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:	The Beeches
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	28 September 2023
Centre ID:	OSV-0003322
Fieldwork ID:	MON-0032172

About the designated centre

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

The Beeches is a designated centre operated by Sunbeam House Services Company Limited by Guarantee located in a town in County Wicklow. This designated centre provides community residential care for up to four adults (male or female) who are over the age 18 years. The designated centre supports people who have severe and profound learning disabilities and may also have physical disabilities. The designated centre is a detached bungalow which consists of four individual resident bedrooms, kitchen, living room, conservatory, shared bathrooms and a staff office. Residents are supported to participate in their local town by using the local shops, barbers, and restaurants. The centre is staffed by a person in charge, a deputy client service manager, social care workers, care assistants and a household staff.

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
Thursday 28 September 2023	10:00hrs to 18:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to inform a registration renewal recommendation for this designated centre. The inspection was announced. A 'nice to meet' you document had been posted to the designated centre in advance of the inspection, which included a photograph of the inspector and the reason why they were visiting the resident's home including information about the inspection process. The person in charge had ensured that the document was made available to residents and their families, with a copy of the document hanging in the house's entrance hall.

On the morning of the inspection, the inspector was provided the opportunity to speak with some of the residents living in the centre. Residents welcomed the inspector and it was clear through engagement with residents that they had been made aware of the inspector's visit.

Through the support of their staff, residents relayed to the inspector their plan for the day. One resident had a chiropody appointment and later was going to the local shopping centre for lunch in one of the cafes. The other resident had plans to enjoy a foot massage that morning and later in the day to visit the shopping centre as well. The inspector observed conversations between the staff and residents to be jovial and light-hearted and residents appeared relaxed and comfortable in their environment. Later in the day the inspector meet the other two residents. One resident had enjoyed an early morning Indian head massage at a nearby local hotel and the other resident, who had returned from a break away, spend most of the day relaxing in their room as well as watching a movie later in the afternoon.

The inspector met with a number of staff throughout the day and spoke in detail with two members of staff. The staff were aware and knowledgeable in the support needs of residents as well as each of the residents' likes and preferences. On observing staff interacting and engaging with residents who expressed themselves through non-verbal communication, it was clear that staff could interpret what was being communicated.

Where appropriate, management and staff advocated on behalf of residents to ensure better outcomes for them. The inspector was informed specialised sensory equipment which was in line with recommendations from an allied health profession had been sourced and purchased for the resident. Staff informed the inspector that the resident had used similar sensory equipment in another service and was aware of how much the resident enjoyed it. There were plans for the equipment to be installed the following week. A member of the resident's family had been consulted in relation to this arrangement also. Overall, the inspector found that while this was a very positive outcome for the resident, improvements were needed so that the consultation process with the resident was clearly documented in their personal plan.

The inspector was informed that two of the residents had recently enjoyed a holiday

away at a forest based holiday resort in Ireland. Staff expressed to the inspector the positive impact the holiday seemed to have residents, including how much each resident appeared to enjoy one to one time as well as spending time in an accessible outdoor environment where they were surrounded by lakes, forests and nature trails.

Overall, the inspector found that residents were provided with a good choice of community activities. Residents attended concerts, visited places that reminded them of their past, went to petting farms and other locations where there were horses and animals of their liking. Residents also enjoyed spending time in the local shopping centre and eating out in cafes and restaurants.

The inspector was informed that residents enjoyed participating in different activities in their own home. For example, residents were supported to part-take in activities such as cooking and baking, spending time on the garden accessible swing, getting hand and foot massages, having their hair done and nails painted, watching movies, listening to music and spending time in their rooms with musical equipment.

Residents and their families were consulted in the running of the centre and played an active role in the decision making within the centre. In advance of the inspection, residents and their families were provided with the option of completing Health Information and Quality Authority (HIQA) questionnaires. On review of the questionnaires, the inspector say that four HIQA Questionnaires had been completed by key working staff who were advocating on behalf of residents. In addition, the inspector was provided with two of the centre's own questionnaires which had been completed by residents' families.

In general, residents relayed in the questionnaires that they were happy with the activities they engaged in, both in their home and out in the community. Some residents noted that their family were always made welcome when they called and that they were provided privacy when they visited. Residents noted that they were happy with the support they receive from their staff. For the most part, residents and their family noted that they were happy with the amount of choice they were provided around their daily lives. Both resident and their families relayed that they knew who to go to should they want to make a complaint.

