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:	No. 4 Bilberry
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	16 February 2022
Centre ID:	OSV-0008060
Fieldwork ID:	MON-0034468

About the designated centre

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

No. 4 Bilberry is a five bedroom, single-storey house located on the outskirts of Cork city. It is registered to provide a full-time residential service to four adults. It is centrally located with shops, restaurants and other community services within a short walking distance. It is also close to public transport services. The centre has two communal living room areas, a kitchen / dining room, a staff office and a staff bedroom. Each resident has their own bedroom. At least two staff are rostered to work in the designated centre when residents are present. Additional staff regularly work in the centre in the evenings and at the weekends to facilitate residents' participation in activities both in the house and in the local community. At night there is one sleepover and one waking night staff. The residents who live in the centre are assessed as having a moderate to severe level of intellectual disability. The focus in No.4 Bilberry is on meeting the individual needs of each person within a homely environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 16 February 2022	10:00hrs to 17:35hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

There was a focus on providing an individualised, person-centred service to each of the residents living in this centre. The staff team knew the residents well and were in the process of supporting them to settle into their new home in a new community. New management structures were in place and work was underway to address identified areas for improvement. Other areas for improvement were identified in this inspection and will be outlined throughout this report.

This was the first inspection of this centre by the Health Information and Quality Authority (HIQA) since it was first registered in October 2021. The inspection was unannounced. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

At the time of this inspection there were three residents living in the centre. These residents had all lived together previously in another designated centre run by the same provider. Management advised that a fourth person had been identified to move into the centre but that there was no current plan or timeframe for this move to take place. Management reported that it was important for the existing residents to adjust to their new home first. Additional support had been provided by the provider's speech and language therapy department to support the residents with their recent move. In addition to providing accessible information about the new centre, support had also been given to the staff team in using visual supports to provide choice making opportunities. A speech and language therapist had also attended a staff meeting to further reinforce the use of LÁMH (a sign system used by children and adults with intellectual disability and communication needs in Ireland).

The centre was a five bedroom house located on the outskirts of Cork city. It had two communal living room areas, a kitchen and dining room, a staff office and bedroom. Each resident had their own bedroom which was recently painted and decorated. Bedrooms were decorated with photographs of the residents themselves and people important to them. Pictures had been placed on drawers and other storage furniture to support residents' understanding. This was consistent with the total communication approach espoused by the service for this centre. Other visual communication supports were observed throughout the centre. The house was observed to be clean throughout. Some maintenance works were outstanding at the time of this inspection however the inspector saw a list of items, some of which had already been addressed, that had been sent to the provider's maintenance department. In the course of this inspection, some other items were identified and reported to maintenance.

On arrival the inspector met with a staff member who had previously worked with these residents in their former home. They were very knowledgeable about the residents and their support needs. This staff member showed the inspector around

the centre. In the floor plans submitted to register the centre, the garage in the back garden was included in the designated centre. Staff spoke with the inspector about proposed plans for the garage to be used for storage and as an additional recreational space for the residents. At the time of this inspection neither staff nor residents were regularly accessing this area. A second refrigerator and a second freezer had recently been delivered and were being stored there. It was planned that these be installed for use in the garage. The inspector went into the garage and observed it to be in a poor state of repair.

Shortly after the inspection began the inspector met with the social care leader appointed to the centre. They had been in this role since January 2022. Later, the inspector also met with the person in charge. The inspector had the opportunity to spend time with two of the three residents. When the inspector arrived at the centre, both of these residents were waiting to leave for their day services. They later returned to the centre and were observed to be at ease in each other's and staff company. They appeared comfortable in the house and moved throughout it freely. A number of activities that one resident enjoyed had been set up in one of the communal living rooms. This included tabletop activities and a television showing their favourite sport. The inspector also saw this resident playing tennis and another ballgame with different members of the staff team.

