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:	Burren Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Announced
Date of inspection:	11 January 2022
Centre ID:	OSV-0004990
Fieldwork ID:	MON-0027184

About the designated centre

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

Burren Services provides a full-time residential service to ten adults with high support needs in the context of their disability. These needs may include medical, communication, mobility and sensory needs. The provider aims to provide residents with a home for life and the age range of the residents supported is from 18 years to end of life. The centre comprises of two adjacent houses in a pleasant, rural but populated area. Five residents live in each house. Given the range of needs that the service aims to meet, the staff skill-mix includes nursing staff, support workers, social care and, housekeeping staff. There are staff on duty at all times. At night there is one staff on waking duty in each house. Responsibility for the day-to-day management of the service is delegated to the person in charge who is currently supported by a team leader in each house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Tuesday 11 January 2022	09:15hrs to 17:45hrs	Mary Moore	Lead

What residents told us and what inspectors observed

The inspector found this was a good person-centred service where notwithstanding the requirement for high support and care from staff, residents enjoyed a good quality of life. There was evidence of management and oversight that was focused on ensuring residents received a safe quality service. Overall, a good level of compliance with the regulations was found and the standard of support and care provided to residents each day was good. However, further action was needed to better assure oversight of and the quality and safety of the service. For example, in risk management, in personal planning and in the providers fire safety arrangements. In addition, the last HIQA (Health Information and Quality Authority) inspection had reported on the matter of resident needs that were not compatible and how this impacted on the quality and safety of the service. While actively managed on a daily basis this was not resolved.

This inspection was undertaken with due regard for the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. On arrival at the centre the inspector noted that staff were vigilant in ascertaining inspector well-being. Staff were knowledgeable of the recent changes made to national infection prevention and control guidance, for example new guidance on facilitating safe visits. Given the high support needs of residents all staff supporting residents were observed to wear the required higher specification face mask. Overall, the inspector concluded the provider had adopted in this centre, procedures consistent with the standards for the prevention and control of healthcare associated infections published by HIQA.

The inspector was largely based in one of the two houses that comprise this designated centre as there was a space removed from the busy communal areas where the inspector could review records and meet with staff. The inspector did briefly visit the other house in the evening when residents had returned from their day service. The inspector did have the opportunity to meet with all 10 residents and the staff on duty, discreetly observe and discuss the care and support provided for residents.

All of the residents living in this centre have high support needs in the context of their disability and other healthcare needs. Verbal communication is not the primary means by which residents communicate and residents did not provide explicit feedback to the inspector on what life was like for them in this centre. Some residents choose not to engage, for example they did not initiate eye contact with the inspector or simply turned away from the inspector. This choice and how it was communicated was respected. Other residents clearly communicated by expression and gesture their interest and curiosity about the inspector in their home. Residents were relaxed and confident in their home and with the staff on duty. For example, as the inspection concluded and the pace of the day eased residents and staff were in the main communal room engaging in a range of individualised activities. In the other house residents were having their evening meal. This was noted by the

inspector to be a relaxed and sociable event and while residents did not engage with each other they were clearly comfortable to share a meal together and to accept any assistance provided by staff.

The inspector did not meet or speak with any resident representatives. Records seen demonstrated that staff maintained contact with families and kept them informed. Staff were very familiar with the changing circumstances of each family, the impact of age, illness and COVID-19 on the ability to visit home or visit the centre. The person in charge confirmed that visits to the centre were facilitated but visitors were required to comply with infection prevention controls as set out in national and local guidance. The provider did seek formal feedback from representatives and the feedback on file in the centre was very positive.

On the day of this inspection residents in both houses spent a large part of the day out of their home. Three residents had a structured off-site day service, the remaining residents received an integrated type service where a range of activities and programmes were delivered from their home. There was an external building that could be utilised for recreational programmes in each house. Both houses were busy and at times challenging environments. Residents were described by staff as active and sociable and enjoyed being out and about in their community supported by staff. Staff were cognisant of the ongoing risk posed by COVID-19, prioritised where possible outdoor amenities or planned trips so that chosen locations were safe and suited to resident's needs. However, staff also told the inspector that reducing the occupancy and activity levels in one house each day reduced the risk of negative peer to peer incidents. These differing needs impacted on the quality and safety of life in one house and will be discussed again in the main body of the report.