Overall, family questionnaires were positive in their feedback and very complimentary about the care and support provided by staff. One family member expressed that there was a 'fantastic staff team and management' working in the centre.

While most of the comments were positive, residents and their family had noted some improvements that they would like to see. One resident noted that they would like to be able spend time in the centre's garden and in particular, requested handrails to support them better access to the outdoor space. One resident noted that they would like more space in their bedroom while another resident said they would prefer a bigger bedroom.

In addition, to the above improvements noted, residents and their families had also raised some issues through the annual report consultation process. For example, in

relation to residents' right to privacy and dignity, a resident referred to their peer entering their bedroom, turning off plugs and shouting. The resident also made reference to the security of their belongings. Another resident raised an issue of negative verbal interactions by a peer.

The designated centre was a detached bungalow which consisted of four individual resident bedrooms, a kitchen, living room, conservatory, shared bathroom, a laundry room, toilet and a staff office. During a walk around of the centre, the inspector observed that the management and staff team were endeavouring to provide the house with a homely and welcoming atmosphere. Many of the walls in the communal areas of the house contained pictures and framed photographs of residents and their families. On observing residents' bedrooms, the inspector saw that residents bedrooms were decorated in line with their likes and wishes and included family photographs, pictures, televisions, music equipment and memorabilia that was personal and of interest to them.

For the most part, the inspector observed the physical environment of the house to be clean and tidy however, not all areas of the premises were conducive to a safe and hygienic environment. There were a small number of improvements made to some of the facilities since the last inspection. For example, there had been improvements to the layout and décor of the sitting room; a new sofa had been purchased and an office desk and chair removed from the room. There were further plans to add more shelving to add a more homely look to the room. In addition, one resident's bedroom had being recently painted. The flooring of entrance from the living room to the kitchen had been altered to allow better access for residents between rooms.

During the walk-around of the house, the inspector observed residents' mobility equipment, personal care item and deliveries to be stored in a number of communal rooms. On the day of the inspection, a delivery of large boxes containing new sensory equipment had arrived however, as there was no other place to safely store it until it had been installed, it was stored in the conservatory room. There were large cupboards in the same room which contained personal care items as well as personal protective equipment.

A new fridge had been purchased and installed in the kitchen however, the inspector observed that the removal of the old fridge resulted in gaps in kitchen units which meant that the area could not be cleaned effectively. Throughout the house the inspector saw a lot of scuffing and chips on walls and doors and door frames and the communal bathroom needed upkeep and repair to the facilities in the room.

Upgrades to the garden area of the house was needed to ensure the house met the needs of all residents, at all times. Upgrades were also needed to ensure the space was accessible to everyone and promoted residents' independence as much as possible. While there was a wheelchair accessible path to and around the garden, other supports were needed so that all residents could access the garden as independently as they were capable of.

In summary, the inspector found that the person in charge and staff were

endeavouring to ensure each resident's well-being and welfare was maintained to a good standard. There was a strong and visible person-centred culture within the designated centre. Residents were provided with choice and options in line with their likes and preferences. The person in charge and staff were striving to promote an inclusive environment where each of the resident's needs, wishes and intrinsic value were taken into account.

The poor state of repair of walls, doors and door frames and bathroom issues had been identified on the previous HIQA inspection in February 2022. Overall, the inspector found that there was considerable upkeep and repair needed in the house. The poor state of repair of the house meant that not all areas of the house could be cleaned effectively and overall, posed a potential risk of the of spread of healthcare-associated infections to residents and staff.

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

The inspector found that the person in charge and staff were striving to provide a safe and good quality service to residents living in the designated centre. The inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of the residents through person-centred care and support. Staff working in the centre were aware of their responsibilities and who they were accountable to. The service was led by a capable person in charge, supported by a deputy manager, a person participating in management and a staff team who were knowledgeable about the support needs of the residents living in the designated centre.

For the most part, there were governance and management systems in place to ensure that the centre was monitored effectively. The inspector found that further to the annual report and six monthly unannounced reviews of the quality and care and support provided to residents, there was a local auditing system in place by the person in charge. The audits were in place to evaluate and improve the provision of service and to achieve better outcomes for residents living in the centre.

