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:	Bantry Respite
Name of provider:	The Rehab Group
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	25 July 2023
Centre ID:	OSV-0002663
Fieldwork ID:	MON-0037403

About the designated centre

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

In this designated centre residential respite services are provided to adults with a sensory or physical disability. The service aims to support residents who have a range of needs but the provider does state that the centre is not suited to those who require a full-time nursing or medical presence, for example those with very high medical needs or requiring end of life care. The centre is usually open from Monday to Saturday, offering residents a five-night stay. The service is also open on six Sundays each year which provides residents with an opportunity for a six- or 13-night stay. The centre is closed for six weeks each year. These closures are planned in advance. A maximum of six residents can stay in the centre at any one time. Each resident has their own bedroom for the duration of their respite stay. Bathrooms are shared between two bedrooms. There are a number of communal facilities in the designated centre including two sitting areas, a visitors' room, an accessible kitchen, a dining area, sun room area, therapy room, and laundry room. There are also two staff offices, bathrooms and bedrooms. The centre is a single-storey building located on a campus operated by the provider on the outskirts of a large coastal town. The staff team is comprised of the person in charge, team leader, and care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 25 July 2023	09:30hrs to 19:30hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This designated centre is a single-storey building located on a campus operated by the provider on the outskirts of a large coastal town. A residential respite service is provided to adults with a sensory or physical disability. The centre is registered to accommodate six residents at any one time. Management advised that most often there are four residents staying in the centre. Each resident has their own bedroom. Ensuite bathrooms are shared between two bedrooms, however due to the occupancy levels, residents often have exclusive use of a bathroom. The centre had two sitting room areas, a dining area, visitors' room, an accessible kitchen, a dining area, sun room area, therapy room and laundry room. There were also two staff offices, bathrooms and bedrooms.

This was an unannounced inspection. On arrival, the inspector was welcomed to the centre by a member of the staff team. Shortly afterwards they met with the team leader and the person in charge who both facilitated the inspection. The inspector was informed that 42 people availed of the respite service offered in the centre. Most residents typically stay in the centre for four weeks each year, although some may stay more regularly due to cancellations. The centre is usually open from Monday to Saturday, offering residents a five-night stay. The service is also open on six Sundays each year which provides residents with an opportunity for a six- or 13-night stay.

There were four residents staying in the centre at the time of this inspection. The inspector had an opportunity to meet, and speak, with two of them. Both residents spoken with were very positive about their experiences of staying in the centre, with one telling the inspector that they loved it there. Both residents had stayed in the centre on a number of occasions. They were positive about the centre itself, including their bedrooms, the staff support provided, describing it as very kind, and the activities they participated in while there. Residents spoke with the inspector about their plans for the week and how they had decided what they would do. Both residents were going to a nearby town that morning. One resident spoke about their plans to go to the cinema that evening, with the other expressing their preference to return to the centre and watch television. A resident also mentioned a barbeque later in the week that they were looking forward to. The residents advised that they got on well together, and with those also staying in the centre that week. They told the inspector that there can be different people staying when they visit, and that they had never had any issues with their peers. The inspector was also told about the day service on the same grounds as the centre. Both residents were familiar with this service and told the inspector that they went there a couple of days every week. Residents were clear that they would feel comfortable in raising any concerns or complaints they may have with any member of the staff team, but advised that they never had any need to. They were also positive about the food available in the centre, explaining that there were choices available every day and that if they wanted something else, staff would prepare it. Residents advised that they could cook if they wished but saw their stays in the centre as a break from their usual

day-to-day life and responsibilities. It was clear that these residents had developed a friendly relationship with each other and also with the staff supporting them. Interactions observed and overheard were respectful and warm. Residents appeared very at ease and comfortable in the centre and with the support provided.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review the feedback received from some residents as part of the annual review process, and also saw a number of compliments received from residents and in some cases their relatives. Residents' feedback was also sought at the end of each stay. This was recorded and available for the inspector to read. Overall feedback was very positive, indicating a very high level of resident satisfaction with the service provided in the centre, as illustrated by one resident commenting that 'you can't improve on perfection', and another describing the centre as 'as good as, if not better than, home'. Staff members were routinely praised and were described as 'excellent', 'so kind', 'helpful' and 'going above and beyond'. Residents' relatives had also provided positive feedback praising the 'exceptional staff' and the opportunities provided to their relative to make friends and enjoy their interests while staying in the centre. One resident described a 'special atmosphere' in the centre and likened it to meeting up with friends.

