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:	Oakvale
Name of provider:	Health Service Executive
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	14 October 2024
Centre ID:	OSV-0002463
Fieldwork ID:	MON-0044915

About the designated centre

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

Oakvale provides high support residential care for up to 28 adults with an intellectual disability and/or autism and acquired brain injury. Oakvale is comprised of five separate bungalows located in a campus setting in County Cork. All 5 bungalows are joined by a link corridor. Two of the bungalows have five bedrooms while three of the bungalows have six bedrooms. Within each bungalow there is a kitchen/dining room, sitting room, bedrooms and bathrooms. All bedrooms are single occupancy rooms. Oakvale is the residents' home and is open twenty four hours a day, 7 days a week. Residents are supported through a medical model of care. The staff team is comprised of nurses and health care assistants who provide support to residents by day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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
Monday 14 October 2024	09:30hrs to 17:45hrs	Deirdre Duggan	Lead
Monday 14 October 2024	09:30hrs to 17:45hrs	Robert Hennessy	Support

What residents told us and what inspectors observed

From what inspectors observed residents in the centre continued to be in receipt of adequate day-to-day supports and were overall being well cared for in the centre. While this inspection found that improvements were occurring, there was limited evidence to show that the provider had full oversight of some ongoing non compliance in the centre or was responding to this in a timely manner. In particular, although noted improvements had been made in relation to the activation of residents, some residents continued to have limited access to community based activity and opportunities to leave the centre regularly. The provider had not yet fully implemented the actions to address this that were outlined in their compliance plan for the previous inspection.

This designated centre comprises a large campus-based building divided up into five individual units linked together by one central corridor. Residents all had their own bedrooms and access to communal kitchens, sitting rooms and quiet rooms in their individual bungalows and also had access to two additional rooms for community activation and internal activities. Office and staff facilities were also provided for in the centre. The centre is registered with a maximum capacity for twenty eight residents. On the day of this inspection taking place, twenty four residents were living in the centre and there were four vacancies. Between four and six residents lived in each bungalow.

All five units were visited by inspectors and in total 15 residents were met or observed by the inspectors in their homes. One unit was empty when an inspector visited as residents were out for a walk, and were observed returning to the centre and having lunch. Inspectors spent time in each unit meeting residents and staff, observing practices and reviewing documentation. Inspectors spoke with and interacted with a number of residents during the inspection. Some residents communicated verbally and others were supported to communicate their needs by staff knowledge of physical and vocal prompts.

Residents were observed to spend time in their bedrooms and in communal areas and the day-to-day supports offered to residents in relation to their physical support needs were observed to be good. Residents were observed to be content in their homes and appeared comfortable with the staff that supported them. Some residents were observed being supported at mealtimes and this was unhurried and respectful. On the day of the inspection, a physiotherapist was on site and some residents were observed being supported to complete physiotherapy programmes.

There was enough staff on duty to attend to the needs of residents and ensure that residents could be appropriately supervised. One resident, who required 1:1 supports to mobilise was observed to be supported in a respectful manner, with a staff member within line of sight at all times to assist the resident should they choose to move around their home. Some staff had worked with some of the residents in the centre for very long periods of time and it was clear that they had

developed trusting relationships with the residents. Residents that spoke to inspectors were positive about the care provided to them in the centre and the staff that supported them.

Inspectors noted that there were pictures displayed on screens in the centre of residents enjoying activities during the summer, and a newsletter initiative had been rolled out to encourage cultural change in the centre. An activities timetable was also observed in the units outlining the scheduled activities offered by the activation staff member and sometimes external activity providers. For example, on the day of the inspection, a number of residents were observed enjoying a music session with a local musician in a communal room in the centre. Residents were heard singing and some residents were observed dancing. Inspectors saw that while this activity was ongoing in the centre, the atmosphere was bright and lively. Afterwards, residents and staff reported to inspectors that they had really enjoyed this. This activity was usually available once or twice a week to residents and on reviewing residents' documentation in the centre, it was evident that this was perhaps the most enjoyable part of the week for some residents. Some residents also left the centre to purchase Halloween costumes and one of these told the inspector about this activity on their return.