Notwithstanding the need for preventative management strategies, the support observed and described by staff was individualised to the needs and wishes of each resident. For example, the inspector saw that residents had different morning routines and a differing pace of life. Staff clearly described how residents communicated if they wanted to engage in a task or activity or not and how this was always respected. However, all staff spoken with said that life for residents individually and collectively would be much better if the providers plan for an alternative placement was progressed.

Both houses provided residents with a comfortable home. Staff described how many of the residents had lived together in other services for many years. Both houses were visibly clean, homely and comfortable and generally well maintained. Modifications were made in response to increasing and changing resident needs. Residents were seen to be provided with any equipment that they needed for their well-being and comfort such as ceiling track hoists and pressure relieving equipment. The person in charge described plans for the further development of both houses. However, there were evident maintenance issues some of which had also been identified by staff that required attention to promote accessibility and resident safety. For example, the main entrance of one house was stepped and unsuited to the needs of all residents and could be needed as an escape route in the event of an emergency. The access ramp to the activity hub did not have a

protective guard rail.

The provider ensured staffing levels and staff skill-mix were suited to the number and the assessed needs of the residents. Staff spoken with had sound knowledge of residents needs and the support and care that residents needed so they enjoyed good health. The care observed reflected what was described such as specific dietary requirements, interventions to maintain skin integrity and controls to minimise to spread of infection. Nursing assessment, advice and care was available in the centre each day but information was shared and all staff worked together as a team. For example, staff responsible for environmental hygiene were advised of any specific infection prevention and control risks.

As described above there was much evidence of good governance and evidence based person-centred practice. However, there was also some evidence of gaps and inconsistency. The findings of reviews, staff knowledge, learning from events such as incidents, complaints and simulated drills were not always reflected in the records that supported day to day practice such as risk assessments, personal plans and, residents' emergency evacuation plans. This resulted in an absence of robust assurance that systems of management facilitated robust, consistent oversight.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

As stated in the opening section of this report there was evidence of governance that was effectively focused on providing each resident with a safe, quality service suited to their needs. The centre presented as adequately resourced. For example, the provider maintained the staffing levels and staff skill-mix that were needed and good provision was made for transport for residents.

However, there were actions from the last HIQA inspection that were not satisfactorily addressed. Local management and oversight had also identified further actions needed to improve the safety of the service. For example, in the arrangements for evacuating residents. In addition, this HIQA inspection found that while there was evidence of good proactive management, there was also evidence of gaps and inconsistency in oversight.

The person in charge worked full-time and had the experience, skills and qualifications needed for the role. The person in charge was supported in the management and oversight of the service by a team leader in each house. It was evident to the inspector from speaking with them that they worked well-together and had a shared commitment to provide residents with a safe person-centred service. However, the person in charge had other areas of responsibility including

two other designated centres. The person in charge also participated on a rotational basis in the provider's on-call management system for one full week every three weeks. The team leaders had allocated administration time but their substantive roles were as members of the staff team in each house. The person in charge discussed when asked by the inspector the challenges and demands of the current management structure and the on-call duties particularly in the context of the COVID-19 pandemic. The team leader described how they were required to cover nursing staff shifts while awaiting the appointment of additional nursing staff. This was now resolved. Therefore, while there was much evidence of good governance these inspection findings and other recent HIQA inspection findings resulted in a lack of assurance as to the appropriateness and effectiveness of the management systems the provider had in place. The inspector was not assured these management systems ensured managers had the capacity to provide consistent management and oversight of the service to assure the delivery of the best possible safe, quality service.