When walking around the centre, the inspector observed that it was cleaned to a high standard, tidy, and well-organised. There were soft furnishings such as blankets, plants and art works on display. Shelves also contained a selection of books and films. This gave the centre a more homely feel. A pool table was also available in one of the living room areas. At the time of the last inspection completed on behalf of the Chief Inspector of Social Services (the chief inspector), repair was required to address a leak by one of the entrance doors. On this occasion, the inspector was informed that although some works had been completed, the issue remained and further works were planned. Since the last inspection some flooring had been replaced. While overall the premises were in good condition, the inspector did note some damaged surfaces. These were seen on a kitchen counter and on some furniture, including the seats in the visitors' room. As a result of this damage it would not be possible to effectively clean these surfaces. Management advised that painting was planned in the centre, on both walls and some stained bedroom furniture. When in the bedrooms, the inspector noted that some were fitted with equipment to support residents with reduced mobility to move from one place to another. Where these were currently in use there were cleaning records in place. Each bedroom had suitable storage available for residents' belongings during their stays in the centre. It was also noted that secure storage facilities were available in each bedroom for the storage of medicines. Despite being in use, the keys were in the locks of four medicine storage cupboards and one medication fridge. This finding will be discussed more in the 'Quality and safety' section of this report. It was also noted that the fittings in some bedroom doors had been changed. As a result there were some marks and holes in these doors. These required review by a competent person to ensure that they would still be effective containment measures to limit the spread of fire, smoke and gases if required in the event of a fire.

As well as spending some time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The inspector also looked at a sample of residents' individual files. These included residents' support plans regarding their assessed health, personal and social care needs. The maintenance of these plans required additional oversight. Staff training records and rosters were reviewed. It was identified that improvement was required in the notification of adverse incidents to the chief inspector, and in the awareness of what events were required to be notified, as outlined in the regulations. A review of medication management practices and the centre's complaints log also highlighted areas requiring improvement to meet the requirements of the regulations.

The next two sections of the report 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 to each resident who stayed in the centre.

Capacity and capability

There was regular management presence in this centre. Evidence on the day of this inspection indicated that the centre was well resourced, that there was learning from incidents to improve the service provided, and there was good oversight of staffing and training. However, areas requiring improvement were identified. These included improved oversight to identify all areas requiring improvement, implementation of all parts of action plans, the consistent implementation of the provider's policies and procedures, and better awareness of the requirements of the regulations.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Care staff reported to the team leader, who reported to the person in charge. They in turn reported to a regional manager who at the time of this inspection was a proposed person participating in management of the centre.

The person in charge was employed on a full-time basis and also fulfilled this role for one other designated centre located on the same grounds. They were fully supernumerary and allocated two thirds of their working week to this centre. The team leader worked in this centre only. They had some supernumerary time each week and also provided direct support to residents. They worked various shifts in the centre, including those at weekends, and overnight. Management presence in the centre provided all staff with opportunities for management supervision and

support. Throughout this inspection management displayed a good knowledge of the residents staying in the centre and the supports required to meet their assessed needs.

The inspector was informed that each member of the staff and management team received one-to-one supervision every three months. This could occur more frequently if required. Staff meetings took place monthly. Management advised that these took place in person and that staff could also join using video conferencing technology. The inspector reviewed a sample of these meeting minutes and saw that a range of topics were regularly discussed. These included those related to the day-to-day management of the centre, such as staff responsibilities, health and safety, safeguarding, infection prevention and control, findings of recent audits, and training, as well as others more specific to residents such as a review of recent stays, complaints, compliments and incidents, and any planning required for residents due to stay in the centre in the near future. These one-to-one and group meetings provided staff with opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents.