The provider and local audits had identified outstanding upkeep and repair work needed to the premises as well as an overall upgrade to the house to ensure it continued to meet all residents' assessed needs. Overall, the inspector found that the timeliness of the provider in addressing the upkeep and repair works, which had also been identified during a HIQA infection, prevention and control inspection in February 2022, was not satisfactory. The poor state of repair of the house was was impacting on the safety, wellbeing, and rights of residents. This matter is discussed

in more detail in the quality and safety section of the report.

Through speaking with the person in charge, the inspector found that they demonstrated sufficient knowledge of the legislation and their statutory responsibilities of their role. The person in charge was familiar with residents' needs and endeavoured to ensure that they were met in practice. There was evidence to demonstrate that the person charge was competent, with appropriate qualifications, skills and sufficient practice and management experience, to oversee the residential service and meet its stated purpose, aims and objectives.

There was a staff roster in place in the centre and overall, it was maintained appropriately. The staff roster clearly identified the times worked by each person including the person in charge and the deputy manager. The inspector reviewed a sample of the centre's actual and planned rosters and saw that there was sufficient numbers of staff with the necessary experience and competencies to meet the needs of residents on a daily basis, however there were a number of staff vacancies which potentially posed a risk to the continuity of care.

The inspector reviewed a sample of staff files and found that they included all Schedule 2 requirements. The inspector spoke with staff throughout the day who demonstrated appropriate understanding and knowledge of policies and procedures that ensure the safe and effective care of residents. The inspector found that, for the most part, staff had the necessary competencies and skills to support the residents that lived in the centre and had developed therapeutic relationships with the residents. On the day of the inspection the inspector observed kind, caring and respectful interactions between staff and residents throughout the day. The person in charge had identified that positive behaviour support training was needed for the staff team and there was a plan in place for the organisation's positive behavioural supports specialists to deliver a course that was tailored to residents' specific needs.

The inspector saw that overall, staff mandatory training was up-to-date and a training needs analysis had been completed to enable staff provide care that reflected best practice. There was a training schedule in place for all staff working in the centre and this was regularly reviewed by the person in charge. The inspector found that staff had been provided with the appropriate mandatory training such as safeguarding, fire safety, safe medicine management, food hygiene and human rights, but to mention a few. Staff were also provided with an array of additional training that was specific to residents' assessed needs.

There was a schedule in place for staff one-to-one supervision and performance management meetings to support staff perform their duties to the best of their ability. Staff advised the inspector that they found these meetings beneficial to their practice.

Overall, the registered provider had established and implemented effective systems to address and resolve issues raised by residents or their representatives. Systems were in place, including information on advocacy services, to ensure residents had access to information which would support and encourage them express any concerns they may have. Complaints received were responded to in a timely manner

and satisfaction levels were recorded.

Overall, the inspector found, on review of a sample of policies, that Schedule 5 policies and procedures were in place and up-to-date. For the most part, the policies and procedures in place in the centre were relevant and were an important part of the governance and management systems to ensure safe and effective care was provided to residents including, guiding staff in delivering safe and appropriate care. However, on review of the centre's safeguarding policy, the inspector found that improvements were needed to ensure it included sufficient information to ensure its effectiveness.

For the most part, the inspector found that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. However, improvements were needed to the information governance arrangements in place to ensure that the designated centre complied with notification requirements at all times.

Registration Regulation 5: Application for registration or renewal of registration

Overall, the application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

There was a new person in charge since the last inspection. They had commenced their role in the designated centre in April 2023. They divided their role between this centre and one other.

The inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives. The person in charge was familiar with the residents' needs and was striving to ensure that they were met in practice.

The inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the person participating in management and a deputy manager, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Staff informed the inspector that they felt supported by the person in charge and that they could approach them at any time in relation to concerns or matters that

arose.

Judgment: Compliant

Regulation 15: Staffing

On a daily basis, staffing arrangements included enough staff to meet the needs of the residents however, current staffing levels were not in line with the statement of purpose. There were four staff vacancies; 1 x permanent role (124 hours p/m) and 3 x specified purpose roles (169, 130, 100 hrs/pm)

The person in charge endeavoured to ensure continuity of care. Core staff team members, who were employed on a part-time basis, worked additional hours to cover gaps on the roster. Staff from another designated centre, managed by the person in charge, who were familiar to residents, also covered gaps on the roster. Relief and agency staff were employed on occasion however, where this was the case, the person in charge employed the same people as much as possible.

