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:	Coastguards
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	14 July 2021
Centre ID:	OSV-0002567
Fieldwork ID:	MON-0033434

About the designated centre

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

This designated centre provides residential care and support for up to seven residents (both male and female) with disabilities. The centre is a large two-story house comprising a well-equipped kitchen, a dining room, a utility room, a sunroom, five bedrooms (one en-suite), and three communal bathrooms. Upstairs comprises a kitchen and sitting room, a bedroom, a bathroom, a storeroom, and an office. There is a garden to the front of the house with a private parking space. To the back of the house, there is a large garden with a patio area and polytunnel. Transport is available to residents so as they can access community-based facilities and trips further. There is a full-time person in charge working in the centre who is supported by a team of nursing staff and health care assistants.

The following information outlines some additional data on this centre.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 July 2021	09:45hrs to 17:15hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspection was undertaken in a manner so as to comply with public health guidelines and reduce the risk of infection to the residents and staff in the centre.

The inspector observed warm and friendly interactions between residents and the staff team supporting them during the inspection. Residents also appeared comfortable in their environment. The inspector had the opportunity to meet with two of the residents that were sitting together. One of the residents was engaging in artwork where the other was relaxing after attending their day service programme. One of the residents showed the inspector some of their plants and flowers in the garden with the support of a staff member. The other resident briefly spoke about their family but chose to have limited interaction with the inspector. The inspector was introduced to a third resident; the resident said hello to the inspector but chose to engage in their preferred activities with the support of staff. The inspector also notes that there was a large staff presence to support residents and promote positive outcomes for them.

A review of a sample of residents' information demonstrated that there were systems in place to address the needs of the residents. Comprehensive assessments of residents' health and social care needs had been completed. The sample of information reviewed established that person-centered plans had been developed for the residents along with individual goals. The achievement of a number of these goals had however, been impacted by the COVID-19 pandemic. Before COVID-19, the group of residents were active members of their community. Residents following receipt of their second vaccination were now beginning to re-engage in community activities, with some residents returning to their day service programmes and other preferred activities such as going out for a coffee.

The inspector found that the provider and staff team supported residents to maintain their relationships with their family members through assistive technology and physical visits when possible. The inspector spoke with three sets of residents' representatives. The inspector received conflicting information regarding aspects of the service being provided to residents. Some family members spoke positively regarding the service being provided, whereas others felt that there were improvements required in a number of areas. The inspector reviewed these concerns as part of the inspection process, and these will be addressed in the Capacity and Capability and Quality and Safety sections of the report.

The inspector observed that there were a number of areas in the house that required repair and decoration. These areas detracted from the centre's appearance and homely environment that other parts of the house had. The inspector was, however, assured that the provider had plans to address these areas in the coming weeks.

In general, there were appropriate auditing practices regarding residents'

information that led to the needs of residents being addressed. The inspector did, however, find that there were improvements required regarding other monitoring practices. The impact of this will be discussed in more detail in the following sections of this report.

Capacity and capability

The inspector was not assured that the provider's existing management arrangements were suitable to ensure that all aspects of the service being provided was appropriate to residents' needs and effectively monitored. There were improvements required to existing management practices, the monitoring of training and staff development records, and the arrangements for managing complaints or concerns.

There was a management structure in place that was led by the person in charge. The centre's person in charge was not present on the inspection day, but the provider had systems in place that ensured that a Clinical Nurse Manager from another centre provided support to the staff team. The Clinical Nurse Manager also facilitated the inspection process.

During the inspection, it was noted that some records and reports were not easily accessible or available for review. This impacted the inspector’s ability to verify if the service being provided was effectively monitored and demonstrated that existing record-keeping practices were not appropriate. There were, as a result, improvements required to the oversight and auditing of information by the provider and person in charge.

The provider had carried out visits to the centre in 2020 and prepared two written reports on the safety and quality of care and support provided in the centre as per the regulations. The information for the first report of 2021 was being collated at the time of inspection.