For example, the inspector discussed and reviewed the management of a complaint that had been received. The inspector saw that the complaint was managed in line with the providers' complaint management procedures. Assurances were provided to the complainant and the complaint was deemed to be resolved. However, the inspector noted that the matters complained of and the assurances given were not overseen to the point where they were robustly addressed in the personal plan so as to support and validate the assurances given. In addition, while there were systems for managing risk and evidence of the review of accidents and incidents, the review of associated risks and existing controls was inconsistent. These examples will be discussed further in the next section of this report.

The provider was undertaking the annual review and the six-monthly reviews of the quality and safety of the service as required by the regulations. The annual review provided for consultation with residents' representatives. There was a 50% response rate to the most recent request for feedback and respondents rated the service as excellent. Feedback from residents and their representatives was included in the quality improvement plan. However, as stated earlier there were actions from internal reviews and HIQA inspections that were not satisfactorily resolved or did not have a specified time frame within which they were to be addressed. For example, the person in charge confirmed that the planned transition of a resident to an alternative more suited placement would not be achieved by the time frame provided to HIQA and no alternative time frame had been identified.

The person in charge and the team leader described the work that had been undertaken with staff to facilitate staff rota changes in one house. Benefits of the new rota described to the inspector included better consistency of staff skill-mix and experience. It was planned to extend this initiative to the other house. The inspector reviewed the staff rota and saw that consistency of staffing was provided for and the daily staff to resident ratio was monitored each day. The staff skill-mix for each house included nursing staff; this reflected the assessed medical and healthcare needs of the residents. The staffing levels in each house differed based on the routines and needs of the residents. For example, three residents in one house attended off-site day services Monday to Friday. The five residents in the other

house received an integrated type service from their home. There were three staff on duty each day in this house until 21:00. Staffing levels in this house were augmented by the allocation of an activities co-ordinator four days each week. A dedicated cleaning staff was employed Monday to Friday and worked in both houses. There was one staff member on waking duty at night in each house.

The person in charge and the team leader were assured as to safety and adequacy of these staffing levels including the need to provide consistent supervision of residents in response to identified risks. For example, the person in charge described how monitoring of behaviour related incidents had not indicated a need for additional staff at the weekends or in the evenings. Night time staffing levels will be discussed again in the next section of this report in the context of risk management and the providers' evacuation procedures.

Staff had access to a broad range of mandatory, required and desired training. The training programme included a suite of infection prevention and control training that was now mandatory for all staff to complete. Individual staff training records confirmed for the inspector that training gaps indicated on the training matrix were incorrect and all staff had completed any training required of them; this training was in date. For example, training in safeguarding, fire safety and infection prevention and control. Additional training reflected residents' assessed needs and included the administration of emergency medicines, training in diabetes care, first aid and basic life support. Staff spoken with confirmed their attendance at training and were knowledge on any matters discussed.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full-time and had the skills, experience and qualifications needed for the role. The person in charge was aware of and committed to their regulatory responsibilities. The person in charge was receptive to the process of inspection and the findings of the inspection.

Judgment: Compliant

Regulation 15: Staffing

The provider monitored and took action as needed to ensure staffing levels and skill-mix were suited to the number and needs of the residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to and had completed a range of training that reflected their role and the assessed needs of the residents that they supported.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained and it contained all of the required information such as each residents date of birth and the date they were admitted to the centre.

Judgment: Compliant

Regulation 21: Records

Any of the records requested by the inspector were in place and available for inspection. For example, the staff duty roster, the maintenance of fire equipment and referrals and follow-up appointments in respect of each resident.

Judgment: Compliant

Regulation 22: Insurance

With its application seeking renewal of registration the provider submitted evidence of having appropriate insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

While there was evidence of good proactive management, there was also evidence of gaps and inconsistency in oversight. The inspector was not assured the management systems the provider had in place ensured managers had the capacity to provide consistent management and oversight of the service to assure the delivery of the best possible safe, quality service.