Inspectors noted that the general atmosphere in the centre appeared to have improved since the previous inspection. Staff were noted to be optimistic and enthusiastic and spoke with pride about some increased opportunities for residents. This included some day-trips during the summer and some residents had also achieved important goals such as visiting their home-places. One staff member spoke with the inspector about how a resident had been supported to visit family in their hometown and that this had been the first time they had visited this location in over 55 years. Staff interactions during this inspection were noted to be pleasant and kind and residents were heard to offered choices about what they wanted to eat and what music they listened to. Staff noted that bus access continued to be limited at times, depending on the availability of staff who would drive the service vehicles. Staff reported that this had generally improved and that management did make efforts to roster drivers across the centre to ensure that residents were able to attend planned activities and medical appointments. Staff did not raise any safeguarding concerns and told inspectors that they felt residents were safe and well looked after in the centre.

Overall, this inspection found that there was evidence of some improvements in the centre but that ongoing non compliance was identified across some areas. The evidence on the day of the inspection indicated that residents were being offered safe services that met their basic day-to-day care needs but further improvements were required to ensure residents personal and social needs were being fully met. 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.

Capacity and capability

Management systems were in place in the centre that supported overall good day-to-day care and support of residents. Appropriate premises and staffing levels were in place to provide for safe services. This inspection found that while some improvements had been made that were having a positive impact for residents, non compliance remained across a number of regulations including staff training and development, governance and management, and notification of incidents. Also, ongoing non compliance was noted in relation to the general welfare and development of residents and this will be covered in more detail under the quality and safety section of this report.

The previous inspection of this centre took place in February 2024, with mixed findings. The provider had submitted an appropriate compliance plan following that inspection detailing how they would bring the centre into compliance with the regulations. Since then, the provider had submitted an appropriate application to renew the registration of this centre and the registration had been renewed. Information received from the provider indicated that there were delays in carrying out some of the actions outlined in their compliance plan and this unannounced inspection was carried out to assess the provider's progress with the compliance plan submitted.

There was a clear management structure present in this centre. The person in charge was supported in their role by a Clinical Nurse Manager 2 (CNM2) and two frontline CNM1 grade staff. Attendants, healthcare assistants and social care workers report to the CNM1. The person in charge reported to a director of services, who was also the registered provider's representative (RPR). Both the person in charge and the CNM2 were supernumerary.

Some of the actions identified under capacity and capability in the compliance plan submitted in respect of the previous inspection had been completed. For example, the risk register had been updated and some issues identified in relation to the management of complaints had been addressed.

Staffing levels in the centre were seen to be good, and overall this contributed to safe and adequate physical care and support for residents on a day-to-day basis. Staff spoken to during this inspection told inspectors that they were well supported in the centre and that the management team were responsive to any issues that arose. The compliance plan submitted following the previous inspection had indicated that the provider planned to introduce a standalone team of social care workers to help address the ongoing issues in relation to resident activation and community access and also hoped this would reduce the likelihood of institutional practices occurring in the centre. However, this staff team, which was initially proposed to be in place in April 2024 was still not in place at the time of this inspection and there was no clear time-line about when this would happen. There was evidence that, in the interim, management had made some efforts to address some of the issues raised in previous inspections, but that residents' lived

experiences continued to be impacted by a lack of access to appropriate activation and meaningful occupation.

A number of initiatives had been introduced by the person in charge and management team to improve staff morale in the centre and promote a culture of person centred care. For example, the person in charge spoke about a newsletter that was circulated around the centre where staff and residents could highlight achievements and showcase activities and days out. Also, the person in charge reported that they had, along with the CNM2 supported two residents to avail of a breakaway. They told the inspectors that they wished to lead by example and hoped that this would encourage staff in the centre to aspire to more meaningful goals for the residents that they supported. Team meeting records viewed in the centre showed that each unit held their own meetings. While some meetings had been documented since the previous inspection and some of these included details in relation to actions arising from that inspection, one unit had not had a meeting since April.

