



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	The Willows
Name of provider:	Redwood Extended Care Facility Unlimited Company
Address of centre:	Meath
Type of inspection:	Short Notice Announced
Date of inspection:	15 December 2020
Centre ID:	OSV-0005724
Fieldwork ID:	MON-0030789

About the designated centre

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

The centre provides residential service for five adults over the age of 18 years with intellectual disabilities, autistic spectrum and acquired brain injuries who may also have mental health difficulties, and behaviours which challenge. The centre is located on a campus setting in a rural area, a short drive from a town in Co.Meath. The objective of the service is to promote independence and to maximise quality of life through interventions and supports which are underpinned by positive behaviour support in line with our model of Person Centred Care Support. Our services are provided in a homelike environment that promotes dignity, respect, kindness and engagement for each resident. We encourage and support the residents to participate in the community and to avail of the amenities and recreational activities. The centre is laid out on one level and can accommodate residents with mobility issues and is fully wheelchair accessible. The centre consists of five individual bedrooms, one bathroom, a shower room and two wc's. There is a kitchen, separate dining area, a large sitting room and three separate communal rooms. The centre is staffed by a combination of staff nurses, support workers and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 15 December 2020	10:25hrs to 16:35hrs	Caroline Meehan	Lead

What residents told us and what inspectors observed

The inspector met four of the residents during the course of the inspection and observed residents being supported in activities. Due to complex nature of residents' needs it was not always possible to ascertain residents' views on the service being provided; however, residents did appear to be content in their home and staff appeared to have a good rapport with residents. Staff were also observed to be respectful and kind in their interactions with residents. Accessible information about the service such as activities and meal choices were displayed for residents, and residents were kept up to date on information regarding the service through residents meetings and an easy read information board.

One resident spent time with the inspector and showed the inspector their own room, which was personalised, had items of the resident's preference and which the resident said they were happy with. One resident was engaged in some art activities and told the inspector they liked doing this. Two residents were supported to go on a bus trip in the morning as was their preference, and one of these residents was supported by a staff member to go for a walk later in the day. From speaking with three staff members and the person in charge, it was evident that staff knew the residents well and were providing a good quality of care and support in line with residents' needs and wishes.

The centre was homely and spacious and the inspector observed that residents appeared comfortable and accessed areas of the centre at their leisure. While there were some environmental restrictions in the centre the inspector observed that staff supported residents to access these areas as per their personal plans. There was a garden to the rear of the property and a sheltered area for residents who smoked, as was their preference. Prior to the recent pandemic two residents had attended day services, and currently activities were being facilitated by the staff in the centre. The person in charge acknowledged that the choices of activities provided to residents required improvement, and the inspector found the choice available was limited and did not provide opportunities for new experiences and skill development.

Capacity and capability

The inspector found the provider had the resources and management systems in the centre to ensure the residents received an effective, safe and consistent service, and had systems in place to monitor the service provided.

There were sufficient staff with the right skills and qualifications and nursing care

was provided in accordance with the residents assessed needs. The centre was staffed by nursing staff and health care assistants, with four staff on duty during the day and two staff at night time. There was currently one nurse vacancy and a recruitment process was near completion for a new staff member on the day of inspection. The inspector reviewed a sample of rosters from the preceding five months and found consistent staffing was on duty, ensuring continuity of care was provided. Rosters were maintained appropriately.

Staff had been provided mandatory training in safeguarding, fire safety and behaviours of concern. Additional training had also been provided in a range of areas including manual handling, epilepsy, feeding, eating, drinking and swallowing, hand hygiene and the use of personal protective equipment. Since the last inspection training in dementia had been facilitated. Training was scheduled for new staff in dementia training, and in fire safety refresher training for another staff.

There were appropriate management systems in place. There was a fulltime person in charge employed in the centre who had recently taken up this post. The person in charge was also responsible for one other designated centre on the campus. Staff told the inspector the person in charge was supportive, approachable and they could raise concerns about the care and support provided to residents if needed. There was a clearly defined management structure. Staff reported to the person in charge and the person in charge reported to the person participating in management. A nurse manager was available at night time on the campus to provide support to staff if required.

The person in charge met with the person participating in management on a monthly basis. While issues identified during the inspection relating to the review mechanisms of restrictive practices were evident, the inspector was assured that overall this governance arrangement ensured that most issues relating to care and support were identified and were being considered. For example, issues relating to the provision of residents' goals and activities had been identified and discussed by the person in charge and the person participating in management, reflective of the inspection findings. Similarly adverse incidents were reviewed by the person in charge with the person participating in management and where required additional corrective action was taken.

The provider had completed six monthly unannounced visits and the inspector reviewed the two most recent visits. Actions had been developed following these reviews and actions were completed or in progress on the day of inspection. For example, outstanding training had been provided to staff, a resident had been supported with an identified personal requirement and a behaviour support plan had been reviewed. One action relating to a resident's goals was still in progress on the day of inspection.

An annual review of the quality and safety of care and support had recently been completed and residents and families had been consulted in relation to this review. Two actions relating to this review were in progress on the day of inspection.