At the time of this inspection all three residents were attending day services. For one resident this was an integrated day service based from the designated centre. This change in the model of service had resulted from the COVID-19 pandemic and was reported to be a positive change for the resident. This was also documented on a recent satisfaction survey completed in the resident's behalf. Staff spoke about the resident's ability to now choose which activities they participated in while also having the opportunity to spend time in a quieter environment when they needed to. The availability of separate spaces within the designated centre to allow residents spend time alone when they wished or needed to, was highlighted to the inspector as one of the benefits of the recent move for these residents.

When the residents were not attending day services there were at least two staff on duty in the designated centre. From review of the roster it was identified that additional staff were regularly working in the centre in the evenings to facilitate residents' participation in activities both in the house and in the local community. At night there was one sleepover and one waking night staff. Many of the staff team had worked with the residents prior to their move to this centre. This continuity of care was of benefit to the residents and the staff team. The residents were beginning to get to know their new local area. They had been to the local supermarket, takeaway restaurant and barber. Some had also participated in local activities such as a park run. Staff spoke with the inspector about supporting one resident to travel to Cork City using public transport to buy clothes.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included recent audits, fire safety documents, staff rosters and training records, resident meeting minutes and accessible information made available to the residents. The centre's risk register was also reviewed and while comprehensive and recently

reviewed, further revision was necessary to ensure that the risk assessments were accurate and reflective of the centre. The inspector also looked at a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. Areas for improvement were identified and will be outlined in more detail in the remainder of this report.

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 living in the centre.

Capacity and capability

Overall, good management practices were observed and the provider adequately resourced and staffed the service. There was evidence of learning from incidents in the centre and implementing changes in response to any identified issues. Although oversight of the care and support provided in the centre was strong in many areas, improvement was required in others. These areas included infection prevention and control measures and residents' personal plans, including the provision of behaviour support. It was also identified that the provider had failed to address one longstanding issue regarding the use of one resident's finances. This will be discussed further in this section of this report.

There was a clearly-defined management structure 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. Staff reported to the social care leader who reported to the person in charge who reported to a sector manager. The social care leader spoke positively about the support available to them. Staff meetings were scheduled fortnightly in the centre and one took place during this inspection. Attendance at these meetings was incorporated into the centre's staff roster. It was also documented that the staff supervision schedule for the year was to be finalised that month.

As the centre was only registered since October 2021, neither an annual review nor an unannounced visit to review the quality and safety of care provided in the centre had been completed yet. The social care leader spoke with the inspector about an audit recently completed by the person in charge. This was reviewed by the inspector. When speaking with the inspector, the social care leader was clear on some areas that required improvement and outlined plans in place to address these issues. They were also very responsive to matters identified throughout the inspection.

Six of the policies and procedures required to be maintained, as identified in Schedule 5 of the regulations, had not been reviewed within the last three years as is required. One of these related to the management of residents' personal property, finances and possessions. The policy that was in place was insufficient to address an

ongoing matter regarding the use of one of the resident's finances. It was noted in two documents reviewed by the inspector, dated more than one year apart, that action was required regarding the use of one resident's money to purchase an insurance policy. In the more recent document, dated December 2021, an action plan indicated that a review regarding this matter was to be completed in January 2022. However this had not taken place and the insurance had since been renewed and paid for by the resident for another year. The person in charge advised that they had escalated this matter to more senior management and were awaiting guidance. The inaction by the provider regarding this issue meant that it had still not been assessed if this was the best use of the resident's money.

The inspector reviewed the training records available in the centre. The social care leader had good oversight of the centre's training needs and provided evidence of training sessions booked in the coming month for members of the staff team. However some gaps were still evident. These included fire safety training and training in infection prevention and control. It was planned that these training gaps would be addressed using online learning.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. This required review to reflect the current management personnel involved in the running of the centre, the reporting and staff supervision structure, the staffing arrangements at the weekends, and the transport resources allocated to the centre.