There were actions from internal reviews and HIQA inspections that were not satisfactorily resolved or did not have a definitive time frame by which they were to be addressed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the required information and was an accurate description of the service provided. For example, the range of needs that could be met and details of the staff-skill mix.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records seen in the centre there were arrangements in place for ensuring HIQA was notified of certain events such as the use of any restrictive practice and, any injury sustained by a resident.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had policy and procedures for the management of complaints that were in date, reflected regulatory requirements and, were implemented as needed.

Judgment: Compliant

Quality and safety

Overall, while improvement was needed, on a day-to day basis residents' well-being, welfare and quality of life was maintained by a good standard of evidence-based care and support.

For example, residents had medical and physical health needs. The inspector saw that residents looked well including a resident who had recently experienced ill-health. While not a nurse led service the staff skill-mix included nursing staff and nursing assessment, advice and care was generally available each day. Staff spoken with had sound knowledge of residents' healthcare needs and the care to be provided. For example, in relation to resident's prescribed medicines, the impact and effectiveness of these. The care observed by the inspector reflected what was discussed with staff. Records confirmed that staff monitored resident well-being and sought advice and care for residents when concerns arose or needs changed. There was evidence of input from general medical practice, psychology, psychiatry, behaviour support, speech and language therapy, physiotherapy and, occupational therapy. The staff teams in each house and the multi-disciplinary team (MDT) regularly met and discussed each resident and the effectiveness of their care and support plans.

The inspector reviewed two personal plans and they were of a good standard. However, the inspector found they did not always fully reflect the knowledge that staff had, the findings of reviews, the care that was actually needed and provided or, the link between different needs. For example, as discussed in the previous section of this report one plan did not adequately address all care needs and assurances provided when concerns were raised. In general, there was evidence of regular and timely MDT review but where a concern had been raised, MDT review had not taken place to review and provide assurance on the care needed and provided. While there were evident nutritional needs and supports were in place these were not set out in a specific nutritional care plan. Some plans were a little generic in nature and again did not reflect the individuality of the care provided by staff. These improvements were needed to better reflect and assure the good care that was provided.

The primary matter arising in relation to residents' needs and the provision of appropriate support was the issue of resident needs that were not compatible; this resulted in negative peer to peer incidents. This was addressed in the last HIQA inspection of this centre and the provider had a plan to provide an alternative placement for one resident. There was MDT consensus that the arrangements in this centre were not suited to the resident's needs. The person in charge confirmed this consensus had not changed and staff spoken with described the need for and the benefits to all residents of a quieter, less busy environment. However, the person in charge confirmed that the timescale provided for the transition (February 2022)

would not now be met due to other service demands that had arisen. The person in charge confirmed that this had been escalated to the senior management team and a further MDT was planned.

There was an active positive behaviour support plan and an active safeguarding plan designed to support the resident and protect peers from harm. The staff team had access to the designated safeguarding officer for advice and support as needed. Staff responsibility for supervision was allocated each day but all staff were responsible for the implementation of preventative strategies. There was an open high risk for the possibility of peer to peer incidents. Staff confirmed that vigilance and preventative strategies were needed every day and reported these were successful in preventing peer to peer incidents but did not address the triggers for the behaviour. For example, certain peers, certain routines and the general activity and busy nature of the house. Staff deployed strategies such as going for walks, accessing the community and accessing programmes in an off-site day service to reduce the numbers of staff and residents in the house. While these arrangements were designed to prevent incidents they did appear to suit the resident who was well and active and reported by staff to enjoy being out and about with staff.

Based on the practice observed and discussions with staff the inspector was satisfied the provider had adopted and implemented procedures consistent with the National Standards for infection prevention and control in community services (2018). These procedures were part of the daily management and routines of this centre. The inspector saw that residents were limited in their understanding of the risk of infection and how to protect themselves. It was evident that management and staff had a shared commitment to safeguard residents from the risk of preventable infection. For example, all staff working in the centre had completed training and were aware of any specific risks and controls in place. Practice was noted to be in line with current national and local guidance. For example, access to and the use of higher specification face masks and revised controls to ensure visits to the centre were safe. Staff confirmed that they monitored their own and resident well-being twice each day. There were ready opportunities in each house for staff to undertake hand hygiene and staff were seen to frequently use these. There were evidence based plans, facilities, equipment and practice in response to specific resident needs. Advice was sought and provided by public health as needed. All staff and residents were reported to be fully vaccinated against the risk of COVID-19.