The previous inspection found that there was inequality present in the centre in relation to activation, with residents with more complex needs or mobility needs much less likely to participate in activation or access the community. Inspectors therefore focused their enquiries on this matter during this inspection. While some improvements were reported by staff and management, the evidence to demonstrate some of these improvements was not clear. The recording systems in place did not allow for accurate and timely audit or review of the activities and social access residents were being provided with. For example, activity records were no longer maintained in the centre.

Although some activities were being recorded in residents daily notes and person centred planning goal progress records, these did not provide a full picture of residents daily activation. For example, often these only recorded medical and personal care information. Also, bus logs in place were often not completed and did not provide any information about the destination or residents on board when the bus was being used. This meant that there was very limited evidence that the provider had full oversight over how often residents were being provided with opportunities to leave the centre. Given the continued ongoing non-compliance and numerous compliance plans received from this provider setting out the actions they would take to address this issue, this did not demonstrate that the provider was responding as strongly as required or maintaining full oversight this issue. The impact of this issue will be further explored in the quality and safety section of this report.

Local management in the centre were not fully informed of the ongoing plans the provider had in respect of the centre and this meant that future planning was difficult. Some further information was requested in relation to outstanding fire safety and capital works that had previously been indicated as due to be completed in the centre. Some information was provided following the inspection indicating that the funder had made specific commitments to commence these works within the next twelve months.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

The registered provider had ensured that the number, qualifications and skill mix of staff in the centre was appropriate to the assessed needs and size and layout of the centre. There was a planned and actual roster maintained in the centre and continuity of care and support was provided to the residents. Nursing supports were available if required to residents.

There was adequate staffing levels in the centre. An inspector reviewed staff rosters and this showed that staffing levels were overall well maintained in the centre and that a regular and consistent staff team supported residents in the centre. Vacancies were covered by regular relief or agency staff. Management and staff in the centre reported that staffing levels were maintained at appropriate levels and did not highlight any concerns in relation to staffing. Inspectors also observed that there was enough staff on duty to meet the care and support needs of residents in the centre on the day of this unannounced inspection. For example, there was enough staff to support residents with personal care, eating and drinking and to provide adequate supervision to keep residents safe in the centre.

The skill mix of staff was overall appropriate to meet the health and care needs of the residents.The staff team consisted of nursing staff, care assistants, household staff and activation staff. Each unit had access to nursing supports by day and night and additional clinical oversight was available from within the providers structures if required for specific areas such as infection prevention and control and dementia supports. Although some improvements were noted, some staff members did not drive the centre vehicles and this is covered under Regulation 13.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had in place a training matrix to maintain oversight of the training needs of staff and identify gaps in training. Inspectors viewed this training matrix for the staff working in the centre. This matrix showed that while staff were provided with training appropriate to their roles, not all mandatory staff training identified by the provider was up-to-date.

Mandatory training provided included training in the areas of manual handling, positive behaviour support fire safety and safeguarding. All staff had completed safeguarding training. However, 23 staff required training in managing behaviour,

six staff had no manual handling training completed and 19 staff required refresher training in this area also. It acknowledged that some training had been scheduled.

The matrix showed that three new staff did not have evidence of formal fire training completed. An inspector was informed by the person in charge that these staff were provided with guidance in this area during their induction.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that the management systems in place in the centre were ensuring that the service provided was effectively monitored. The provider had also not ensured that the written report of the most recent six-monthly review was completed in a timely manner and available to residents and their representatives and the chief inspector.

Inspectors reviewed the annual review and the unannounced six monthly reviews available in the centre. Inspectors were told that an unannounced visit by a representative of the provider had taken place a number of weeks prior to this inspection as required to carry out this review but that the written report was not yet available and the actions arising from this had not yet been communicated to the local management team in the centre, including the person in charge. This written report on the safety and quality of care and support provided in the centre and plan in place to address any concerns was not available to the management of the centre and the chief inspector at the time of this inspection. Inspectors also noted that the visits for the purpose of these reviews took place in the evening and at night only. This meant they were not fully reflective of the overall service provided in the centre.

The registered provider had ensured that the centre was adequately resourced in the areas of staffing and the provision of health care. However, the previous compliance plan had outlined plans to provide for additional staff that would be appropriately skilled to support residents with additional meaningful activity and community access. At the time of this inspection, despite some efforts by the provider, those identified staff were not yet in place and the provider was unable to provide a time-line for when these roles would commence.