Management advised that there was currently one vacancy on the staff team. This shortage was addressed by a group of regular relief staff. Planned and actual staff rotas were available in the centre. From a review, the inspector assessed that staffing was routinely provided in line with the staffing levels outlined in the statement of purpose. Typically there were three staff working in the centre during the day, and two staff who completed sleepover shifts by night. However, if necessary to meet a resident's assessed needs, a waking night staff was provided. This level of staffing support had been provided in one of the actual rosters reviewed by the inspector.

Management had good oversight of staff training needs and had a recently updated staff training matrix available for review. Not all staff were trained in the safe administration of medications, including epilepsy management. However, there was evidence that there were enough staff on duty with this training at all times, and further training was planned. The inspector reviewed records regarding the training areas identified as mandatory in the regulations. While the majority of staff had recently completed the necessary training, it was identified that two relief staff who worked regularly in the centre required training in the management of the behaviour that is challenging including de-escalation and intervention techniques. This training was not planned.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed on 20 July 2023 (the week prior to this inspection) and involved consultation with residents, as is required by the regulations, staff, and some residents' relatives. An unannounced visit had taken place in October 2022 and again in March 2023. Where identified, there was evidence that the majority, but not all, actions to address areas requiring improvement were being progressed or had been completed. These reports referenced that all actions from the previous report completed on behalf of the chief inspector had been completed. However as referenced in the opening section of this

report, the premises issues regarding a leak were ongoing. When reviewing six-monthly visit reports it was noted that the representative of the provider at times found that previous actions had not been addressed. In both reports completed in 2022, it was identified that improvement was required in the documentation of complaints in the centre. This was also a finding of this inspection.

When reviewing the complaints log, it was found the records maintained did not meet the requirements of the regulations. The actions taken on foot of a complaint, and whether or not the complainant was satisfied were not clearly recorded. This has been a finding in other centres operated by this provider. It was noted in a 2023 unannounced visit report that the use of an online reporting system had addressed these previously identified shortcomings. However, the inspector reviewed these online records and the same issues remained. On the day of this inspection, management provided evidence that any complaints made were investigated promptly, and that measures required for improvement were put in place. The majority of complaints recorded had been resolved locally. There was one exception to this. The inspector read a complaint made by a resident in April 2023. From a review of the record and speaking with management, the resident's satisfaction with the outcome of this complaint was not clear. Management advised that this complaint had been closed, however it was indicated that the resident had not yet been made aware of this outcome, or of details of the appeals process, as is required by the regulations. Management advised that it was planned to discuss this with the resident during their next stay in the centre. In addition to not meeting the requirements of the regulations, this complaint had not been managed in line with the provider's complaints policy which outlined that any complaints not resolved within 30 days are to be escalated for an internal enquiry.

In addition to the audits and reviews required by the regulations, management reported that the person in charge also completed a monthly audit of various aspects of the service provided in the centre. Other audits were also regularly completed such as six-monthly environment assessments. The inspector reviewed a medication management audit completed in May 2023 which identified no areas requiring improvement. As will be outlined in the next section of the report, this was not consistent with the findings of this inspection. When reviewing the provider's medication management policy the inspector read that each service is required to develop and document its own comprehensive local medication management procedures. As will be outlined later in this report, it was identified that many of the practices in place in the centre for residents who took responsibility for their own medicines were not outlined in these procedures.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the chief inspector. It was identified that one incident involving the alleged abuse of a resident had not been notified within three working days, as is required. It was noted that no notifications had been submitted regarding minor injuries sustained by residents while in the centre. On the day of this inspection, the inspector read accounts of incidents where a resident sustained bruising, and another where a minor injury required first aid. The inspector queried why these, and any other minor injuries, had not been notified to the chief inspector at the end of each quarter of each calendar year, as is required

by the regulations. Management advised that they were not aware of this regulatory requirement. This omission had not been identified in any of the audits or reviews completed in the centre.

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the number and skill mix of staff was appropriate to the number of residents staying in the centre at any one time, and their assessed needs. Staffing levels were also found to be in line with those outlined in the statement of purpose. A review of documents in the centre indicated that planned and actual staff rosters were in place and were properly maintained.