The premises was visibly clean, there were cleaning schedules to guide staff on what was to be cleaned and how often items were to be cleaned. Staff had a range of domestic type cleaning products available to them and used a colour coded system of cleaning. Staff described how they completed cleaning and disinfecting. Staff described how they managed resident's personal laundry on an individualised basis, segregated linen and used water soluble bags if needed. For example, if linen was considered soiled or possibly infected. The person in charge told the inspector that the provider had up-skilled a core group of staff and planned to commence internal reviews of infection prevention and control arrangements in its' centres. Some very minor issues such as some mould on one shower tray were highlighted to the person in charge at verbal feedback of the inspection findings

It was evident from the practice observed, staff spoken with and records seen that there was a strong awareness of and systems for the identification and management of risk so as to keep residents and staff safe. For example, the controls in place to prevent negative peer to peer incidents, the spread of infection and staff awareness of the evacuation procedure. Tools such as an evidence based assessment informed the need for and the use of equipment such as bedrails. However, there was some inconsistency and gaps in identifying and reviewing risk and its control. This created some absence of assurance that all risks were adequately managed. For example, while there was a risk assessment and a plan for manual handling neither addressed the possibility that one staff may have to undertake this task in the event of an emergency.

There were systems for reviewing accidents and incidents and evidence of action taken in response such as further referral to the MDT. However, this process was inconsistent and did not always lead to a review of the associated risk assessment and the existing controls. For example, the possible risk of ingestion of latex products or the risk posed by bedroom windows that were unrestricted for residents with a risk for choking and a risk and history of leaving the centre without staff.

Additional controls needed to reduce risk to resident safety were outstanding. For example, the alternative placement, the widening of a door to facilitate bed evacuation and uneven external surfaces and steps. Staff confirmed that some but not all floor surfaces that had been identified as a slip, trip and fall hazard had been rectified.

There was evidence of good fire safety management systems. For example, equipment such as the fire detection and alarm system, the emergency lighting and fire-fighting equipment were all inspected and tested at the required intervals. Staff attendance in simulated drills was monitored and residents actively participated in these drills. The drills were scheduled to reflect different times and scenarios. Generally good evacuation times were achieved but resident needs had recently changed and increased in one house. There was evidence of proactive management and a recent external review of the evacuation procedures had been sought and completed. This review had established that one staff on their own could evacuate each house at full occupancy. However, the review in one house had also concluded that the time taken to evacuate all residents could be reduced. The inspector noted that the recorded time should be improved on. The additional time taken was due to the requirement of staff to use a hoist to evacuate a dependent resident from bed. The bedroom had an external door but the door and the external ramp did not facilitate evacuation of the bed. The person in charge and the team leader spoke of plans to source a specific evacuation device and to complete the works needed to the door and the ramp. These works had been requested but there was no agreed timescale for their completion. Evacuation procedure recommendations had also been made in the other house. However, the inspector saw that these recommended changes to the evacuation procedure were not included in the residents' evacuation plans.

Regulation 10: Communication

The personal plan included information of how residents communicated their wishes, choices and needs. The inspector saw that residents used a range of purposeful strategies including words, gestures and facial expressions in their interactions with staff and these were understood and respected by staff. Residents had access to the Internet and were supported by staff to access and use a range of media.

Judgment: Compliant

Regulation 11: Visits

Staff followed national guidance and implemented a range of controls so that visits to the centre could be safely facilitated.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had daily opportunities to participate in activities at home, in the community and in off-site day services in accordance with their wishes, interests and abilities.