Planned and actual staff rotas were available in the centre. From a review, the inspector assessed the staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose. There was a regular staff team in place with a small group of relief staff also working in the centre, as needed.

To date no complaints had been made in the centre. The required templates were available, if required. Information regarding the complaints officer and the complaints processes were available, including in an accessible format developed for residents.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to register this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing was provided in the centre in line with the staffing levels as outlined in a statement of purpose. Additional staff were regularly employed in the centre to facilitate activities. There was evidence of continuity of support provided to the residents. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Training gaps were identified in the management of behaviour that is challenging including de-escalation and intervention techniques and medication management. This training was scheduled for March 2022. Some staff also required training in fire safety and infection prevention and control. It was planned to address these gaps using online learning.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

Although there was evidence of strong oversight in many areas of service provision, improvement was required in protection against infection procedures, development and review of residents' personal development plans, the fire safety precautions in place in the centre and the provision of behaviour support. It was also identified that

an ongoing issue regarding the use of one resident's finances had not been addressed by the provider.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the management personnel involved in the running of the centre, the reporting and staff supervision structure, the staffing arrangements at the weekends, and the transport resources allocated to the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all restrictions in place in the centre had been recognised. As a result their use had not been notified to HIQA, as is required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

No complaints had been made to date in the centre. The complaints policy was available in the centre, including in a format accessible to the residents.

Judgment: Compliant

Regulation 4: Written policies and procedures

Six of the 21 policies and procedures required to be maintained, as identified in Schedule 5 of the regulations, had not been reviewed within the last three years as is required.

Judgment: Substantially compliant

Quality and safety

Residents received person-centred care that supported them to be involved in activities that they enjoyed. Residents' independence and community involvement was encouraged and they appeared happy to live in this centre. Areas where improvement was required were identified. These included residents' personal development plans, the availability of recent assessments and plans to support residents at times of distress, measures to protect residents from infection, and the fire safety arrangements in the centre.

As previously outlined in this report, each resident attended a day service and was being supported to get to know their new local community by the staff team. All three residents regularly visited their family homes with staff supporting these visits, as requested. From the documentation reviewed by the inspector and from speaking with members of the staff team, it appeared that the move to this centre had been positive for all three residents. Residents and the staff team had received input from the provider's speech and language therapy department to support the move to this centre.

Two of the three residents living in the centre had hearing impairments. There was evidence throughout the house of visual aids in place to support residents' understanding and to provide them with opportunities to communicate with the staff team. The core staff team had all completed training in LÁMH (a sign system used by children and adults with intellectual disability and communication needs in Ireland) and this had been an agenda item at a recent staff meeting attended by speech and language therapist.

The inspector reviewed a sample of the residents' personal plans which were found to be comprehensive in nature and outlined supports that residents required. Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding healthcare plan who was in place. However, it was not always possible to tell if the effectiveness of these plans had been assessed or reviewed. There was evidence of regular appointments with medical practitioners including specialist consultants as required. There was also evidence of input from allied health professionals such as speech and language therapists. A number of referrals had also been submitted seeking additional supports from occupational therapy, psychology and behaviour support. A summary profile had been developed for each resident to be brought with them should they require a hospital admission.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. At the outset of their conversation with the inspector, the social care leader highlighted that residents' personal development plans were a key area for improvement. Additional input and guidance was being provided in this area by a member of the provider's quality team. The inspector reviewed the plans available. One resident did not have a plan developed in the last 12 months. The documentation available regarding their most recent plan, developed in December 2020, indicated that it had

not been reviewed at any time. Another resident's plan was completed in February 2021. In the following 12 months only one review, in May 2021, of the resident's goals had taken place. The provider's own processes outlined that a review was required every three months. Given these findings, management's focus on this area and the provision of additional supports was welcomed.