Staff personnel files, and the information and documents specified in Schedule 2 of the regulations, were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre had access to appropriate training, including refresher training. The majority of staff had recently attended the training identified as mandatory in the regulations. The exception to this related to two relief staff who worked regularly in the centre. Neither of these staff had attended training in the management of behaviour that is challenging including de-escalation and intervention techniques, as required. This training had not been scheduled at the time of this inspection. Staff had also completed training in other areas, including human rights.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there was a clear management structure in place and evidence that the centre was sufficiently resourced, there was a need for improvements to ensure that the service provided was safe, consistent, and effectively monitored. The annual review and other audits completed had failed to identify a longstanding non-compliance with the regulation regarding the notification of incidents. The local medication management procedures did not reflect all of the practices in the centre regarding residents who took responsibility for their own medicines while staying in the centre. It had not been identified that some of these practices were not consistent with the provider's medication management policy. Although identified previously, effective actions had not been implemented to ensure the record of complaints in the centre was consistent with the requirements of the regulations. There was an evident knowledge gap regarding the requirements of some regulations. Residents' personal plans also required a more timely update to ensure that staff had access to the most up-to-date information when supporting residents in the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There were clear admission criteria to access the services provided in this centre. These were outlined in the statement of purpose. There was a written agreement provided to residents in advance of each stay. These outlined any fees to be charged or voluntary contributions requested.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. On review, the inspector identified that this required revision to ensure that the organisational structure, staffing complement in whole-time equivalents, current registration conditions, and the size of the rooms in the designated centre were accurate. These were addressed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

One allegation of abuse of a resident had not been reported to the chief inspector within three working days, as is required by this regulation.

As referenced in the findings regarding Regulation 7: Positive Behaviour Support, not all restrictive practices used in the centre had been recognised. Therefore the chief inspector had not been informed of their use, as is required.

It was also identified that written reports had not been submitted regarding any non-serious injuries to residents that occurred in the centre. It is a requirement of this regulation that these reports are submitted at the end of each quarter of each calendar year.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was evidence that any complaints made were investigated promptly and measures for improvement were put in place. The record of complaints required improvement to clearly document the actions taken on foot of a complaint, the outcome of the complaint, and whether or not the complainant was satisfied. It was also identified that one complaint had not been escalated in line with the provider's own complaints policy and was closed without promptly informing the complainant of the outcome and the appeals process in place, as is required by the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that residents' received a personalised service from a dedicated staff team when staying in this centre. A review of documentation and the inspector's observations indicated that residents' rights and independence were promoted and that residents enjoyed staying in this centre. As highlighted previously improvements were required regarding medication management procedures in the centre. The timely updating of personal plans to reflect changes in circumstances also needed to be improved.

As outlined in the opening section of this report, residents expressed a very high level of satisfaction with this service. Residents were positive about the facilities available, the supports provided by staff, and the opportunities available to them to engage in activities of their choosing while staying in the centre.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance to staff members on the various supports to be provided

to residents while they stayed in the centre. Information was available regarding residents' interests, likes and dislikes, daily support needs including any aids or equipment used, communication abilities and preferences, sleep routines and preferences, healthcare and medication support needs, and other relevant person-specific needs such as mealtime or swallowing support plans. These plans very clearly outlined both residents' needs and preferences in each support area. Residents' personal plans also included a recently reviewed personal emergency evacuation plan (PEEP) for staff to implement should a fire or other emergency occur.

Prior to a resident's stay in the centre, the resident, or in some cases their representative, was contacted to assess if there were any changes in their support needs since the previous stay. At the start of each visit residents also had an opportunity to inform staff of any changes and to outline how they would like to spend their time in the centre. Residents' personal plans were reviewed at least annually, as is required by the regulations. Minutes of these review meetings showed that residents were very involved in these reviews, often taking the lead in the review process. While proposed changes were noted, it was found that personal plans were not always updated to reflect these changes, for example one resident expressed a wish to have access to a particular type of bottle so that they could easily and independently have a drink. This was not reflected in this resident's personal plan. For another resident, it was noted that a number of changes had been communicated at the annual review meeting held in March 2023. These had yet to be reflected in the resident's personal plan although they had stayed in the centre twice since then. Management advised that these updates had been made and would be printed and made available to all staff prior to this resident's next stay in the centre. The inspector's review of annual review records also identified that there was not always documented follow-up on recommendations made at each review, or a person identified as responsible for pursuing these objectives. These are requirements of the regulations.