Also, effective use of resources was not always evident during this inspection. For example, it was reported that transport for wheelchair users was an issue in the centre and this impacted on some residents ability to leave the centre for activity and community access. It is acknowledged that the local management team and staff in the centre had taken some steps to try to address this concern since the previous inspection and that some improvements were noted in this area. A number of vehicles were available that were dedicated for use by residents in this centre, including a wheelchair accessible bus. However, on examining the limited records

available in relation to the bus booking schedule for the previous months, an inspector saw that the accessible bus was not regularly booked or used by the units in the centre that required wheelchair accessible transport and that it appeared to be regularly idle, despite there being sufficient staff numbers on duty in the centre to facilitate recreation and external activity.

Records in place in relation to transport use and activity levels in the centre were not always completed accurately and full provider oversight of this was not demonstrated during this inspection. This made it difficult to determine the root cause and true extent of these issues and also to clearly demonstrate any improvements. This is discussed further in other sections of this report.

Some improvement in overall compliance with the regulations was noted since the previous inspection and this appeared to be having a positive impact on the overall lived experiences of some residents in the centre. However, the evidence reviewed during this inspection showed that the provider had not responded fully and was not maintaining full oversight of previous non compliance identified in the centre. For example, this inspection found ongoing non compliance under a number of regulations, including Regulations 13, 16, 28 and 31. While it was evident to inspectors that some efforts had been made to address some of the issues identified in previous inspections, the provider had not fully implemented the compliance plan submitted to the Chief Inspector following the previous inspection. For example, adequate and equal opportunities to activation for residents had been highlighted in the previous report. At the time of this inspection, the provider had no clear process in place in relation to auditing and oversight of activation in the centre and had not implemented the plan in relation to introducing a team of social care staff to reinforce and implement a shift in the culture and practice in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was present in the centre and contained all of the information as specified in the regulations. This document was submitted as part of the application for the renewal of the registration of the centre and was reviewed prior to the inspection. Some amendments had been made since the previous inspection to ensure that this reflected accurately the services and facilities provided in the centre and the accessing of services outside the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not notified the chief inspector in writing, of all incidents that had occurred in the designated centre. An inspector reviewed a sample of the accident and incident records that were kept in the centre. Three peer-to-peer safeguarding incidents of a verbal nature were identified that had not been notified to the Chief Inspector. Also, some safeguarding incidents that had been notified, had not been notified within a three day period as is required by the regulations and another three day notification submitted contained incorrect information.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints policy and this was viewed on display in the centre. Easy-to-read guidance in relation to how to make a complaint was available to the residents also. When speaking with some of the staff working in the centre, they presented as familiar with the complaints procedures in place. There was evidence that residents and their representatives would be supported to raise issues or concerns and that these concerns would be taken seriously and used to inform ongoing practice in the centre.

Improvements were noted by inspectors in the recording of complaints. Complaint logs were reviewed by inspectors and these showed that complaints received were being documented as required, with evidence of follow-up by the person in charge in response to complaints received. It was seen that complaints were recorded as appropriate in this log, including any actions taken on foot of the complaint, the outcome of the complaint, and the satisfaction of the complainant. The person in charge spoke about the complaints that had been received in the designated centre and how these were responded to.

Judgment: Compliant

Quality and safety

Overall, the supports provided to the 24 residents that availed of residential services in this centre were ensuring that residents were safe and that their physical and personal care needs were being met. However, despite some improvements, ongoing non compliance was identified in relation to general welfare and development and residents rights and some ongoing issues were also identified in relation to fire safety precautions, personal planning and premises.

Overall, the premises was well equipped, accessible, and suited to meet the needs of the residents at the time of this inspection. Efforts had been made to personalise

residents bedrooms and individual units to minimise the impact of the institutional nature of the building. Ongoing upgrading and maintenance was occurring in the centre to ensure the premises was kept in a good state of repair, and the centre presented as warm and comfortable for residents on the day of this inspection.