Some of the residents in the centre engaged at times in distressed behaviour. HIQA had been notified of minor injuries that had resulted from these behaviours. On review of these residents' files there was not always a plan in place to guide staff in how to support residents at these times. It was also noted that where plans were in place they had not been reviewed in the last 12 months, as is required by the regulations. Previous plans referenced matters that no longer applied since the residents moved to this centre. Referrals had been submitted seeking additional supports in this area.

As outlined previously, residents moved freely throughout the centre. There were storage facilities in each bedroom and residents had access to their own belongings. When walking through the centre, it was identified that some food items, including bread and chocolates belonging to residents, were stored in the staff bedroom which was locked. It was also identified that sharp knives were locked away when not in use. This was a control measure implemented to mitigate the risk posed by an assessed hazard. The restricted access to these items had not been recognised as a restraint and therefore had not been subject to the provider's own policy and procedures regarding restrictive practices or reported to HIQA, as is required by the regulations.

As outlined in the opening section of this report, the house was observed to be clean and recently decorated. Some maintenance issues had been addressed, others were on a waiting list, and others were identified in the course of this inspection. However the garage, which was included in the floor plan of the designated centre, was in a poor state of repair. The inspector observed it to be unclean, with a recently broken window, and a hole in the roof. It was therefore not suitable for the storage of food. The person in charge informed the inspector that the recently purchased a freezer and refrigerator would not be installed in the garage until maintenance works had been completed.

An audit of the infection prevention and control (IPC) practices in the centre had been completed monthly since the centre was registered. The inspector reviewed these audits and noted that the same results were noted each time and the same action was carried over on each document, namely the need to do a full review of the centre's IPC procedures at a staff meeting. Given the ongoing pandemic and the importance of protecting residents and staff from all infections, this topic should have been prioritised. It was also noted that the gap identified in this inspection regarding one staff member's infection prevention and control training was not identified through this audit process. A monthly checklist had also been completed by the centre's IPC lead which also did not identify this training gap.

All of the infection prevention and control training completed by staff had been done online. The inspector asked if there had been any practical training assessment or

auditing of IPC practices. The social care leader advised that they had recently requested that a trainer within the organisation complete practical hand hygiene assessments with the staff team. No dates had been confirmed at the time of this inspection. While in the centre the inspector observed one staff member wearing multiple rings and nail varnish. This was not consistent with the provider's own IPC policies and procedures.

As outlined previously in this report, with the exception of the garage, the centre was observed to be clean. There was a cleaning checklist in place. The inspector identified a number of gaps on this checklist in recent weeks. The social care leader advised that while they regularly checked the premises for cleanliness they did not routinely review the checklist. They advised they would begin to do this and would discuss the cleaning checklist at the next staff meeting. Although clean, some damaged surfaces were observed, for example on the storage unit in one of the communal bathrooms. As a result it would not be possible to effectively clean this surface.

The inspector reviewed the COVID-19 contingency plan in place for the centre. This required some additional information regarding the staffing arrangements / allocation should one or more residents be either suspected or confirmed to have COVID-19. Through discussion it was identified that the information in the plan regarding isolation hubs also required review.

It was planned that residents' meetings were held monthly in the centre. However these had occurred more regularly since the residents moved into the centre in November 2021. Topics covered at these meetings included visits to family members, outings and activities, upcoming celebrations such as Christmas, and if the introduction of visual supports to facilitate choice at mealtimes. A review of documentation, the inspector's observations and conversations with members of the staff team indicated that residents' rights were promoted and that residents enjoyed living in this centre.

Each resident in the centre had a folder with accessible documents. These folders included easy-to-read information regarding safeguarding, the provider's complaints process and the HIQA national standards. The information in these folders needed to be updated as they did not include the residents' guide relating to this centre. Although it had been provided to HIQA as part of the registration application, the residents' guide was not available in the centre and had not yet been provided to the residents.