The provider had assessed that no residents who stayed in this centre required a behaviour support plan. There was evidence of consultation with a behaviour support practitioner regarding one resident shortly after they started attending the service. It had been agreed that a plan was not required. The inspector reviewed a related risk assessment in place, and also noted a number of proactive approaches to prevent or reduce the likelihood of an incident occurring documented in this resident's personal plan. These supports appeared to be effective.

At the outset of this inspection, management informed the inspector that following a recent review they had recognised that the use of movement sensors was a restrictive procedure. They had implemented the provider's policy and also planned to notify the chief inspector of their use, as is required by the regulations. Management confirmed that these, and other restrictive measures, were only used with residents' consent. It was explained that some residents requested they be used, as these were the arrangements in their homes. When reviewing one resident's personal plan, the inspector saw records of night-time checks completed every 30 minutes. This had not been recognised as a restrictive procedure. Management committed to subjecting this practice to the provider's policy and

notifying its use to the chief inspector.

The inspector reviewed the medication management processes in place. Management advised that although the majority of residents self-administered, staff did administer medication to some residents who stayed in the centre. The inspector was showed secure storage facilities in a staff office, which included a separate area to store out-of-date or other medicines to be returned to the pharmacy, as is required by the regulations. A member of the management team spoke with the inspector about the various medication reconciliation processes in place which included completing a count of all medicines received on residents' arrival in the centre and comparing these with current prescriptions. Medicine counts were then completed twice a day, and again prior to residents leaving the centre to return home. It was confirmed that all medicines administered by staff working in the centre must be provided in their original packaging and clearly labelled. This was in keeping with the provider's own policy. Management advised that a resident who was due to stay in the centre in the coming weeks was prescribed a Schedule 2 / controlled drug. Management were aware of the additional storage and record keeping requirements regarding these medicines, and were in the process of ensuring that all required systems would be in place before this resident's arrival in the centre.

At the time of this inspection, all four residents staying in the centre were responsible for their own medication. The inspector saw evidence that recent assessments of capacity in this area had been completed. The inspector asked about the practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines in this situation. Management advised that there was a current prescription on file for each resident and that on their arrival to the centre residents were asked if staff could count their medicines and compare them to their prescription. Residents could decide not to facilitate this request, and this choice was respected. This was the case for one resident in the centre at the time of this inspection. Management advised that if any resident did decline, a risk assessment was completed. The inspector reviewed this risk assessment and others completed regarding the risks associated with residents self-administering their medicines. Each of these referenced the secure storage of medicines as a control measure to mitigate against these risks. However, as referenced in the opening section of this report, all storage facilities containing medicines on the day of this inspection were not secured. One of these was a medication fridge. The inspector noted that although staff were monitoring the fridge temperature daily, no corrective action had been taken when this had fallen below the acceptable range. This was addressed immediately when highlighted by the inspector. The inspector was informed that no records were maintained regarding the self-administration of routine or PRN medicines (medicines taken as the need arises). Management also advised that some residents brought medicines with them to the centre that were not labelled or in their original packaging. Management advised that they accepted this as part of their aim to provide a 'home away from home' service to residents. This arrangement was not in keeping with the provider's medication management policy, and was not documented in the local medication management procedures. When not stored in original packaging it was not possible to determine if these

medicines were consistent with residents' current prescriptions.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. The layout of the centre provided three communal areas and a separate visitors' room for residents to meet with visitors. Due to the nature of the service provided in the centre, many residents did not have visitors during their stays. However, the inspector was informed that due to the central location of the centre, one resident used their respite stays as an opportunity to meet with people they may not meet otherwise.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests, and wishes. On the day of this inspection residents spoke about their plans for that day and the remainder of the week. These included visiting a nearby town to do some shopping, going to the cinema, and attending a barbeque. A review of the records completed at the beginning and end of residents' stays showed that residents were supported to go shopping, out for dinner, and on a variety of day trips in the West Cork area during their stays in the centre. Some residents also attended a day service located on the same grounds while staying in the centre.