While the provider had ensured that the 2020 annual review of the quality and safety of care and support had been carried out as per the regulations, the review had failed to identify all areas that required improvement and, as a result, had not ensured that the service being provided was effectively monitored. The inspector does note that the actions that were identified in the report were addressed appropriately by the person in charge.

A review of the staff team's training needs analysis records identified gaps in staff members' required training. The provider had identified that a large cohort of the staff team required basic life support training. Training had been arranged for staff. However, there were three staff that had yet to complete the training. There were also improvements required to the monitoring of staff members’ completion of training as available records did not match the actual training that staff had

completed.

The existing systems for the management of complaints were reviewed, and it was found that there were improvements required. Four complaints had been registered for 2021. While these complaints had been listed as being addressed, there was no evidence to show how this had been achieved or if the complainant was satisfied with the outcome.

As mentioned earlier, there was a large staff team in place to best support the needs of the residents.The staffing numbers were appropriate to the number and needs of the residents. Some of the residents required one-to-one support on a twenty-four-hour basis, and there were systems in place to assure this. A review of the roster also demonstrated that there was a consistent staff team supporting the residents.

Overall, while there were improvements required to the monitoring practices in a number of areas. The service being provided to residents was, for the most part, effectively monitored and was leading to positive outcomes for residents.

Regulation 15: Staffing

The provider had ensured that the number, and skill-mix of staff was appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The arrangements in place to ensure that staff members were provided with and attended necessary training required improvement.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector was not assured that the existing management structures and monitoring practices were appropriate. The information available for review did not demonstrate that all aspects of the service were being assessed and evaluated appropriately. There were enhancements required to the record-keeping practices, monitoring practices, and ensuring that reviews completed identified all areas that

required improvements.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had not ensured that all aspects of the complaints procedure were appropriate.

Judgment: Substantially compliant

Quality and safety

While residents were receiving appropriate care and support, there were improvements required in areas such as protection against infection, risk management, and residents' rights.

There had been a significant COVID-19 infection outbreak in the centre during the early months of 2021. The inspector reviewed infection control practices and found there were a number of areas that demonstrated that the provider had adopted Infection control practices that were in line with the Health Protection Surveillance Centre (HPSC) guidelines. There were risk assessments developed to support staff to respond to possible cases, an outbreak amongst residents, staff members, and the management of staffing numbers. There were also a number of information sheets that had been developed for staff to follow during the outbreak that contained the required information.

Nonetheless, despite the significant outbreak of infection, the inspector observed that there were areas of the centre that had not been cleaned in line with the enhanced cleaning schedule that had been developed. This was brought to the attention of the Clinical Nurse Manager, who promptly responded to the issue.

Also, the information available for review in relation to infection control practices did not demonstrate that an investigation into the outbreak had occurred or that learning had been prioritised following the outbreak. The inspector spoke with a member of the provider's senior management team on the day following the inspection and was informed that these reviews had been completed. The inspector offered the provider the opportunity to submit evidence of these reviews. However, this had not been submitted before completion of this report.

The provider's risk management procedures were reviewed, and it was found that there were some improvements required. The reviewed information did not demonstrate that there were appropriate risk control measures in place for certain

practices. As noted earlier, some residents received twenty-four-hour, one-to-one support from staff members. This included a resident being supervised overnight by a staff member in the resident's bedroom. The inspector notes that this was at the resident's request. The provider had, however, failed to carry out a risk assessment regarding lone working and, in particular, this practice.

The inspector found that there was a review required of the systems regarding the management and ongoing review of risk. A risk register had been created for the centre. While there was evidence of the register being reviewed regularly by the person in charge, there were improvements required to ensure that all environmental and social care risks were captured on the register.

The inspector did observe that residents' risk assessments were under regular review. They were found to be detailed and resident-specific. The assessments clearly outlined the potential risk and the control measures in place to reduce them.

