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:	Cairdeas Services Belmont
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Waterford
Type of inspection:	Unannounced
Date of inspection:	02 November 2022
Centre ID:	OSV-0005077
Fieldwork ID:	MON-0034523

About the designated centre

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

The statement of purpose outlines that the centre provides full-time care, to 11 adult residents, both male and female, with severe intellectual disability and have additional care needs including support with behaviours that challenge, and age related healthcare needs. The residents require full-time nursing care and this is provided with the nursing staff supported by care assistants. The centre comprises two bungalows in close proximity to each other. The premises are suitable for purpose and the residents all have their own bedrooms, with suitably adapted bathroom facilities. There were suitable and homely communal areas to meet the residents' needs. Both have small gardens attached. The centre is located in a large town with easy access to local services and amenities.

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
Wednesday 2 November 2022	10:00hrs to 18:00hrs	Lisa Redmond	Lead
Wednesday 2 November 2022	10:00hrs to 18:00hrs	Miranda Tully	Support

What residents told us and what inspectors observed

On the day of this unannounced inspection, the inspectors met with six of the ten residents that lived in the designated centre. The designated centre comprised of two houses, located in a congregated setting. Both houses had been decorated to reflect residents' unique personalities, likes and preferences.

Overall, the inspectors found that improvements were required to ensure the designated centre increased the levels of regulatory compliance. There was a poor level of oversight and monitoring in the centre, which resulted in areas for improvement not being identified through provider auditing and review systems. However, inspectors were assured that residents were safe in their home, and that staff members were focused on providing support to residents in a caring and professional manner.

The first house visited by inspectors provided supports to residents who required a high level of staff support, including nursing care. The inspectors met with one resident briefly, as they were on their way to their day service. Staff spoken with advised the inspectors that this resident required a structured and strict routine, therefore the inspectors supported them to continue to carry out their daily routine with minimal disruption.

One resident living in this house was supported in their home each day by staff members. This resident was having a lie-in on the morning of the inspection. Staff members advised inspectors that the resident required supports to manage behaviour that is challenging. Staff members communicated potential triggers to the inspectors, to ensure the inspectors' presence had a minimal impact on the resident. Inspectors were supported to review the resident's behaviour support plan before they met with them. It was evident that staff members were aware of the contents of this plan, evidencing that they knew the resident well, and advocated their individual needs.

In the second house, staff members provided supports to residents who had a high level of medical support needs, including end-of-life care. Staff told the inspectors that residents were provided with reflexology, massage and music therapy in their home. During the inspection, a number of residents were receiving reflexology. Staff members advised that residents enjoyed these therapies. One resident had drifted off to sleep due to the relaxed state they were in following reflexology. These supports evidenced that residents were supported to receive therapies to meet their emotional and spiritual needs, particularly towards the end of their life. However, improvements were required in relation to the documentation relating to end-of-life supports for residents, to ensure that their wishes and preferences at end of life were clearly outlined, and that all staff were aware of this. This was of particular importance as relief and agency staff were working with residents on a regular basis, including on the day of this inspection.

The inspectors met with a resident who had recently moved to this designated centre from one of the organisation's community houses. The reason for the resident's transition was that they now required nursing care, due to increased medical needs. The resident told the inspectors that the house was 'good'. The resident appeared content and relaxed as they sat with other residents that they now lived with. A number of residents could not express their views about living in their home to the inspectors. Residents were observed interacting with their environment and staff members. When one resident communicated by their behaviour that they may be experiencing anxiety, inspectors left their home to reduce footfall. When inspectors met with the resident later that day, they appeared to be relaxed and content. The resident was planning to go for a drive with a staff member.

At the time of the inspection, there was a noted incompatibility issue with the resident group in one of the two houses. It was documented that this negatively impacted residents' lived experience in the centre. While the inspectors acknowledge the arrangements in place to safeguard residents, this issue remained ongoing on the day of inspection. In order to manage compatibility issues, staff were directed to the behaviour support plan for each resident, however inspectors found behaviour support plans did not adequately guide staff in such instances.