Judgment: Compliant

Regulation 17: Premises

There were a number of maintenance issues that required attention to improve accessibility and reduce the potential for risk that presented to resident safety. These included;

- repair of the boundary fence that had collapsed
- repair of the driveway and surrounding uneven external surfaces of one house
- review of the stepped main entrance of one house
- the provision of a protective rail to an unguarded ramp used by staff and residents
- completion of work to floor surfaces deemed to be a risk for slips and falls
- review of wooden floor surfaces that needed to be resealed and tiles that

were cracked in the utility area.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Staff were aware of the importance of good nutrition to resident health and well-being. Care was informed by resident choices and recommendations made by services such as speech and language therapy and dietetics. The inspector saw that meals were a sociable event and residents enjoyed the appealing main meal provided on the day of inspection. Staff discreetly provided any assistance needed and the provision of adapted utensils supported other residents to be independent at mealtimes.

Judgment: Compliant

Regulation 20: Information for residents

The residents guide contained all of the required information and presented that information in a way that promoted access and resident understanding. For example, how a resident could access any inspection reports and how to make a complaint.

Judgment: Compliant

Regulation 26: Risk management procedures

There was an evident culture of risk management. However, there was also some inconsistency and gaps in identifying and reviewing risk and its control. This created some absence of assurance that all risks were adequately managed. For example, in relation to manual handling, the ingestion of inedible and unsafe items and the risk of a resident leaving the centre without staff when it was unsafe for them to do so.

Additional controls needed to reduce risk to resident safety were outstanding.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Based on the practice observed and discussions with staff the inspector was satisfied the provider had adopted and implemented procedures consistent with the National Standards for infection prevention and control in community services (2018).

Judgment: Compliant

Regulation 28: Fire precautions

A recent external review of the evacuation procedures had been sought and completed. This review had established that one staff on their own could evacuate each house at full occupancy. However, the review had also concluded that the time taken to evacuate all residents could be reduced. The additional time taken was due to the requirement of staff to use a hoist to evacuate a dependent resident from bed. The person in charge and the team leader spoke of plans to source a specific evacuation device and to complete the works needed to the door and the ramp. These works had been requested but there was no agreed timescale for their completion.

Recommendations had also been made in the other house. However, the inspector saw that these recommended changes to the evacuation procedure were not included in the residents' evacuation plans

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plans were of a good standard but there was scope for improvement. The plans did not always fully reflect the knowledge that staff had, the findings of reviews, the care that was provided or the link between different needs.

The primary matter arising in relation to residents' needs and the provision of the appropriate support was the issue of resident needs that were not compatible; this resulted in negative peer to peer incidents. This was addressed in the last HIQA inspection of this centre and the provider had submitted a plan to provide an alternative placement for one resident. However, the person in charge confirmed that while the plan to source an alternative and more suited placement had not changed , the timescale provided for the transition (February 2022) would not now be met. The person in charge confirmed that this had been escalated to the senior management team.

Judgment: Not compliant

Regulation 6: Health care

Staff spoken with had sound knowledge of residents' healthcare needs and the care to be provided. The care observed by the inspector reflected what was discussed with staff. Records confirmed that staff monitored resident well-being and sought advice and care for residents when concerns arose or needs changed. Residents had access to the clinicians and services they needed.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents required support to manage behaviour of concern and risk to themselves and others including staff and peers. In the context of needs that were not compatible staff described how they implemented preventative strategies on a daily basis to reduce the risk of behaviour related incidents occurring. Staff had completed training in responding to and preventing the escalation of behaviours. There was access as needed to psychiatry, psychology and behaviour support. There were systems for monitoring the use of any restrictive practice but the approach to support was therapeutic. However, triggers for behaviour were actively managed on a daily basis until a placement better suited to resident needs was provided. This is addressed in Regulation 5.

