedial works required in this house and therefore had no quality improvement plan in place which was time-bound . Staff spoken with informed inspectors that cleaning the mould areas had become a weekly cleaning task to manage this situation but they did not feel this was ideal.

All of the residents' rooms were personal to them, and contained their personal items, including photographs and items relating to their hobbies and interests. It was clear that residents kept their own rooms as they chose, with as many personal items as they chose. Their rights were also respected in the communal areas of the house. As said, there were various areas for them to use, and each resident chose where to spend their time. One resident enjoyed a garden space with a personalised shed, while another resident had a music room. In addition, two residents engaged with their local community through employment, and sporting events.

Information about public health advice was available to residents, and staff could describe how they supported residents both in their home and in the local community. One resident was heard asking a staff when meeting inspectors if a mask was required and the staff was heard advising them it was their choice but masks were readily available if they required one. During public health restrictions various activities had been introduced in the centre while residents were spending much of their time at home. Residents had now returned to all their preferred activities and enjoying their local community.

The provider had staff had ensured throughout the pandemic that residents were supported to maintain a meaningful life and were not subjected to unnecessarily restrictive arrangements, and that they were now returning to engaging with the community.

Overall, inspectors found that multiple strategies were in place to safeguard residents from the risk of all infectious diseases; however, the provider had failed to ensure that the environment and facilities were maintained in optimum condition.

The next two sections of the report outline the findings of this inspection in relation to IPC practices, the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives in relation to infection to and control.

## Capacity and capability

Overall, as said in the previous section, the provider had not ensured appropriate IPC measures were in place in this centre and inspectors found that there was poor oversight by the management team of the gaps evident which resulted in poor IPC measures in this centre.

While there was a clearly defined management structure in place which identified the lines of accountability, including an appropriately experienced and qualified person in charge, however inspectors noted that the oversight of the management team was ineffective, which included documentation and effective oversight of the systems in place in line with their policies and procedures. The management team were aware of improvements required but there was no quality improvement plan clearly showing the actions required, persons responsible and time frames for completion. There was a clearly identified team with responsibility for managing and advising on infectious diseases, including a staff member identified as IPC specialist within the organisation, however this had not been effective in this centre and did not escalate the risks that were evident i relation to IPC. In addition, the provider had failed to recruit an additional coordinator to further strengthen the management team, which was an action agreed from a provider assurance report in 2020.

Policies and procedure had either been developed or revised in accordance with best practice. These included policies and procedures relating to visitors, IPC, hand hygiene, decontamination, laundry and waste disposal.

There was a contingency plan in place which clearly outlined the steps to be taken in the event of an outbreak of an infectious disease, inspectors found that the plan could be implemented as required. A 'centre specific risk assessment' had been completed by the provider which included guidance in relation to all expected events in the event of an outbreak of an infectious disease. This document covered deputising arrangements in the event of a shortfall of management cover, a shortfall in the provision of PPE, the management of staffing and plans for isolation if required.

Staffing numbers were adequate to meet the needs of residents, including the requirement to ensure that residents were facilitated to have a meaningful day . Staff training was up to date and included the required training to ensure adherence to public health guidelines.

Staff had been in receipt of all mandatory training, including training relating to the current public health guidelines. Training records reviewed by inspectors showed that they were current, including training in relation to the use of PPE, breaking the chain of infection and hand hygiene.

Staff supervisions were up to date and regular staff meetings were undertaken. Staff meetings included infection control as a standing item. A handover at each change of shift was maintained and this included reference to the wellness of residents.

Inspectors had discussions with staff on duty on the day of the inspection, and all staff members could describe the current guidelines, and told inspectors of

additional supports that had and could be put in place in order to maximise the quality of life of residents. They could describe in detail the support needs for each resident, both during the outbreak, during the community restrictions, and currently with a return to normal activities.

In summary, inspectors found residents' safety and welfare was paramount to all systems and arrangements that the provider had put in place in this centre. The provider ensured that residents were supported and encouraged to choose how they wished to spend their time; however, improvements were required to ensure that the centre's environment and facilities were maintained in optimum condition.

## Quality and safety

Inspectors found that the provider had not ensured that effective IPC arrangements were in place in this centre which included effective oversight and accountability of the management of risk in IPC measures in this centre.

The provider had measures in place to ensure that the wellbeing of residents was promoted and that residents were kept safe from infection. This included adherence to national public health guidance, staff training and provision of information about infection control and COVID-19 to inform staff and guide practice. These measures were effective and none of the residents had contracted COVID-19 during the pandemic. Overall, while there was evidence that a quality and safe service was being provided to residents, some arrangements in the centre did not protect residents from the risk of infection. Improvements to some internal surface finishes and to the documentation of the cleaning schedule were required to ensure that effective cleaning could consistently be carried out. In addition, inspectors found gaps evident in the cleaning records which were not identified by management.