At all times, the inspectors observed kind and caring supports being provided to residents. Where residents were receiving end-of-life care, the atmosphere in the residents' home was calm and relaxed. Residents were supported to rest in bed, watch television and have a cup tea as inspectors visited their home.

However, inspectors did observe poor practices in relation to governance and management, fire safety, and infection prevention and control. 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 provided.

Capacity and capability

Managerial oversight in the designated centre required significant improvement. It was identified that provider auditing was not comprehensively identifying and/or addressing issues and areas for improvement in the designated centre.

There was evidence however that staff members were supported to engage in supervision and probationary meetings with the person in charge. Staff members stated that they felt supported by the person in charge, and communicated to inspectors that they could raise issues/concerns if required.

Overall, the findings of this inspection would evidence that there was a lack of proactive management, and identification of areas for quality improvement in a number of areas. Inspectors also observed practices that demonstrated a lack of

awareness of best practice guidance, particularly with respect to infection prevention and control, fire safety and risk management. This included the wedging of fire resistant-doors and the inappropriate storage of personal protective equipment (PPE) beside a sluice. These will be further discussed in this report under each specific regulation.

Regulation 23: Governance and management

Inspectors reviewed provider auditing reports completed in the designated centre. This included six monthly unannounced visit reports and annual reviews which are required in line with regulatory requirements. Inspectors found that they provided little documentary evidence of the areas of care and support reviewed, to provide assurances that a comprehensive review of service provision had been completed. It was evident that these systems failed to identify and address areas to ensure compliance with the regulations, and quality improvement in the centre.

A report which identified a compatibility issue in one of the centre's houses had been completed in July 2020. One action identified that one resident should live in a separate apartment area. Inspectors advised that there had been no progress on this action since the compatibility issue was identified. The compatibility issue was referenced in the most recent six monthly visit report. However, the action plan did not identify any action to be taken, or areas for improvement in relation to this issue. From discussions with staff members, it was noted that compatibility issues had improved, but that this was due to the natural changing profile of residents in the centre rather than actions taken by the registered provider.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors reviewed incident and accident reports on the organisation's online incident management system. It was evident that incidents including allegations of suspected abuse and the use of restrictive practices were notified to the chief inspector in line with regulatory requirements.

Notifications of the expected and unexpected deaths of residents had been notified to the chief inspector. These notifications provided detailed information regarding the care and support provided to residents at the end of their life.

Judgment: Compliant

Quality and safety

Inspectors were assured that residents were safe in their home. However, significant improvements were required to ensure best practice in relation to fire safety and infection prevention and control. Although clearer guidance for staff was required in aspects of residents' health care and positive behaviour support, it was evident that residents were generally well supported in these areas.

It was noted that there was a low level of safeguarding incidents occurring in the centre. Where there was a compatibility issue in the centre, residents were supported with a safeguarding plan and a positive behaviour support plan. The compatibility issue related to one resident entering the personal space of another resident, which may cause the other resident anxiety, leading to the risk of a physical incident. This was not clearly documented. It was also not evident what response staff members should use to redirect residents. This meant that guidance for staff members was unclear. This was important as agency and relief staff were providing to supports to residents on the day of the inspection.

Emergency lighting, fire alarm systems and fire-resistant door sets were provided. However, improvements were required to ensure that fire safety practices promoted effective containment, in the event of an emergency. In one of the designated centre's houses, inspectors observed a fire-resistant door that had been wedged with a chair. A second fire-resistant door was wedged open at one side. This would impact the containment of fire and/or smoke, in the protected corridors. These wedges were removed immediately once they were identified.

Regulation 17: Premises

One of the designated centre's houses was noted to be in a good state of repair. This house was large and spacious, and provided a calm and relaxed atmosphere to residents with high medical needs, and those entering the end stages of life.

The other house required some premises works due to general wear and tear. This included the replacement of flooring, which staff members were seeking quotes for. Two rooms in this house were used for storage. One room in particular was particularly cluttered with items such as radiators, bed bumpers, wheelchairs and shower chairs. One door in this room was blocked due to the volume of items stored there. It was also noted that it would be very difficult to ensure this area was kept clean due to the volume of clutter. A review of storage arrangements was required.