There were no safeguarding concerns in the centre at the time of this inspection. The inspector reviewed the risk register. Although only developed in recent months, some high-rated risk assessments had not been reviewed within the documented timelines. The scoring of some risk assessments required review to ensure that they were reflective of the risk posed by identified hazards in the centre. For example in discussion with the social care leader they acknowledged that the implementation of the outlined control measures in place, which included staff supervision when in the kitchen, effectively reduced the likelihood and therefore overall risk posed by a resident eating food directly from the freezer. Actions generated from the December

2021 multidisciplinary reviews of residents' personal plans included specific risk assessments. These had not been completed at the time of this inspection.

Systems were in place and effective for the maintenance of the fire detection and alarm system and emergency lighting. Residents all had personal emergency evacuation plans (PEEPs) in place, and these were in the process of being revised. The social care leader explained that given the location of the centre on a busy road and the assessed needs of the residents, consideration had been given to revising the assembly point. All three residents of the centre had been assessed as requiring staff support to evacuate. Two of the residents had hearing impairments and poor road safety awareness. One fire evacuation drill had been completed since the residents moved into the centre in early November 2021. On review, it was identified that only two of the three residents had participated in this drill. The third resident was in their family home at the time. Management committed to completing a drill involving all three residents on the day of inspection. It was also observed that the primary escape route from the centre included two doors which were routinely locked, each with a different key. Keys were available in break glass units. Given the assessed needs of the residents, the location of the centre, and the staffing arrangements by night (where one of the two staff on duty is asleep), the inspector requested that the evacuation procedure including the escape routes be revised by a competent person.

Regulation 10: Communication

Residents were supported to communicate in line with their assessed needs and wishes. Staff had a good awareness and understanding of each resident's needs and required communication supports. There was evidence of a total communication approach in the centre.

Judgment: Compliant

Regulation 11: Visits

Although most often residents chose to visit their family homes, residents were welcome to have visitors in the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents in the centre had access to their personal belongings. There was adequate space and storage in each resident's bedroom. Residents had the opportunity to be involved in the management of their laundry in line with their preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with their wishes, interests and assessed needs. Staff had a good knowledge of residents' preferred activities and were supporting them to get to know and spend more time in their new community. One resident was benefitting from an integrated day service that was based from the centre.

Judgment: Compliant

Regulation 17: Premises

The premises were clean and decorated in line with residents' interests and preferences. Parts of the centre were in need of maintenance such as replacing bedroom lights and repairs to flooring. Although not in use at the time of the inspection, the garage was included on the floor plans of the designated centre. This was in a poor state of repair and not suitable for the storage of food as was planned.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with choice at mealtimes which consisted of wholesome and nutritious food. One resident's individual dietary requirements were met in the centre. The staff had a good awareness of residents' support needs at mealtimes.

Judgment: Compliant

Regulation 20: Information for residents

The guide prepared in respect of the designated centre met all of the requirements of this regulation. However, although completed, the residents' guide had not been provided to each resident, as required by this regulation.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was evidence that residents were well supported with the transition between designated centres. A number of core staff from their previous centre continued to work with them. Consideration had been given to each resident's needs and preferences when setting up the environment in the designated centre. Input had also been provided by the provider's speech and language therapy department to aid the transition.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register had been recently reviewed. It was identified that further review was required to do ensure that the risk ratings were reflective of the risk posed by the hazards identified and that specific assessments were reviewed in line with the stated timelines.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19.The centre was observed to be clean however some surfaces in high risk areas, such as a shared bathroom, were damaged so could not be cleaned effectively. While there was observed good practice in line with the centre specific guidelines and provider's policies on the day of inspection, it was noted that one staff member was wearing nail varnish and a number of rings. This was not consistent with the provider's policies and procedures. Practical assessments of hand hygiene had been proposed but were not yet planned. A review of the centre's contingency plan was required to ensure that staffing arrangements were clearly outlined and all information regarding the use of isolation hubs was up to date. Infection prevention and control audits had been