Judgment: Compliant

Regulation 17: Premises

The centre was observed to be clean and well decorated. At the time of the last inspection it was identified that works were required to address a leak by one of the entrance doors. The provider had tried to address this previously and at the time of this inspection there were further planned works. This leak did not pose a medium-high risk to residents' safety. When in the centre it was noted that some surfaces, including those on a kitchen counter and on some furniture, required repair or replacement. Due to the damage observed it would not be possible to effectively clean these items.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was evidence that residents were offered a choice of wholesome food while staying in the centre. Residents had opportunities to be involved in food preparation in line with their wishes. Residents reported that they were very happy with the food available in the centre. There were separate food storage and preparation facilities available for residents with coeliac disease. There were recently reviewed plans in place for residents who had been assessed as having swallowing difficulties.

Judgment: Compliant

Regulation 26: Risk management procedures

The sample of risk assessments read by the inspector had been recently reviewed. It was identified that not all control measures outlined in assessments to mitigate against the risks posed by specific hazards were in place, for example, it was identified that the required staffing ratios in place to safeguard residents and staff during specific tasks were not in place on one occasion. It was also identified that a control measure in place to reduce the likelihood of a resident dropping their medication was not included in the associated risk assessments.

Judgment: Substantially compliant

Regulation 28: Fire precautions

This regulation was not inspected in full. When walking around the centre it was noted that the fittings on some fire doors had been changed. These doors required review by a competent person to ensure that they would still be effective containment measures, if required in the event of a fire. Of the sample reviewed, all residents had a recently reviewed personal emergency evacuation plan. Management reported that evacuation drills took place regularly and residents spoken with on the day of the inspection were aware of the centre's evacuation procedures. There was an external door in each bedroom to aid evacuation.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

On the day of this inspection all four residents staying in the centre took responsibility for their own medicines. This was in line with residents' wishes and recently completed assessments. The inspector observed that none of the residents' medicines were stored securely despite suitable facilities being provided. This was not in line with the provider's medication management policy, the local medication management procedures, or associated risk assessments. A number of the practices implemented in the centre regarding residents who wished to, and had been assessed as able, to take responsibility for their own medicines were not consistent with documented policies and procedures. For example, management advised that at times residents brought in medicines that were not in their original packaging or labelled. This was not consistent with the provider's policy and was not referenced in the local procedures. When not in original packaging it was not possible to determine if these medicines were consistent with residents' current prescriptions. It was not identified that the temperature of a refrigerator used to store medicine was not within the required range. This was addressed immediately when highlighted by the inspector.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of health, personal, and social care needs had been completed for each resident in the previous 12 months, as is required by the regulations. A personal plan was in place to provide guidance to staff in supporting residents' assessed needs. Residents were involved in the annual review of their personal plan. Although recommendations made had been documented, the outcomes and names of those responsible to pursue the recommendations within agreed timescales were not always noted. It was identified that personal plan documentation was not always updated in a timely manner following reviews and changes in residents' circumstances.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Staff were aware of residents' healthcare needs, including epilepsy support plans, and liaised with general practitioners, medical consultants, and other health and social care professionals, as required. There was evidence that staff had sufficient information and resources available to support residents to participate in recommended

programmes, such as physiotherapy exercises.

Judgment: Compliant

Regulation 7: Positive behavioural support

None of the residents who accessed services in the centre had a behaviour support plan in place. Where this had been considered there was evidence of consultation with a behaviour support practitioner working for the provider. The finding regarding staff training is reflected in Regulation 16.

There were very few environmental restrictions in use in the centre. Those that were used, were in place due to requests from residents. Management had recently identified some other restrictive practices used in the centre, for example, movement sensors. However on the day of this inspection, it was also identified that one resident was checked very regularly overnight. This had not been subjected to the provider's restrictive practices policies and procedures.

Judgment: Substantially compliant

Regulation 8: Protection

All safeguarding concerns had been addressed in line with the provider's and national safeguarding policies. There was evidence of liaison with the local safeguarding and protection team, as appropriate. Actions, as outlined in safeguarding plans, were in place on the day of inspection. The delay in notifying the chief inspector of an allegation of abuse is reflected in the findings for Regulation 31.