Residents' homes were decorated to make them homely with residents' personal items and photographs on display. Each of the designated centre's houses had a back garden. Plans were in place to provide residents in one house with a sensory

garden, with these works ongoing at the time of the inspection.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk register was provided to the inspectors for review. A risk assessment had been developed for the previously mentioned compatibility issue in one of the designated centre's houses. It noted interim control measures such as the provision of behaviour support plans, however there were no long term control measures documented. It was also noted that these plans did not contain clear guidance for staff members on the management of the compatibility issue. This is actioned under regulation 7, positive behavioural support.

Inspectors reviewed the provider's response to an incident whereby a resident left the centre unsupervised and unobserved by staff members. There was evidence of actions taken to ensure a similar incident did not reoccur, and the resident was found unharmed a number of minutes later. However, given that this resident did not have any safety awareness, this was noted to be a significant event.

There were inherent risks associated with a number of practices observed by inspectors. This included the poor storage of PPE beside a sluice and issues with effective fire containment. The lack of awareness regarding this, in conjunction with the poor standard of providing auditing posed a risk. Although inspectors were assured of residents' safety, this demonstrated poor assessment and management of risk in the designated centre.

Judgment: Not compliant

Regulation 27: Protection against infection

Significant improvements were required to ensure the designated centre demonstrated best practice with regards to infection prevention and control practices. This included waste management, and the storage PPE and cleaning products.

Inspectors observed a clinical waste bin outside of the centre, which was filled with PPE that was consistent with the level of PPE worn when there was suspected/confirmed COVID-19 in the centre. Staff members spoken with told inspectors that this waste had been outside for a considerable amount of time. This was evidenced by the volume of cobwebs present, and that it had been a matter of months since there had been suspected/confirmed COVID-19 in the centre.

Sluicing was carried out in both of the designated centre's houses. In one of the

houses, PPE including face masks and gloves were stored beside the sluicing area. In the other house, mops and buckets were stored beside the sluicing area. This posed a risk of transmission of infection.

Inspectors observed mops and buckets stored outside in the rain. Mop buckets were observed to be filled with rainwater and debris.

Soft furnishings were observed stored on top of a sink. Therefore, access to the tap was blocked, preventing staff members from completing running water checks as a preventative measure for legionella.

Judgment: Not compliant

Regulation 28: Fire precautions

In one of the designated centre's houses, inspectors observed a fire-resistant door that had been wedged with a chair, and a second fire-resistant door was wedged open at one side. In the other house, inspectors noted a wooden panel between the kitchen and the protective corridor. A fire competent person attended the centre and verified that this panel was not fire-resistant. Assurances were provided to inspectors that this would be addressed as a matter of priority.

Inspectors reviewed evacuation records, and noted a recent evacuation drill that was carried out with minimal staffing. It was noted that this drill had occurred only days before the inspection. The evacuation time did not provide assurances that all residents could be safely evacuated in the event of a fire. On discussions with the person in charge, it was noted that staff members had not adhered to the fire evacuation protocol during this drill, which included using the alarm system to seek assistance from staff in neighbouring designated centres. The person in charge advised that this drill would be repeated, and learning communicated to staff members.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to healthcare services, including multidisciplinary services such as psychiatry, psychology and speech and language therapy. Residents were seen by general practitioners (G.P), and nursing input was provided in the centre. The person in charge had ensured that residents' healthcare needs were assessed.

Residents were supported to receive support at times of illness, including at the end of their lives. Supports were provided to meet their spiritual and emotional needs.

This included the provision of alternative therapies which had a positive benefit for these residents. However, residents' wishes in terms of end of life care were not clearly documented, to ensure their rights and choice at end of life were respected.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

In line with the assessed needs of residents, behaviour support plans had been developed for residents. For the most part these plans were comprehensive and detailed proactive and reactive strategies to support residents to manage behaviour that is challenging. Staff members were comfortable in communicating residents' behaviour support needs to inspectors, to ensure their presence did not cause any unintentional anxiety to residents. Inspectors observed residents engage in proactive strategies outlined in one resident's behaviour support plan, including using manual signing methods to communicate with them. However, some aspects were not in implementation for example a resident's visual schedule. Staff members spoke about the behavioural triggers for one resident. Upon review, this was not noted in their behaviour support plan.