The Inspector observed a lack of awareness of institutional practices that impacted residents' rights to privacy and dignity. A sample of residents' information was reviewed, the inspector noted that on admission to the service, a resident had agreed to staff members carrying out checks once per night. This practice had however, increased to half-hourly checks. A note had been added to the residents' support plan that stated the resident had been reassured about the checks, but there was no reasoning provided as to why this practice had been increased. This had the potential to impact on the resident's privacy and dignity and to interrupt their sleep.

Assessments of the residents' health and social care needs had been completed. There was a system where monthly key-working reports were completed that provided a review of residents' achievements, medical appointments, and areas that they required support. The inspector observed that these reports were up to date for most residents, but there were gaps in recordings for others. Residents' person-centered plans had recently been reviewed, and there were plans in place to hold meetings with residents and relevant stakeholders in the coming weeks. The existing plans were detailed and captured the needs of the residents and how they should be supported. The review of information also demonstrated that when possible, residents were being supported to engage in activities of their choosing.

The review of information demonstrated that residents had access to appropriate healthcare professionals and therapeutic services. The sample of information reviewed demonstrated that for some residents, the COVID-19 pandemic had led to a number of medical appointments being postponed. There was evidence of the staff team seeking to confirm or rearrange dates on behalf of the residents. There was also evidence of members of the provider's multi-disciplinary team supporting staff and providing assistance to residents when required.

There were arrangements in place that ensured that residents had access to positive behavioural support if required. The inspector reviewed a sample of residents' behaviour support plans and found them to be resident-specific. The provider ensured that there were regular reviews of the plans; the plans captured the needs

of the residents and were focused on alleviating the cause of the challenging behaviours. The reviewed information also demonstrated that residents' medication was under regular review by members of the provider's multidisciplinary team to ensure that the prescribed medication best suited the needs of the residents.

Overall, the inspection found that there were systems in place to support residents. There were, however, a number of areas that required improvement in order to ensure that the residents were receiving the best quality service.

Regulation 26: Risk management procedures

There were improvements required to the providers risk management procedures in particular ensuring that there were appropriate control measures in place and that risks were appropriately identified.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The information available for review did not demonstrate that an investigation into the outbreak had occurred or that learning had been prioritised following the outbreak. Furthermore, the inspector found that the provider's cleaning schedule had not been followed and that, as a result, an area of the centre used by residents had not been cleaned appropriately.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider’s multidisciplinary team and person in charge had developed individualised supports for residents and these were promoting positive outcomes for residents.

Judgment: Compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate

healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were arrangements in place that ensured that residents had access to positive behavioural; support if required.

Judgment: Compliant

Regulation 9: Residents' rights

The Inspector observed a lack of awareness of institutional practices that impacted residents' rights to privacy and dignity.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Coastguards OSV-0002567

Inspection ID: MON-0033434

Date of inspection: 14/07/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A training plan is in place and all staff were facilitated BLS training. Three remaining staff have to complete BLS which will completed by 31/08/2021. All training records will be audited on a monthly basis by the PIC. The training matrix will be updated to accurately reflect the actual training completed by staff. The planned monthly audit will identify staff members who current training is due to expire and ensure they are scheduled for refresher training in a timely manner. The system to records staff professional development will include the filing of all training certificates to support oversight and monitoring of staff training needs and planning updates	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Person in charge (PIC) is currently assigned to two designated centres. From the 23/08/2021 PIC will be assigned to one designated centre. The frequency of monitoring completed audits to be carried out by the PIC will be increased from every 6 seeks to monthly. The Assistant Director of Nursing (ADON) who is registered as a PPIM will provide increased clinical oversight and governance	

thorough more regular site visits, increasing from once every 10 day period to once within a 5 day period or more often as required. They will also maintain daily phone contact with the PIC.

Up skilling of all staff nurses in area of shift leader duties ensuring that the entire team is working towards high compliance with regulations. "Shift leader checklist" template developed and put into action on 09-08-2021. This check list is completed by the PIC along with the shift leader monthly and records to be maintained in the training folder.