Judgment: Compliant

Regulation 9: Residents' rights

Residents staying in the centre received an individualised service adapted to their needs and preferences. Residents participated in meetings at the beginning and end of their stays where they outlined what they wished to do while in the centre, and then had an opportunity to review and provide feedback before leaving. Management also called residents in advance of and following their stays to provide additional opportunities for consultation and feedback. Many residents lived independently and their independence was very important to them. Management

and staff supported residents to be as independent as possible and exercise choice and control as they would when in their own homes.
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 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bantry Respite OSV-0002663

Inspection ID: MON-0037403

Date of inspection: 25/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Relief staff completed online MAPA training 19/07/2023 and 31/07/2023. PIC has contacted the training department to schedule face-to-face Crisis Prevention Institute (MAPA) training for staff. This will be completed by 30/11/2023.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Monthly Oversight review meetings with PPIMs and members of the Quality & Governance Directorate will be scheduled until all actions are completed, the first meeting will take place before 22/09/2023. The purpose of these meetings is review progress towards compliance and address any new issues as they emerge. • Actions arising from this inspection will be tracked on the Providers online action tracking system, these will be monitored and signed off by the PIC and the Regional manager. • The provider's board will be provided with a copy of this report and will receive monthly updates on actions relating to non-compliances until all these actions are closed. • At staff team meetings the PIC will remind staff of their responsibilities under organizational policies including complaints, restrictive practices etc.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • Regional Manager supported PIC with new monitoring system to ensure notifications are sent to HIQA on time. This was implemented on 04/08/2023.	

• At most recent Team meeting HIQA notification requirements were discussed with the staff team, this took place on 29/07/2023.

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Going forward the PIC will evidence that complainants are satisfied with the resolution and or the actions that have been taken to resolve the complaint and where complainants are not satisfied this will be escalated as per the Provider's Complaints Policy. • The Regional Manager (PPIM) will review complaints on a regular basis to ensure all complaints are addressed as per policy.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Required areas of the service to be painted and part of kitchen counter top replaced. This will be completed by 31/12/2023. • New chair will be purchased for visitor's room; this will be completed by 30/09/2023.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • All Risk assessments to be re-read and signed by staff as understood to ensure that all staff are informed of control measures within risk assessment. This will be completed by 15/09/2023. • Risk Assessment in relation to use of plate for safe medication administration has been updated to ensure information is consistent with support plans. This was completed on 21/08/2023.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire Engineer assessed the fire doors and door has been sealed following this inspection. This was completed on 15/08/2023.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Person in charge has updated local guidelines and client admission paperwork for respite stays. The updated "beginning of stay form" will inform residents that staff will be reminding all clients to keep the medication secure in the locked cabinets provided. Daily staff handover has been updated to remind staff to complete this task. This was completed on 28/07/2023.	

• Person in charge has met with Medication Practice Development Trainer to review practices regarding the safe storage and packaging of medication during respite stays. This was completed on 11/08/2023. • Medication Risk Assessment, Support Plans and Local Medication Procedure have been updated to reflect practice in relation to the use of dosette boxes in the service. This was completed by 21/08/2023.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • Support Plan has been updated as required. • Person in Charge to support Team leader with Team Leader Weekly Audit to ensure files are fully updated prior to clients stay. 16/08/2023 • Person in Charge will sign off and date all Annual Needs Assessments once completed.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Behavioral Therapist will meet PIC and Regional Manager on 23/08/2023 to review all current and potential restrictive practices in the service, documentation and notifications to be updated to reflect outcome meeting. This will be completed by 15/09/2023.

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	30/11/2023
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	31/12/2023
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	Not Compliant	Orange	31/12/2023

	safe, appropriate 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	15/09/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/08/2023
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	21/08/2023
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working	Not Compliant	Orange	04/08/2023

	days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	04/08/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	27/07/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation	Not Compliant	Orange	27/07/2023

	into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	21/08/2023
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	21/08/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	15/09/2023
Regulation	The person in	Substantially	Yellow	15/09/2023

07(5)(c)	charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Compliant		