completed monthly however the one action generated from each of these audits since the centre had opened had yet to be completed.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. One evacuation drill had taken place since the centre opened, however all three residents of the centre were not present at the time. Management committed to completing a fire drill on the day of inspection. The main escape route from the centre involved two locked doors, each locked with a different key. Given the assessed needs of the residents, the location of the centre, and the staffing arrangements by night (where one of the two staff on duty is asleep), the inspector requested that the evacuation procedure including the escape routes be revised by a competent person.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. The effectiveness of some plans needed to be assessed to ensure they were addressing residents' identified healthcare needs. Improvements were also required in the development and review of residents' individual goals. Work was underway regarding residents' personal development plans at the time of this inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one, did not have a recently reviewed behaviour support plan in place. Plans and assessments that were in place either did not reflect the recent move to a new environment or else did not provide guidance regarding specific behaviours.Referrals had been submitted requesting specialist input in this area. Some restrictive procedures in place in the centre had not been identified as such and had therefore not been subject to the requirements of the provider's own policy. Referrals to the provider's restrictive practice oversight committee were sent on the day of inspection.

Judgment: Substantially compliant

Regulation 8: Protection

There were, and had been, no safeguarding concerns in the centre at the time of this inspection. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the residents' individual needs. Residents were encouraged and supported to increasingly exercise choice and control in their daily lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially 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 No. 4 Bilberry OSV-0008060

Inspection ID: MON-0034468

Date of inspection: 16/02/2022

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will ensure that staff have access to all appropriate training, including refresher training. Staff that have not completed Positive Behaviour Support raining have been submitted to the training department for Introduction to Positive Behavior Support training and MAPPA training on the 7/3/21. All training will be completed by 30/6/2022. Medication Management training for 1 staff was completed 9th and the 10th of March 2022 and a practical examination was completed on the 22/03/2022. All outstanding staff for IPC and fire safety training are currently completing this training on-line for completion by 30/3/22. The Person in Charge will ensure that the Staff Team are included in the IPC audits and audit finding in the Centre as part of their practical IPC training.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has ensured that :- - The Team Leader reviews to cleaning schedule and that all identified gaps are followed up on a timely basis. - The Person in Charge has reviewed the quarterly IPC and the Monthly IPC Audit with the Team Leader 16/3/22	

- The PIC will ensure that all Staff will have completed all IPC refresher training by 30/3/22.
- The Provider has ensured that a maintenance plan has been developed with the Facilities Department which includes all IPC maintenance. 11/3/22 and that these works together with other maintenance works are completed by 31/07/2022
- The Person in Charge has reviewed all personal development plans with the Team Leader and with the Keyworkers. All POMS meetings for the Persons Supported took place on the 8/3/22 supported by the Quality team and other relevant stakeholders including Persons Supported and family members. Quarterly reviews will take place accordingly.
- The PIC has ensured that all persons supported have participated in a fire drill, the last fire drill took place on the 18/2/22.
- The PIC has ensured that referrals have been submitted to Positive Behaviour Support Services for two of the Persons supported. The PIC and the SCL have had a phone consultation with an Intensive Support Worker on the 21/2/22 to discuss these referrals.
The Local Procedure for the Management of Monies that belong to Persons Supported by the Services will be reviewed and updated and will include guidance on supporting individuals to do a cost/benefit analysis of maintaining private health insurance having regard to impact on their quality of life. The procedure will be applied to the individual residents who currently make private health insurance payments and outcome discussed with individual/their representative for final agreement on whether to continue with the policy or not. [31/5/22]

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Provider will review and update the Statement of Purpose of the Centre to reflect the management personnel involved in the running of the Centre, the reporting and the staff supervision structure, the weekend staffing arrangements at the weekends and information on transport, currently shared with Day services. [31/3/22]

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge has completed a restrictive practice audit with the Team Leader on 16/3/2022. Where practices are restrictive, referrals have been submitted to Services Behavior Standards Committee for sanctioning.