All provider annual and six monthly reviews will identify all areas that require improvement which will be monitored through increased ADON presence by conducting weekly site visits at a minimum.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints outstanding will be dealt with and closed off by 31/08/2021. Management to meet with one complainant to further discuss unresolved complaint to make efforts to resolve any outstanding issues at a local level. Complaints records maintained will document the complainant's satisfaction with the outcome of the investigation of the matter raised.

Complaints procedure will be adhered to as per local complaints policy.
All service users and relevant stakeholders will be made aware of "Your Service Your Say" at residents meetings, at Person Centred planning meetings and easy read information posters and leaflets erected in communal areas of the unit and in the residents personal easy read box files.

Annual Family Questionnaire to be circulated in quarter 3, 2021, to all family members and actions followed up on. Report will be compiled from feedback received and will be completed and on site in all areas in quarter 4 2021.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
PIC has conducted a review regarding the implementation of one residents Positive

Behavior Support and Management plan on the 20-08-2021.
Findings regarding the appropriate implementation has been communicated to all staff through the communication diary and a staff meeting held on the 20-08-2021. Staff are asked to read and sign the support plan to confirm their knowledge and understanding of same. Going forward all updated plans will be discussed at staff meetings so any changes can be discussed and time given to seek clarity if required so all staff are aware of how to translate behavior support plans into practice.

Ongoing review of Risk Register and Safety Statement by PIC and all staff to be aware of risks and supporting plans in place for all risks in the center. Risk assessment reviews and appropriate controls will be a standing agenda item at staff monthly meetings effective immediately to ensure a positive risk taking focus to ensure the safety of each resident while simultaneously promoting their independence.

Incident management is a standing agenda item at CNM2/PIC/DON/ADON monthly Quality, Safety, Risk and regulatory compliance meetings. DON/ADON to ensure each CNM2/PIC are afforded appropriate time and opportunity at these meetings to discuss specific incidents that have occurred ensuring effective learning is shared across all designated centres.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Closing review letter from Public Health is now on file and readily available to all staff. Learning notice developed by the Director of Nursing office on the 05-08-2021 and shared across all designated centers following this outbreak. The Director of Nursing will ensure learning is circulated more promptly following any future outbreaks that may occur in the service going forward. This will be a standard agenda item under Infection Prevention & control at monthly CNM2/PIC/DON/ADON Quality, Safety, Risk and regulatory compliance meetings.

Cleaning schedule reviewed and updated on the 15-07-2021 and is in operation capturing all areas of the designated center detailing the work plan in place daily for each area. The cleaning schedule will be checked to ensure the cleaning frequency is being adhered to by the most senior person on each shift.

Infection Prevention Control (IPC) audit completed on 16/07/2021 and weekly IPC audit to be completed by a designated staff member. Staff member allocated this responsibility on the weekly staff allocation list as a means of ensuring staff responsibility and compliance in this area.
In addition, the PIC will complete an Infection Prevention and Control Audit monthly.

Audit records will be maintained in the designated centers Quality and Safety folder.

Learning notices are developed following all HIQA inspections and circulated to all designated centers. To ensure shared learning at all staff grades going forward, these learning notices are discussed at monthly unit staff meetings and monthly Quality, Safety, Risk and regulatory compliance meetings.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: All residents have been met with on the 19-07-2021 regarding their individual night time supports and required nightly checks. Individual support plans have been updated to ensure that each check is person centered and in line with each resident's wishes and preference. Updates complete on the 19-07-2021. Ongoing reviews to occur with each resident as their need changes but ensuring that each resident's wishes are respected.

The rationale for the frequency of night time checks will be documented in each resident's support plan and proportionate to the identified risk to ensure their safety and wellbeing.

Audit of residents Person Centered Plans are to be completed by the PIC on the monthly Metric audit tool as a means of ensuring compliance in this area.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	12/09/2021
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	23/08/2021
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of	Substantially Compliant	Yellow	31/08/2021

	Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
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	31/08/2021
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	15/07/2021
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is	Substantially Compliant	Yellow	13/08/2021

	informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/08/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	19/07/2021