Regulation 15: Staffing

There were sufficient staff with the right skills and qualifications to meet the assessed needs of the residents. Consistent staffing was provided, and the rosters were maintained appropriately. Nursing care was provided in accordance with the residents assessed needs

Judgment: Compliant

Regulation 16: Training and staff development

Staff had been provided with mandatory and additional training including refresher training.

Judgment: Compliant

Regulation 23: Governance and management

There were appropriate management systems in place. There was a clearly defined management structure and a fulltime person in charge was employed in the centre. A nurse manager was available at night time on the campus to provide support to staff if required.

The centre was resourced effectively to meet the needs of residents. Monitoring of the centre was completed in line with the regulations and six monthly visits and an annual review of the quality and safety of care and support had been completed by the provider.

Judgment: Compliant

Quality and safety

Overall the inspector found that residents were provided with a good quality of care and support in accordance with their assessed needs. The diverse needs of residents were respectfully supported by staff in the centre. Some improvement was required in the the provision of behavioural support and in the development and provision of residents' activities and goals. One aspect of fire safety had not been satisfactorily

addressed since the last inspection.

Each resident had an assessment of need completed based on the outcomes of multidisciplinary team members assessments. Assessments of need were up to date and had been reviewed regularly throughout the year. The inspector reviewed personal plans for three residents. Overall personal plans were in place which guided the practice in the provision of care and support, in order to meet residents identified needs. However, plans in relation to social care and the development and implementation of person centred goals required review. While residents had been supported to achieve some goals, there was a significant delay in some cases in developing new goals for residents and there was no evidence to confirm if a recent goal for a resident had been implemented. While there was a daily activity list for residents, this was limited to one centre based activity a day. Residents had been supported to engage in some other activities outside of the centre such as walks on campus and bus drives. This was discussed with the person in charge who acknowledged the development of goals and activities for residents required review and had been identified in the recent annual review and six monthly visit by the provider.

Residents were provided with timely access to healthcare, and residents were reviewed regularly by a range of healthcare professionals in accordance with their needs. For example, residents had access to a general practitioner, psychiatrist, occupational therapist, speech and language therapist, dietician, and physiotherapist. Residents healthcare needs were monitored on an ongoing basis in line with healthcare plans.

Support was provided to residents to manage their emotional needs; however, improvement was required to ensure the plans to guide the support for residents with behaviours of concern were current and reflected the actual practice in the centre. In addition, the oversight of restrictive practices in the centre required review.

Residents could access the services of a behaviour specialist. The inspector reviewed a behaviour support plan and found the reactive strategies were not in line with the current practice in the centre. This plan referred to a personal safety plan as part of the behaviour support plan, however, physical interventions outlined in the personal safety plan were no longer in use in the centre and this personal safety plan had last been reviewed in 2018. Staff confirmed that no physical interventions were currently used in the centre. There were a number of environmental restrictive practices in use in the centre. Restrictive practices were documented as reviewed by the person in charge, during management meetings, and at multidisciplinary team meetings. However, it was not evident from documentation if these reviews considered if environmental restrictive practices were the least restrictive procedure, for the shortest duration. In the absence of plans to reduce restrictive practices, it was also not evident from documentation, the rationale for continuing restrictive practices at their current level.

Staff were knowledgeable on the rationale for use of environmental restrictive practices and on the proactive and reactive strategies to support residents with their

emotional needs. Staff had been provided in training in behaviours that challenge and in therapeutic interventions, and one newly recruited staff member was due to complete training in therapeutic interventions in the coming days.

The inspector reviewed records of incidents in the centre. There were no current safeguarding concerns in the centre and staff reported that residents were safe in the centre. The measures outlined in notifications made to HIQA since the last inspection were in place on the day of inspection. Staff were knowledgeable on the types of abuse and on the reporting procedures in the event of safeguarding concern. All staff had up-to-date training in safeguarding.

Intimate care plans were comprehensive with detailed guidance on the support residents required with their personal care, ensuring their privacy and dignity was maintained.

There was a system in place for assessing and managing risks in the centre. The centre had a risk register which specified the nature of risks, and control measures in place to mitigate these risks. Individual risks had also been assessed in accordance with residents needs and the inspector found the measures outlined in risk management plans were implemented in practice. For example, specified staffing levels were provided for residents to manage their emotional needs and measures to mitigate the environmental hazards associated with smoking were observed to be implemented in practice. There had been a number of notifications submitted to HIQA relating to accidental injuries and the inspector found all incidents had been appropriately followed up with the relevant healthcare professional. There was a system in place for reporting and investigating adverse incidents in the centre and a records of all incidents and subsequent reviews were maintained in the centre.