Given the size of this centre and the number of staff employed, residents were largely supported by a consistent staff team that knew them well, and it was evident that staff cared about the residents that lived in the centre, and were committed to ensuring that residents were well looked after and safe in the centre. Storage of equipment was an issue in some areas of the centre. Fire safety works and some building works were planned in the centre that would enhance the facilities available to residents. The provider submitted further information following the inspection to the inspectors about their plans to accommodate residents safely while these works were being completed.

Some of the actions identified in the compliance plan submitted in respect of the previous inspection had been completed and improvements were noted in during this inspection across most of the areas looked at. For example, a rights restriction committee was now in place and was reviewing restrictions in the centre. Significant work had been completed by the management and staff of the centre to collate information and put in place new personal plans for all residents. It also appeared that overall, residents were getting out and going on more day trips since the previous inspection. Also, efforts had been made to ensure that residents were supported to visit family members over the summer period. Inspectors were told that the management team had made efforts to ensure that drivers on the staff team were rostered to facilitate planned activities and family visits as much as possible.

However, as mentioned in the previous section of this report, ongoing issues were identified around access to activities. As part of the compliance plan submitted following the previous inspection, the provider had committed to putting in place an additional team of social care workers in an effort to address this issue. At the time of this inspection, that staff team was not in place and there was no clear time-line in relation to this. This meant that some residents were still spending long periods of time without being offered meaningful opportunities to leave the centre.

Daily notes reviewed in the centre for residents showed that some residents did not routinely leave the centre and there was little evidence to suggest that there were regular opportunities for some residents to make choices about accessing the community or what they did on a daily basis. There were some indications that staff were making greater efforts to provide in-house activity to residents but it was difficult to evidence this based on the information available to inspectors. Further improvements were required to ensure that all residents were regularly and consistently offered a chance to be involved in ordinary activities in ordinary places that met their social, emotional and developmental needs.

Residents were afforded privacy in their own personal spaces and staff were observed to interact with residents in a dignified and supportive manner. For example, staff were seen to consult with residents about their preferences, to knock

before entering bedrooms, and to provide support with personal care and eating and drinking in a dignified and relaxed manner. A rights review committee had been put in place since the previous inspection.

Inspectors observed that residents were offered some choices in this centre. For example, staff were heard to offer residents choices in relation to meals and snacks. Inspectors observed residents being assisted to complete physiotherapy programmes and an inspector observed one resident being encouraged and supported to use a bike pedal exerciser. It was seen that the resident was afforded an opportunity to do this at a time of their own choosing. When they declined initially, the staff member supporting them respected this wish and offered this activity again at a later time instead.

Regulation 13: General welfare and development

Inspectors saw some evidence that some improvements were ongoing in relation to residents' access to activity and community access. It was evident that some residents were accessing local cafés and restaurant and residents spoke about going out to the beauticians and hairdresser. Some residents had enjoyed trips to the local cinema. A number of residents had been supported to visit their homeplaces during the summer and meet with family members, including some residents that had not done so since they were children. Inspectors saw pictures of residents going on day trips over the summer and there was an activity schedule available to guide staff and residents about the in-house activities available to residents, such as music, baking and art and crafts.

However, the evidence seen on this inspection indicated that residents were still not being offered equal opportunities in relation to accessing activity and the community. As mentioned in the capacity and capability section of this report, there was limited documentation available in relation to activity records and bus logs to show how often individual residents were supported with activities. Inspectors viewed the daily records of a sample of residents across a number of units in the centre. These were not always completed daily and often contained limited information so it was difficult to obtain a full picture in some cases of how residents spend their days. Some of these records indicated that some residents left the centre regularly and also engaged in regular in-house activity on a daily basis. Other residents however, particularly those who were not fully mobile and had higher assessed needs, did not have regular activity documented and there were indications that some residents were still not leaving the centre on a regular basis to access the local community. For example, in one residents' daily notes reviewed for the two weeks prior to the inspection it was seen that the resident had engaged in three music sessions in the centre and left the centre for a drive or walk in their wheelchair on two occasions, twelve days apart. This resident communicated with the inspector during the inspection and visibly brightened when interacting about photos of a previous equine related activity that was on display in their bedroom. However, the records viewed indicated that aside from attending music sessions

down the hallway from their bedroom, this resident spent almost all of their time in their bedroom watching TV or listening to music. There was no evidence that other activities were offered regularly to the resident.