There was a staff roster in place and overall, it was maintained appropriately. For the most part, the staff roster clearly identified the times worked by each person including the person in charge and the deputy manager. On the day of the inspection, the person in charge made a small enhancement to the roster to ensure it better reflected work-shifts completed by agency staff.

Staff who spoke with the inspector demonstrated good understanding of the residents' support needs, their personalities and overall their likes and preferences. Staff advocated for residents on a regular basis which resulted in positive outcomes for residents. Staff were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents living in the centre.

There was a training matrix in place that supported the person in charge to monitor, review and address the training needs of staff. Overall, staff training was up-to-date including refresher training. In line with a resident's recent changing needs, the person in charge had identified the need for positive behaviour support training. There was a plan in place to provide this training to staff within the next month.

Staff were provided with training in safeguarding, fire safety, safe medicine practices, epilepsy, Feeding Eating Drinking and Swallowing Difficulties (FEDS) and Human Rights, but to mention a few.

Supervision and performance appraisal meetings were provided for staff to support them perform their duties to the best of their ability.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

Judgment: Compliant

Regulation 23: Governance and management

The provider had carried out a review of the quality of care and support provided to residents living in the centre through an annual review and through six monthly unannounced reviewed. The annual report covered the period between August 2022 and 2023 and was comprehensive in nature. The report acknowledged the outstanding upkeep and repair work needed in the centre and the negative impacts in posed to the residents including the associated infection control risks. The providers health and safety audit, completed in 2023 also acknowledged the outstanding upkeep and repair work that was required to be completed.

There was a tentative plan in place which was at the initial stages. Overall, the inspector found that the provider had not provided adequate assurances that the centre's premise would come into compliance within an appropriate timeframe. The inspector was advised that consultation with residents and families, regarding the plan, had yet to take place and that this could possibly lead to changes to the current plan in place.

Some improvements were needed to the information governance management systems in place to ensure their effectiveness at all times. The provider had not submitted the required information requested to be sent ten days in advance of the inspection. For example, the centre's safeguarding policy, the risk management policy or the centre's most recent annual report had not been submitted to HIQA as required.

Notwithstanding the above, in addition to the annual report and six monthly unannounced reviews completed, the provider had completed an medicine management audit, a health and safety audit and an infection prevention and

control audit. Furthermore, the person in charge carried out monthly audits of different service delivery areas to assist them in ensuring that the operational management and administration of the centre resulted in safe and effective service delivery.

Team meetings were taking place regularly and they demonstrated reflective practice and shared learning among the staff team.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was in place for the designated centre. The statement of purpose was found to contain all of the information as required by Schedule 1 of the regulations. The statement of purpose had been recently reviewed and updated and was available to residents in the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

In general, the person in charge had ensured that incidents occurring in the designated centre, required to be notified to the Chief inspector, including three day, quarterly and six-monthly, had been notified.

However, on review of a complaint and two issues of concern, recorded on the designated centre's online system, (that resulted in negative impacts for other residents), the inspector found that the appropriate notification related to these incidents, had not been submitted to office of the Chief Inspector.

On two occasions where a NF06 had been submitted, improvements were needed to the information contained within the notification to ensure adequate assurances were provided. For example, not all notifications provided sufficient information to demonstrate that they had been appropriately screened and submitted to the national safeguarding team.

Judgment: Not compliant

Regulation 34: Complaints procedure

There had been four complaints logged in the designated centre in the last twelve

months. Some of the complaints were made by family members and some by staff advocating on behalf of residents.

There was an effective complaints procedure that was in an accessible and appropriate format which included access to an advocate when making a complaint or raising a concern.

This procedure was monitored for effectiveness, including outcomes for residents and endeavoured to ensure that residents received good quality, safe and effective services.

Overall, the inspector found that where a complaint had been made, they had been dealt with in an appropriate and timely manner with actions were followed up and overall, satisfaction levels noted.

Judgment: Compliant

Regulation 4: Written policies and procedures

Overall, on review of a sample of policies, the inspector found that Schedule 5 policies and procedures were in place and up-to-date. There were systems in place that ensured staff were informed and knowledgeable of the policies and procedures in place.