The PIC will return all restrictive practices in the next quarterly notifications to the Authority. 30/4/2022

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The Provider will ensure that all policies required under Schedule 5 are updated 30/6/22	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Provider has ensured that a maintenance plan has been developed with the Facilities Department which includes building works on the garage to bring the building up to the required building standards. This work will be completed by 31/07/2022	
Regulation 20: Information for residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Information for residents: The PIC has ensured that each of the residents have a copy of the Residents Guide in their bedrooms for their information. 16/3/22	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider has ensured that the Centre's Risk Register was reviewed on the 10/3/22. All risk ratings were reviewed and are reflective of the risk posed. The PIC will continue to support the Team Leader to ensure that the risk assessments are reviewed in line with the Organisation's stated time lines.
As part of the review the following identified risks were included on the register,
- the risks of consumption of chemical products
- the risk associated with the storage of sharp knives
- The risks of over-consumption of food items such as bread and dilute.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider has ensured that a maintenance plan has been developed with the Facilities Department which includes all IPC maintenance. 11/3/22
All works will be completed by the 31/07/2022

The PIC has discussed the Services policies with the staff team along with a full discussion of the Services guidelines on infection control procedures on the 16/3/2022. All staff are aware of their role and will work to the Services Guidelines. The PIC and Team leader will seek to involve staff team members in the ICP audits and feedback findings to team meeting for practical learning purposes.

The PIC will arrange for hand hygiene assessments to take place in the Centre. Assessments will be completed by the 30/4/2022.

A full review of the Centre's contingency plan was completed by the PIC. All information in relation to staffing arrangements and isolation hubs in the event of a Covid 19 outbreak has been updated. 16/3/2022

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Provider has ensured that all Persons Supported have participated in a fire drill, the last fire drill took place on the 18/2/22.

The Provider will ensure that a review of the evacuation procedure and current escape routes will be reviewed by the Services Fire Safety Officer 30/4/2022.

The Person in Charge has ensured that all staff training gaps are planned to be addressed by 31/3/22

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:
The PIC will ensure that the Services Nurse Oversight will review the effectiveness of each residents identified healthcare plans by 30/4/2022
The PIC has reviewed all personal plans with the SCL with the Keyworkers. All POMS meetings for the Persons Supported took place on the 8/3/22 supported by the Quality team and other relevant stakeholders including Persons Supported and family members. Quarterly reviews will take place of Personal Goals.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider has ensured that
- The PIC has ensured that referrals have been submitted to Positive Behaviour Support Services for two of the Persons supported. The PIC and the SCL have had a phone consultation with an Intensive Support Worker on the 21/2/22 to discuss these referrals.
- Current Behaviour Support Plans will be reviewed and updated Guidance will be made available to all staff on how to support residents during periods of distressed behaviours will be set out [30/4/22]
- The PIC has completed a restrictive practice audit with the SCL 16/3/2022. Where practices are restrictive, referrals have been submitted to Services Behaviour Standards Committee for sanctioning.
- The PIC will return all restrictive practice notifications to the Authority on a quarterly basis as required by the regulations. 30/4/2022

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	30/06/2022
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	31/07/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/07/2022
Regulation 20(1)	The registered provider shall	Substantially Compliant	Yellow	16/03/2022

	prepare a guide in respect of the designated centre and ensure that a copy is provided to each resident.			
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.	Substantially Compliant	Yellow	31/05/2022
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	10/03/2022
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	Not Compliant	Orange	31/07/2022

	healthcare associated infections published by the Authority.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/04/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/03/2022
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/03/2022
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	Not Compliant	Orange	30/04/2022

	occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/06/2022
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/04/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or	Substantially Compliant	Yellow	30/04/2022

	circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	08/03/2022
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.	Substantially Compliant	Yellow	30/04/2022
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	Substantially Compliant	Yellow	16/03/2022

	evidence based practice.			
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/04/2022