It is acknowledged that some residents were enjoying a quieter pace of life as they aged. However, there was very limited evidence that all residents were being offered opportunities for alternative activities or opportunities to engage with others on a regular basis. There was also limited evidence to show that the facilities available in the centre were fully used for the benefit of residents. For example, there was a well equipped sensory room with a water-bed in the centre. This room was observed to be used only once during the inspection. The use of this room for storing wheelchairs and other equipment indicated that this room was not in regular use. Also, at least six residents in the centre required a wheelchair bus for transportation. Generally only one or two of these residents could travel in the bus at any one time. A ten week sample of bus booking logs was reviewed for the late summer and early autumn period. This indicated that very often this bus was not booked for use at all, and the records indicated it was not used regularly by the units that accommodated those residents identified as requiring this type of transport. The person in charge told inspectors that most staff were not willing to drive this vehicle and that it was hoped to purchase a second wheelchair accessible vehicle with fundraising money.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents and was generally accessible to the residents that lived there. The premises was originally purpose built and was suited to the needs of the residents that lived there at the time of the inspection. It was observed to be very clean throughout and suitably decorated and residents had access to both private and communal spaces. Equipment and facilities for use in the centre was seen to be maintained. For example, labels on specialised beds and baths showed that this equipment was regularly serviced.

Inspectors were informed by management of the centre that some works were planned to ensure that the centre continued to meet the needs of residents. For example, there were plans to extend some bedrooms and this would allow for additional storage and the use of hoists and larger mobility equipment if required by residents in the future.

Although overall, the centre presented as well maintained, some ongoing maintenance was required to ensure that the premises was kept in a good state of repair externally and internally. For example, some windowsills and fittings in bathrooms showed signs of water damage that would prevent effective cleaning.

Although the centre was very large, storage was an issue in most units and some items of mobility equipment were observed to be stored in a sensory room as well as in storage rooms and utility rooms. Some flooring was also noted to be marked and damaged in bedrooms and communal areas.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Processes and procedures relating to risk were set out in an organisational risk management policy and this had been reviewed and was in date at the time of this inspection. This was seen to set out the identified risks in the regulations. The registered provider had put in place systems for the assessment, management and ongoing review of risk. A risk register was in place in the centre and was reviewed by an inspector. The risks identified in this had been reviewed in May 2024.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, the centre was observed to be clean and well maintained. Household staff were employed to assist in the general upkeep and cleaning of all areas of the centre. In one unit, a trolley used for storing equipment for PEG (percutaneous endoscopic gastronomy) equipment was observed to be stored in a quiet room that was freely accessible to residents, visitors and staff. This had the potential to present some infection prevention and control risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not ensured that effective fire safety management systems were in place in all units of this centre at the time of this inspection. Appropriate containment measures were not observed to be consistently in place in all units of the centre.

Fire safety systems such as emergency lighting, a fire alarm system, fire extinguishers and fire doors were present and observed by the inspectors. It was observed by inspectors during the inspection that some doors were not fitted with automatic closure devices and that some doors were wedged open due to the mag-

locks not operating correctly. For example, in one unit, a fire door into a dining room was observed to be wedged to allow a resident who mobilised using a wheelchair to independently access this space. In total, inspectors observed at least four doors held or wedged open during the inspection. This practice had been highlighted to the provider during the previous inspection of the centre also.