On speaking with the person in charge and a number of staff, the inspector was advised that, where changes, updates or new policies were made, the person in charge notified staff of the changes through email and at team meetings. There was an online system where staff reviewed the policies which also monitored if staff had read and understood them.

However, on review of the updated safeguarding policy in place, the inspector found that further review was needed. This was to ensure that the policy was comprehensive in nature and contained sufficient information to ensure it guided staff in delivering safe and appropriate care. This has been addressed under regulation 8.

Judgment: Compliant

Quality and safety

The inspector found that the person in charge and staff were endeavouring to ensure that residents' well-being and welfare was maintained by a good standard of evidence-based care and support. It was evident that the person in charge and staff

were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. However, the inspector found, that to ensure better outcomes for residents, as well as a safer environment, significant improvements were required to the upkeep, repair and layout of the premises. In addition, improvements were also needed to the areas of positive behavioural supports, safeguarding procedures and fire precautions.

Overall, the inspector found that the design and layout of the premises had not ensured that residents were living in an accessible, safe, comfortable and homely environment. In addition, a number of the outstanding upkeep and repair works meant that they could not be cleaned effectively and in turn posed a potential infection prevention and control risk.

An previous inspection of the designated centre in February 2022 found that the provider was at the initial stage of exploring potential changes the layout and structure of a number of rooms in the house to ensure that the premises continued to meet the changing needs of residents living in the designated centre. On this inspection over a year later, there was now a plan, but it was at the initial stages and was tentative until stakeholder consultation had taken place.

Overall, the poor upkeep and repair of the premises, the lack of storage space, the size of bedrooms and the layout of the kitchen and conservatory, was negatively impacting on residents' lived experience in their own home.

There had been some improvements to the infection prevention and control measures in place in the house since the last inspection and in particular, to the local monitoring systems in place. The person in charge had put in place new and improved cleaning checklists, including deep cleaning checklist and a flushing check list. There were improvements to cleaning and decontamination of residents equipment. A residents bedroom and a communal toilet facility had been painted and new seating had been purchased for the sitting room.

However, due to the ongoing poor state of upkeep and repair of the premises, the provider had not ensured that residents were in receipt of care in a safe and clean environment that minimised the risk of acquiring a healthcare-associated infection.

All staff had received up-to-date training in the safeguarding and protection of vulnerable adults. Staff spoken with were familiar with reporting systems in place, should a safeguarding concern arise and safeguarding was regularly discussed at staff meetings.

There had been an increase in safeguarding incidents notified to the office of the chief inspector since the last inspection. This trend primarily related to behavioural incidents occurring in the centre, that were impacting negatively on other residents. However, the inspector found that not all incidents of a potential safeguarding nature were appropriately screened. The arrangements in place did not ensure that, on all occasions, when potential safeguarding risks were raised by staff or the person in charge, that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements.

The organisation's safeguarding policy had been reviewed and updated in July 2023 however, the inspector found that the policy did not contain sufficient detail to demonstrate that it was consistent with relevant legislation, professional guidance and international best practice and a further review of the policy was required.

Overall, the provider and person in charge promoted a positive approach in responding to behaviours that challenge. Staff had been provided with training in behaviours that challenge and de-escalating techniques. The person in charge had identified that positive behavioural supports training was needed to enhance the training already provided to staff and overall, to ensure better outcomes for residents.

There were systems in place to ensure that where behavioural support practices were being used that they were documented and reviewed. However, the inspector found one instance where a resident who was presenting with behaviours that challenge had not been referred to the appropriate professional in a timely manner. In addition, the positive behaviour support plan in place for the resident had not underwent an appropriate clinical review in three years. As a result, the resident was not adequately supported to manage their behaviours and at times, this had impacted negatively on other residents.

The inspector saw there where restrictive procedure were being used, they were based on centre and national policies. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual. The restrictive policy and procedure had been reviewed and updated by the provider in 2023. The person in charge and staff had carried out a review of the restrictive practices in place in the centre, which resulted in better outcomes for residents and ensured that the least restrictive for the shortest duration was in place.