The centre was two houses, in a rural town. One was in a residential area near the town centre and the other was nearby on the outskirts of the town. The location of the centre enabled residents to visit the shops, coffee shops, restaurants, bar and other activities in the town. The centre had dedicated transport, which could be used for outings or any activities that residents chose. Some of the activities that residents enjoyed included outings to local places of interest, going out for coffee and restaurant meals, housekeeping tasks, table-top games and crafts, personal treatments and music. There was also a well maintained and furnished accessible garden where residents could spend time outdoors.

During a walk around the centre, the inspector found that it was decorated and furnished in a manner that suited the needs and preferences of the people who lived there. Both houses were kept in a clean and hygienic condition throughout. The kitchens in both houses were bright and comfortable, and were well equipped with readily cleanable and suitable equipment for cooking and food storage. Surfaces

throughout the house were of good quality, were clean and were well maintained. Wall and floor surfaces in bathrooms were of impervious materials which could be easily cleaned. However, inspectors found that mould was evident in five rooms in one house and one room had significant mould and damage to the walls and decor as a result. Staff spoken with discussed the intensive cleaning this required which had increased over time.

A supply of colour coded cleaning equipment and materials such as mops, cloths and buckets was provided in addition to an adequate supply of cleaning materials. Both houses had laundry facilities for washing and drying clothes and the laundry of potentially infectious clothing and linens was being managed in line with good practice. There was a plentiful supply of face masks, and staff were wearing face masks at all times during the inspection.

Good waste management arrangements were also in place in the centre which increased infection control safety. Refuse collection was supplied by a private contractor and bins were suitably and hygienically stored while awaiting collection. Arrangements were also in place for the segregation, storage and disposal of clinical waste.

Residents were supported to achieve the best possible health by being supported to attend medical and healthcare appointments as required. Throughout the COVID-19 pandemic, residents continued to have good access to general practitioners (GPs) and a range of healthcare professionals. Residents were supported to access vaccination programmes if they chose to, and were assisted to make informed decisions about whether or not to become vaccinated.

Family contact and involvement was seen as an important aspect of the service. Although visiting restrictions had been in place during the earlier part of the COVID-19 pandemic, visiting has now fully returned to normal in line with national public health guidance.

## Regulation 27: Protection against infection

The provider did not have effective oversight of IPC arrangements at the centre to ensure areas for improvement were recognised and addressed. Improvements included :

- Five rooms in one house had evidence of damp on the day of inspection.

- Inspectors found poor oversight by the management team,

  - poor audits,
  - lack of quality improvement plans to address any failings,
  - failure to recognise or list areas for improvement in the annual report of

quality and safety of the service completed for 2022, and
- failure to complete actions as specified in correspondence with HIQA.

- The provider visit had not been completed within the required time frame, this audit failed to identify IPC issues or specify actions required, with timescales or persons responsible.

- There was a reliance on the staff team to complete audits, with no evidence of oversight by the management team.

- Risk management arrangements failed to identify whether or not areas of concern had been escalated to senior management.

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** | |
| **Quality and safety** | |
| Regulation 27: Protection against infection | Not compliant |

# Compliance Plan for Holly Services OSV-0004694

## Inspection ID: MON-0038483

## Date of inspection: 27/02/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 27: Protection against infection | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The provider did not have effective oversight of IPC arrangements at the centre to ensure areas for improvement were recognised and addressed.
There is a clear Management Structure in place to ensure effective oversight of IPC arrangements in this Designated Centre. This includes the Service Co Ordinator as the PIC and the Area Manager as the PPIM.
Improvements included :
- Five rooms in one house had evidence of damp on the day of inspection.
The Service Coordinator has liased with the Facilities Manager and a building contractor. A plan is in place to address the dampness issue in one house in this designated centre. Works are planned to commence on the 6th June 2023 and should be completed within three months.
- Inspectors found poor oversight by the management team,
• poor audits,
• lack of quality improvement plans to address any failings,
• failure to recognise or list areas for improvement in the annual report of quality and safety of the service completed for 2022, and
• failure to complete actions as specified in correspondence with HIQA.
Auditing systems within this designated centre have been reviewed to ensure effective oversight by the Service Coordinator. This includes weekly and monthly checklists and the 6 monthly internal uannounced audit.
The annual report for this designated centre has been reviewed to reflect areas which require improvements.
In reviewing the governance and management for a number of Designated Centres, the Organisation has restructured the managers and their area of responsibility. The Organisation is now recruiting for another full time supernumerary Manager to add to this area. This will enable the current PIC to dedicate more time to this Designated Centre.

- The provider visit had not been completed within the required time frame, this audit failed to identify IPC issues or specify actions required, with timescales or persons responsible.
The 6 monthly auditing system has been reviewed ensuring a SMART action plan. A new time bound schedule is in place for 2023 provider visits to ensure audits are carried out within the required time frame.
- There was a reliance on the staff team to complete audits, with no evidence of oversight by the management team.
The Service Coordinator has reviewed the auditing systems within this designated centre to ensure effective oversight. The Service Coordinator is now carrying weekly audits in this designated centre.
- Risk management arrangements failed to identify whether or not areas of concern had been escalated to senior management.
A risk management system is in place to ensure areas of concern are escalated to senior management. This is outlined in the BOCSI National Risk Management Policy and Procedure.

## 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 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 | 30/09/2023 |