During previous inspections the management in the centre had indicated that there were ongoing fire upgrading works taking place in the centre. This included the replacement and widening of some fire doors, the adjustment of others and the fitting of magnetic closure systems on fire doors. As this is a large centre, this work was occurring in phases over a lengthy period of time. However, since the previous inspection no further progress had taken place in relation to this larger piece of work, and at the time of the inspection the provider did not appear to have a clear plan in place about when the remaining works would occur. Some further information was requested from the provider in relation to this and some assurances were requested in relation to the safety of the fire doors in-situ. The information provided indicated that the provider was ensuring that the existing fire doors were subject to review and required maintenance to ensure that they operated as they should.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that, overall, appropriate assessments were completed of the health, personal and social care needs of residents living in the centre. The registered provider was ensuring that, insofar as is reasonably practicable, arrangements were in place to meet the assessed needs of each resident. Person centred planning had been completed and documented for residents since the previous inspection and significant efforts had been made to update all residents documentation so that it appropriately reflected their ongoing needs and aspirations. Inspectors reviewed a number of residents files during this inspection. Annual assessments of need had been completed and were seen to have been updated and reviewed when residents were seen by an allied health professional. Plans in place for residents contained relevant guidance for staff about the assessed needs of residents and these were being updated as required to reflect changing circumstances. An inspector saw that in some plans recent audits had been completed to ensure that the information in personal plans was accurately recorded and up-to-date. Residents had been supported to set goals and there was some evidence in planning documentation that residents were being supported to achieve these, with progress recorded in most of the plans reviewed.

Overall, there had been significant improvements in the area of personal planning in the centre. Some ongoing work was required to ensure that the goals identified for all residents were meaningful and that the progress of goals was consistently documented across all residents' plans. This would ensure that all plans outlined the

supports required to maximise the resident's personal development in accordance with their wishes. Also, one resident was supported with nutrition and hydration with a PEG when they were refusing to eat meals or have adequate fluid intake. There was no guidance in their plan about when this should be used.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider was providing appropriate health care for each resident, having regard to residents' personal plans. Overall, residents in this centre had access to a variety of healthcare supports, including access to a number of allied health professionals. A review of residents' files showed that residents had access to speech and language therapy, physiotherapy, occupational therapy, chiropody, neurology, psychiatry, and dietetics input, among others. On the day of the inspection inspectors were introduced to a physiotherapist who was on-site for a number of hours to provide physiotherapy services to residents. Annual multidisciplinary meetings were on file for a sample of residents reviewed. Residents were supported to make and attend medical appointments and full time nursing care was provided in the centre as required.

Judgment: Compliant

Regulation 9: Residents' rights

The evidence found on this inspection indicated that efforts were made to respect residents' rights in this centre, but that residents did not have full freedom to exercise choice and control in their daily lives in relation to external activity. As identified on previous inspections all residents did not have access to meaningful occupation and to regular community access and this impacted on residents' capacity to exercise personal independence and choice in their daily lives. Some improvements had been made in this area, but this inspection found that wheelchair users continued to be particularly impacted.

During previous inspections it had been identified that one resident did not wish to remain living in the centre and wished to move back to where they had grown up and had natural supports, such as family and community connections, nearby. They also wished to return to their previous day services, which could not be facilitated while she lived in this centre. At the time of this inspection, that resident remained in the centre and inspectors were told that an alternative placement had not been successfully sourced to date, but that there was ongoing discussion in relation to this. Management reported that the resident appeared to be happy in the centre and continued to have access to advocacy services. An inspector spent some time with

this resident and spoke with her also. This resident had moved into a different unit and did appear to be content in their home at the time of the inspection and told the inspector that they were happy that this transfer between units had occurred. They had also recommenced attending day services two days a week as per their wishes. It was noted that this residents' wishes in relation to alternative living arrangements continued to be explored and documented through her personal plan.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Oakvale OSV-0002463

Inspection ID: MON-0044915

Date of inspection: 14/10/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Mandatory training is scheduled regularly and staff are required to attend. Where new staff commence and are awaiting formal training the induction provides guidance in the relevant areas with procedures and resident support plans to guide staff in the relevant areas. For example, all staff receive instruction in what to do in the event of a fire and how to support people who require support with behaviour as part of their induction. Regrettably, due to unplanned leave and other unanticipated issues some staff had not completed all required training on the day of the inspection. • A plan is in place to ensure all staff have received updated training in the required areas no later than 14.04.2025 and formal fire training for the 3 new staff was completed on 12.11.2024. • The Management and Governance Team are reviewing the provision and uptake of training to address any barriers to staff partaking in training and refresher training within the required timeframes. 28.02.2025	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The unannounced visit by a person nominated by the provider had been carried out within the required timeframe. Regrettably, due to unforeseen circumstances the report had not been provided to the PIC and disseminated to all relevant people on the day of inspection. The Management and Governance Team are reviewing the time of day the	