For the most part, the inspector found that the systems in place for the prevention and detection of fire were observed to be satisfactory. The fire-fighting equipment and fire alarm system were appropriately serviced and checked. Local fire safety checks took place regularly and were recorded. For the most part, fire drills were taking place at suitable intervals however, some improvements were needed to the frequency of them. On the day of inspection, a fire safety risk had been identified due the ineffectiveness of one of the corridor fire doors. The person in charge promptly followed up and the door was fixed within a few hours. However, the checking systems in place to monitor the effectiveness of the fire doors required review.

The provider had ensured that the risk management policy met the requirements as set out in the regulations. There was a risk register specific to the centre that was reviewed regularly. Individual and location risk assessments were in place to ensure the safe care and support provided to residents. Residents were supported to part-take in activities they liked in an enjoyable but safe way through innovative and creative considerations in place. For the most part, there were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre however, improvements were needed to ensure that appropriate risk assessment

were completed regarding the potential IPC risks the outstanding upkeep and repair work posed.

The inspector found that safe medical management practices were in place and were appropriately reviewed. There were written policies and procedures for the management of medicines in the centre, including on the prescribing, storage, disposal and administration of medicines. The inspector found that the medicine arrangements and practices were appropriate and in accordance with the provider's associated policy. The person in charge had ensured that the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing and disposal and administration of medicines.

Regulation 17: Premises

The upkeep and repair work posed a potential risk to the infection, prevention and control measures in place in the residents' home. In addition, the poor state of repair to some of the areas of the house, impacted on the homeliness and aesthetics of the residents' living environment. On a walk-around of the house, some of the areas of disrepair observed included, scuff marks on walls, badly scuffed and chipped timber and paint on doors and door frames, poorly filled-in holes in walls, gaps between kitchen units, raised exit door frames (impacting on egress) and warped shelving in the bathroom.

The lack of sufficient storage in the designated centre meant that residents' personal care items were stored in a large cupboard in the dining room. In addition, residents' mobility equipment was stored in communal spaces and in some cases parked in hallways while the resident was in their bedroom, which potentially obstructed or slowed down easy access to the fire evacuation route.

A number of residents required specialised manual handling equipment in their bedrooms which lessened the space in the rooms and in some cases impacted on the provision of adequate storage for residents.

There was a pathway leading out to the garden however, not all residents were able to access it as independently as they were capable of, due to lack of appropriate support railings.

The centre's annual report had identified, most of the above works including the provision of an external sheltered area to the front of the house (fire point area). In addition, the provider had identified that an upgrade to the house was needed so that it continued to meet the changing needs of residents however, the plans in place for the upgrade were at initial stages and very tentative.

The timeliness of completing the premises work was not satisfactory; Many of the above issues had been raised in a HIQA infection prevention and control inspection in February 2022 and remained outstanding.

The potential risks associated with the outstanding premises works and in particular IPC risks, had not been adequately assessed or included in the centre's risk register.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of the regulations. The guide was written in easy to read language and was located in an accessible place in the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured that the risk management policy met the requirements as set out in the regulations.

There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. There was a risk register specific to the centre that was reviewed regularly that addressed social and environmental risks.

For the most part, there were individual and centre risk assessment in place with appropriate control measure in place to mitigate the risk. However, the potential risks associated with the outstanding premises works and in particular IPC risks, had not been adequately assessed or included in the centre's risk register. In addition, the potential risks, associated with a resident entering other residents' rooms uninvited, required review. These have been addressed under Regulation 17 and 8.

Judgment: Compliant

Regulation 27: Protection against infection

There was considerable upkeep and repair required to the premises of the designated centre which was ongoing since the last inspection. This meant that all areas of the centre was not conducive to a safe and hygienic environment. In addition, not all surfaces could be effectively cleaned, which in turn, posed a potential risk of the spread of infection to staff and residents. (Primarily, the impact the outstanding upkeep and repair work has on IPC measures has been addressed under regulation 17).

Since the last inspection there had been some improvements to the systems in place that endeavoured to mitigate the risk of spread of infectious decease.

There were improvements to the cleaning checking list in place, which included a deep cleaning of areas of the house. More recently, the cleaning checklist had been further improved so that it was comprehensive in nature and more user-friendly than the previous system.