Judgment: Compliant

Regulation 8: Protection

The provider recognised safeguarding risks and had strategies in place to protect residents such as when needs were not compatible in this shared living arrangement. The person in charge was vigilant in ensuring that all staff completed up-to-date safeguarding training. Staff had access to the designated safeguarding officer for advice and support such as when deciding if an incident required screening and notification to HIQA.

Judgment: Compliant

Regulation 9: Residents' rights

The support observed were respectful of the individuality, privacy and choices of residents. Staff at all times spoke respectfully of residents and confirmed that if a resident did not wish to comply with a particular request or routine this was respected.
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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Burren Services OSV-0004990

Inspection ID: MON-0027184

Date of inspection: 11/01/2022

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to come into compliance with Regulation 23: Governance and management the PIC and PPIM are currently undertaking a strategic review of the services under their remit and are going to restructure and strengthen the governance structures by realigning some current management posts. Once complete this will ensure more time is available to the Person in Charge to oversee the smooth running of the Designated Centre and support the role of the team leaders to assure the delivery of a safe quality service. In addition to strengthen the governance and oversight arrangement the team leader is going to do a trial of working a different roster where she will work less hours per day and less weekends but will work more days during the week. Therefore this will increase supervision and support in the Designated Centre and increase availability to the Multi D Team. At the present time the provider is carrying out a review of the On-Call system which when completed should lead to a reduction in the amount of time that the Person in Charge shall be on call.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: In order to come into compliance with Regulation 17: Premises: the PIC is in the process	

of following up on a number of maintenance issues and has put the following actions into place:
• The social housing body which owns the premises has agreed to repair the boundary fence once works on the septic tank system have taken place .We are awaiting planning permission before progress this project.
• The driveway and surrounding external surfaces will be repaired by the social housing body also. Once the septic tank at the back of the property has been repaired. It is not feasible to repair the driveway or fence until these work are complete as there will be heavy vehicles needing access to the site.
• In view of the recent changing needs of the Residents the PIC will seek to secure funds from the provider to change the steps at the main entrance to a ramp in one house.
• A protective rail has been organised by the PIC for the ramp to the Hub which is used by staff and residents.
• The floors which were identified as being a risk for slips and falls have all been repaired and repairs to the other identified wooden floor and the cracked tiles are in the process of been repaired.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to come into compliance with Regulation 26: Risk Management Procedures: the PIC has put the following actions into place:
• A manual handling assessment for one person supported has been updated.
• All other relevant risk assessments identified as requiring review have now been reviewed and updated with some additional controls being identified and put into place.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In order to come into compliance with Regulation 28: Fire precautions the PIC has put the following actions into place:
• A funding request and work order for double external exit doors have been made to adapt one resident bedroom to include the installation of a ramp.
• The team leader is trialing an evacuation sheet to see if this is suitable
• A manual handling assessment will be carried out for the resident
• All PEEPS in another house have been updated

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

In order to come into compliance with Regulation 5 the PIC has put the following actions into place:

• All personal plans and care plans have been updated and all will be subject to ongoing review and evaluation.

• An MDT meeting was held on 03/02/2022 to review discuss and future plan in an effort to address the ongoing incompatibility issues in one house that is resulting in negative peer to peer incidents. At this meeting it was agreed that an assessments of needs would be carried out for two residents to establish what are the most appropriate supports required for each Resident going forward to address incompatibility. This assessment of need will involve carrying out a thorough Personal Outcomes Interview with all key personal supporting the residents by a trained interviewer from the Quality and Training Department in conjunction with the Psychology Team. These assessments will then provide the reliable knowledge for what is the ideal living situation and personal goals required for two of the residents, which shall form the personal plan for both residents also for 2022.

• Once a clear plan of future needs is developed a business plan will be developed on the basis of these recommendations in order to secure funding to base the service on the Individualized assessed needs of both residents.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	01/11/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Substantially Compliant	Yellow	01/06/2022

	to residents' needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	04/02/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	01/07/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	01/10/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there	Substantially Compliant	Yellow	01/05/2022

	is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.			