reviews are carried out, the intervals of the reviews, and the measures in place to mitigate risk of unforeseen events impacting the timeframes and will make any required amendments to ensure compliance with the requirements of the Regulations 31.01.2025
• Activity recording sheets were reinstated in residents' support files on 01.12.2024 to ensure auditing of the activity for residents is more easily available to the management of the centre. The PIC and CNMs are reviewing the activities for each person consistent with their will and preference.
• An evaluation of service user needs, service provision and governance requirements in the centre will commence on 16.12.2024 and will be carried out by a National HSE Team with expertise to determine any enhancements required. The findings will be utilised by the management team to ensure the skill mix and staffing levels are appropriate to meet residents' needs. Additionally, a Social Care Leader position has approved for filling for St Raphael's Services. The purpose of the post will be to enhance the social care culture in St Raphael's Services by supporting staff to embed the culture in the service

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Director of Services and CNM3 (PIC) are reviewing the system in place for ensuring that all required notifications are submitted, that notifiable events are notified within the required timeframe and that all required information is submitted. Any required system improvements will be implemented to ensure the issues raised are addressed 31.01.2025

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• Activity recording sheets were reinstated in residents' support files on 01.12.2024 to ensure auditing of the activity for residents is more easily available to the management of the centre. The PIC and CNMs are reviewing the activities for each person to ensure they are consistent with their will and preference and address any barriers to people accessing activities they wish to partake in. Any required improvements will be put in place. In addition, the findings of the evaluation of the service as referenced in the response to the non-compliance under Regulation 23 will inform required improvements in this area.
• The use of vehicles including the wheelchair accessible vehicle will be reviewed by the Management and Governance Team to ensure that any barriers to people being

supported to avail of transport is resolved 28.02.2025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A review of the required maintenance issues was carried out with maintenance staff on 11.12.2024 and all required maintenance will be completed no later than 28.02.2024.
• Storage is being reviewed by the PIC to ensure there is adequate and suitable storage 28.02.2025

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The PEG (percutaneous endoscopic gastronomy) equipment trolley was returned to the storage room which is only accessible by staff on 15.10.2024

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A plan is in place for the required refurbishment of the center as outlined to the regulator at previous inspections. In order to ensure the comfort and safety of residents the HSE is purchasing suitable houses to accommodate people to reside while the works are being undertaken. HSE Estates are working to ensure the purchase and required fit out of houses is progressed as expediently as possible notwithstanding the challenges related to the current housing market which has made this more challenging particularly considering the type of houses required to ensure houses are registered as per the Regulations.
• Regular walk arounds of the center are carried out by the CNMs to ensure the use of wedges are not used for fire doors and this has been addressed with all staff and has been added as a regular agenda item at staff meetings. 25.11.2024
It is noted that a door referenced in the report to accommodate a wheelchair user is not a fire door and when the center is refurbished it will be replaced with a suitable door to

ensure the wheelchair user can move freely between the rooms

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 care plan for the resident who requires a PEG at specific times has been reviewed to ensure clear guidance for staff 15.10.2024
• Work is ongoing to improve the social care model in the service and ensure that all residents are supported to identify and are supported to achieve meaningful goals consistent with their will and preference.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• As per responses to the non-compliance with Regulations 5 and 13 and the substantial compliance with Regulation 5 work is ongoing in the center to continue to improve the access to activities and the support for residents to identify and achieve meaningful goals for residents. This will continue to be a priority for the service and the findings from the evaluation of the service as outlined in the response to the non-compliance with Regulation 23 will be used to identify further measures required in respect of this.
In addition, the renewed Rights Review Committee which was established in 2024 is continuing to work to ensure the required mechanisms are in place to enhance the rights based model of support in the service.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	31/03/2025
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/03/2025
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Not Compliant	Orange	31/03/2025

	their wishes.			
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.	Not Compliant	Orange	31/03/2025
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	31/03/2025
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/03/2025
Regulation 23(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/03/2025

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/12/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Substantially Compliant	Yellow	31/12/2024

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2025
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	31/12/2024
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident	Substantially Compliant	Yellow	31/12/2024

	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.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2024