A weekly flushing checklist had been implemented for the taps in the bathroom to provide evidence that they were in use and cleaned. However, oversight of the check-list required improvement to ensure its effectiveness. For example, on reviewing samples of the monthly housekeeping audit, there were a number of gaps and anomalies regarding the weekly checklist that had not been followed up.

The plinth in the communal bath and shower room was observed to have rust on it. This had been identified on the previous infection, prevention and control HIQA inspection in February 2022 and on the provider's recent health and safety audit however, had not yet been addressed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety checks took place regularly and were recorded appropriately. The mobility and cognitive understanding of residents was adequately accounted for in the evacuation procedures and in residents' individual personal evacuation plans. All staff had received suitable training in fire prevention and emergency procedures, building layout and escape routes, and arrangements were in place for ensuring residents were aware of the procedure to follow.

For the most part, fire drills were taking place at suitable intervals however, improvements were needed to ensure that simulated night-time evacuations were taking place in a timely manner. A review of the most appropriate was to ensure residents could be evacuated safely during the night was completed and it was found that it would be more appropriate and less disruptive to residents to complete a simulated night-time evacuation instead. However, the development of a simulated plan was at an initial stage and it had been over a year since the previous night-time evacuation.

On the day of inspection, a fire safety risk had been identified due the ineffectiveness of one of the corridor fire doors. The person in charge promptly followed up and the door was fixed within a few hours. However, the checking systems in place to monitor the effectiveness of the fire doors required review. For example, there was a weekly fire safety check in place in the house where fire doors were checked for their effectiveness when the alarm sounded. On review of the checking list, the inspector saw that there were a number of gaps in the last two

months.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicines used in the designated centre were found to be used for their therapeutic benefits and to support and improve each resident's health and well-being. Medication was reviewed at regular specified intervals as documented in residents' personal plans. Overall, the practice relating to the ordering; receipt; prescribing; storing; disposal; and administration of medicines was appropriate

Residents' medication was administered by staff who were provided with appropriate training. On speaking with the inspector, staff were confident and knowledgeable regarding safe medicine practices and arrangements in the centre.

There were guidance documents in place to ensure that medicines were administered as prescribed and these were accurate and sufficiently detailed. Where there was PRN medication, (a medicine only taken as required), there was protocols in place to support and guide staff around their administration.

The inspector observed medicines to be securely and appropriately stored in a locked medicine cabinet. Where medicines were removed from the centre, for activities or family visits, there were safe systems in place to ensure the safe transport of the medicines.

There were numerous local checks in place to ensure safe medicine practise. In addition, an annual medication audit had been completed in October 2022 and an external pharmacy audit completed in March 2023.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that there was a system in place for assessing residents' needs and for ensuring that plans were in place to meet those assessed needs. On a review of residents' files, the inspector saw that care plans were updated annually and were written in a person-centred manner. Staff spoken with were knowledgeable regarding residents' assessed needs and were observed providing support that was in line with residents' care plans.

Residents were provided with an accessible format of their plan to support a better understanding of the content. In addition, residents were provided with 'memory books'. Staff supported the resident to design and make the books as a way of

remembering special occasions, milestone birthdays, family events and relatives who had passed. The books contained an array photographs, pictures and art and craft materials and were personal to each resident. The inspector was advised that residents enjoyed looking through the books and were often observed smiling and appeared happy when doing so.

There was a document audit included at the front of each resident's personal plan and this provided good oversight to the person in charge of the upkeep and update of the plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

There had been an increase in behavioural incidents in the designated centre, some of which resulted in safeguarding incidents.

On review of a positive behaviour support plan, the inspector saw that the resident had met with an appropriate allied health professional in 2020 and from this a plan was put in place in April 2020. However, there had been no further engagement or review by an appropriate allied health professional until April 2023. Overall, the timeliness of positive behavioural supports provided to the resident had not been satisfactory and potentially increased the risk of further behavioural incidents occurring in the centre.

There were a number of restrictive practices in place in the centre. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals. The restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis.

The person in charge carried out a review of restrictive practices in the centre and found a number of areas for improvement which overall, resulted in better outcomes for residents and a less restrictive environment. For example, where residents were provided with nightly sleep checks every thirty minutes, a review and assessment was completed which resulted in the restrictive practice ceasing for three residents and being reduced for one resident.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that the recent increase of peer to peer safeguarding incidents occur in the centre was primarily due to an increase in behavioural incidents, which had impacting negatively on other residents living in the house. On speaking with

staff and a review of records, the inspector found that the increase in behavioural incidents was likely due to the change of pain-management medication for a resident.