As previously noted, clearer guidance was required to support staff members with the day-to-day management of resident compatibility issues in the designated centre.

Judgment: Substantially compliant

Regulation 8: Protection

Residents had intimate care plans in place which detailed the level of support they required to meet their hygiene needs. Staff spoken with, were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse.

Notwithstanding, the identified ongoing compatibility issue, there were systems in place to ensure that residents were safeguarded from abuse in the centre. Where there were safeguarding concerns, there was evidence that appropriate safeguarding plans were in place which were monitored, reviewed and dealt with appropriately.

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	
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cairdeas Services Belmont OSV-0005077

Inspection ID: MON-0034523

Date of inspection: 02/11/2022

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	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Provider level and local auditing will be carried out with more attention to detail and incorporate a clear action plan to address any areas for improvement • The annual review for 2022 will be carried out by the PIC and Service Manager as part of an overall review of the service provision for the year. Required actions arising from the annual review will be detailed and tracked in the form of a SMART action plan. • The compatibility issue which relates to two residents has been reviewed; strategies are in place to reduce the likelihood and impact of any negative interactions between both residents. Strategies that are in place which have been successful in reducing incidents between the two residents continue and are subject to regular review by the MDT	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • New flooring has been ordered and will be fitted in early January 2023 • A review of the storage within the house has occurred and identified areas de-cluttered, ensuring that no doors are blocked. • All unused equipment has been removed from the house and returned to the HSE.	

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• A full review of the centres risk assessments and management plans will be carried out taking into account the findings of this inspection

• Provider auditing in this centre will be more robust and incorporate the review of the risk identification and management systems in place within the Designated Centre.

• A Health, Safety and Risk Officer post is currently being recruited for the South East Region. Once appointed this position will play an integral role in supporting and strengthening the risk management systems in place across the organisation.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• PPE has been removed from the clinical waste bin. The clinical waste bin was placed in safe storage on the 02/11/2022.

• All PPE is stored in correct areas within the residence and removed from the sluice area. The appropriate storage of PPE has been discussed at staff team meetings. The storage of PPE be subject to regular checks by the PIC and as part of local auditing, that occurs in the centre.

• The sluices have been removed from the utilities in both residents.

• The storage of mops will be reviewed and alternative arrangements will be made to ensure that mops are stored appropriately.

• Soft furnishings were removed from on top of the sink and stored appropriately on the 02/11/2022.

• Local IPC audits will be carried out with greater attention to detail and where relevant include quality improvement planning to ensure areas that require improvement are addressed appropriately.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Following the inspection, maintenance of the door holders was carried out and all are working effectively within the centre.
• Staff have been reminded of the need to use appropriate door holders and not to wedge any doors with chairs or other inappropriate means.
• Since the time of the inspection, a repeat fire drill has been carried out with a reduced evacuation time recorded. Learning from drills will be shared with the staff team.
Wooden panel between the kitchen and the protective corridor has been made fireproof.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A meeting was held with the PIC, Social Worker and the individual supported to discuss their End of Life Choices on the 09/11/2022. This is an ongoing live document as a lot of time, discussions, thought, care, consideration and support is required while discussing End of Life with individuals supported.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The strategies in place to address the compatibility issue between two residents will be reviewed and expanded on in residents support plans to ensure that guidance for staff is clear.
One residents behavior support plan will be reviewed and updated to include all behavioural triggers

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	31/01/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	02/12/2022
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 to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	28/02/2023
Regulation 26(2)	The registered provider shall	Not Compliant	Orange	28/02/2023

	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.			
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	31/01/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	21/11/2022
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	Not Compliant	Orange	16/12/2022

	to safe locations.			
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.	Substantially Compliant	Yellow	09/11/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Yellow	31/01/2023