On review of incidents, the inspector found that the arrangements in place had not always ensured that potential safeguarding concerns, were appropriately reviewed, screened and reported in accordance with national policy and regulatory requirements.

While a number of safeguarding incidents had been appropriately reviewed, screened and followed up, this had not occurred in all cases. From a sample of records reviewed, two issues of concern and one complaint, which related to behavioural incidents that impacted negatively on other residents, had not been appropriately reviewed, risk assessed, screened or appropriately. For example, records relating to the two issues of concern clearly described the upset caused to two other residents. The complaint related to a behavioural incident that impacted on the privacy and dignity of a resident while they were in a very vulnerable situation.

The provider had updated their organisation's safeguarding policy in July 2023. The inspector found on review of the updated safeguarding policy that it was not comprehensive in nature and did not adequately demonstrate that it was written for the service, clear or easily accessible. While the policy referred to other legislation and professional guidance, including national safeguarding policy, it had not adopted the information adequately into the policy to ensure its effectiveness in guiding staff in delivering safe and appropriate care to residents.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for The Beeches OSV-0003322

Inspection ID: MON-0032172

Date of inspection: 28/09/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The recruitment process is ongoing to back fill open roles. Interviews have taken place and will continue to be scheduled. The PIC completes the roster at least one month in advance, where possible staff within the cluster will backfill the gaps, if required Agency staff are being used, all agency staff have received an induction and will be working with regular staff and are clearly marked on the roster.	
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 engaged a site inspection with an engineer, the outcome of this report will determine the next steps in the works project. On receipt of the outcome the provider will begin a consultation process with families and staff. 31/01/2024 Following a miscommunication on documents required prior to the inspection the PIC submitted the required documents prior to inspection date.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The incidents noted during inspection have now been notified to HIQA and the Safeguarding and Protection Team. Further guidance on submitting sufficient information notifications to ensure they have been appropriately screened and submitted to the national safeguarding team will be discussed at the next staff meeting scheduled.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The provider has engaged a site inspection with an engineer, the outcome of this report will determine the next steps in the works project and the plan will be updated with	

stricter timeframes.

As part of the upgrade works a storage solution will be factored in.

The provider will create a short term works list to address minor works which may pose a risk of infection to the residents.
Scuff marks on walls to be cleaned, chipped timber to be made safe, chipped paint to be removed. These works are scheduled to be completed by 31/12/2023

One resident now requires the support of a walker, the resident is accompanied by staff when using the walker and can access the garden pathway should they wish.

The IPC risks associated with the outstanding upgraded works have been added to the risk register. 07/11/2023.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The PIC will review monthly housekeeping audit to monitor it is completed accurately and outstanding tasks are followed up.
A new plinth is being ordered and will be in place by 31/12/2023.

The IPC risks associated with the outstanding upgraded works have been added to the risk register. 07/11/2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A revised nighttime evacuation plan was devised with PIC, PPIM in conjunction with the Quality and Compliance Senior Manager, this plan was then practiced on 27.10.23, this will be conducted monthly until all staff have completed same and PIC is happy with its delivery.

The Health and Safety rep will now include checking for gaps in the bell test records weekly and the fire door check records.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behavior training has been scheduled for 09.11.2023 with the provider's Behavior support Specialist.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
One residents pain management plan is under review with their GP, this has shown some improvements in the residents' presentation.

The incidents noted during inspection have now been notified to HIQA and the Safeguarding and Protection Team.

The PIC has discussed incidents which may be viewed as safeguarding with the staff team, all incidents are recorded on the providers software system and reviewed by the PIC and PPIM.

The Provider is currently reviewing the Safeguarding policy to ensure its effectiveness in guiding staff in delivering safe and appropriate care to residents. 31/12/2023

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2023
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.	Not Compliant	Orange	31/12/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
Regulation	The registered	Substantially	Yellow	31/12/2023

23(1)(c)	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.	Compliant		
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/12/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/10/2023
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	Substantially Compliant	Yellow	31/10/2023

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	11/10/2023
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	09/11/2023
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	09/11/2023

Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	31/12/2023