Suitable measures were in place for the prevention and control of infection. There was sufficient personal protective equipment (PPE) in the centre and enhanced PPE supply was observed to be available if required, in the event of a COVID-19 outbreak. Adequate hand hygiene facilities were available and hand sanitising stations were provided throughout the centre. It was evident that residents had been provided with information in relation to infection control and COVID-19. For example, a resident was observed to independently use hand sanitiser, and accessible information was displayed for residents on the recent pandemic. Up-to-date information was also displayed for residents on the current level of restrictions. Staff were observed to adhere to public health guidelines for example, social distancing and wearing face masks. A contingency plan was developed in response to the COVID-19 pandemic, which had been reviewed and updated in recent days to reflect a change in the provider's provision of an isolation unit. Residents had been assessed as to the risks in relation to COVID-19 including their response in relation to self-isolation. Staff were observed to attend to cleaning in high touch areas during the inspection. There was a system in place for checking staff and visitor temperatures and symptoms. Training had been provided in hand hygiene, and in donning and doffing PPE in response to the recent pandemic.

Some of the actions from the previous inspection were completed in relation to fire

safety. Adequate measures were in place for the containment of fire, and a fire drill was completed within a satisfactory timeframe, with the minimum numbers of staff on duty at the time. Personal emergency evacuation plans were developed for each resident; however, the support measures outlined in one resident's plan were not consistent with the support measures outlined by two staff members. Staff had been provided in training in fire safety and refresher training was planned for one staff member as required.

Regulation 26: Risk management procedures

There was a system in place for assessing and managing risks in the centre. The centre had a risk register which specified the nature of risks, and control measures in place to mitigate these risks. Individual risks had also been assessed in accordance with residents needs and the inspector found the measures outlined in risk management plans were implemented in practice.

There was a system in place for reporting and investigating adverse incidents in the centre and a records of all incidents and subsequent reviews were maintained in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

Suitable measures were in place for the prevention and control of infection.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate measures were in place for the containment of fire, and a fire drill was completed within a satisfactory timeframe, with the minimum numbers of staff on duty at the time. Personal emergency evacuation plans were developed for each resident; however, the support measures outlined in one resident's plan were not consistent with the support measures outlined by two staff members. Staff had been provided in training in fire safety and refresher training was planned for one staff member as required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date assessment of need completed based on the outcomes of multidisciplinary team members assessments. Most personal plans were in place which guided the practice in the provision of care and support, in order to meet residents identified needs. However, plans in relation to social care and the development and implementation of person centred goals required review. There was a significant delay in some cases in developing new goals for residents once previous goals were completed, and there was no evidence to confirm if a recent goal for a resident had been implemented. The provision of meaningful activities for residents also required improvement.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with timely access to healthcare, and residents were reviewed regularly by a range of healthcare professionals in accordance with their needs. Residents healthcare needs were monitored on an ongoing basis in line with healthcare plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Support was provided to residents to manage their emotional needs; however, improvement was required to ensure the plans to guide the support for residents with behaviours of concern were current and reflected the actual practice in the centre. The process for reviewing restrictive practices required improvement, as it was not evident that the continued use and level of some environmental restrictive practices, were the least restrictive and for the shortest duration.

Judgment: Not compliant

Regulation 8: Protection

There were no current safeguarding concerns in the centre and staff reported that residents were safe in the centre. The measures outlined in notifications made to HIQA since the last inspection were in place on the day of inspection. Staff were knowledgeable on the types of abuse and on the reporting procedures in the event of safeguarding concern. All staff had up-to-date training in safeguarding. Intimate care plans were comprehensive with detailed guidance on the support residents required with their personal care, ensuring their privacy and dignity was maintained.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Willows OSV-0005724

Inspection ID: MON-0030789

Date of inspection: 15/12/2020

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 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PEEP plan for one resident has been reviewed and updated. This resident now has in place a rescue pack that works to entice him to evacuate the house in the event of a real fire. All staff members have received refresher fire training to reflect this new practice. The resident's risk assessment has been updated to reflect the new measures required.</p>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Each resident's care plan in relation to social care and personal development will be reviewed and updated. Each resident's personal goals will to be reviewed by the PIC and Keyworker and where appropriate an MDT member. A more comprehensive system of goal tracking has been devised and implented. Staff will receive individual mentoring / training sessions on how to assist / support residents to develop meaningful goals and the tracking and recording process. The PIC will maintain oversight of goal implementation and progress. The PPIM through monthly governance will review the goal setting and implemnetation processes for the service.</p>	

Regulation 7: Positive behavioural support	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:</p> <p>The Talbot Groups internal audit for restrictive practices has been updated to reflect the HIQA issued self-assessment tool.</p> <p>This audit will be completed on monthly basis by the PIC and reviewed by the PPIM to ensure adequate review of all restrictive practices.</p> <p>The process of reviewing restrictive practices will be improved by the introduction of an additional checklist to evidence all inputs and considerations taken during restrictive practice reviews.</p> <p>The Positive Behavior Support plan referred to in the report, is under review by the PBSP specialist and the staff team in The Willows, to be completed by the 15.01.2021. This plan will be updated to reflect the service users' current needs and the actual practices within the service.</p> <p>All service user's PBSP are reviewed on a regular basis and review dates are tracked by the PIC and the MDT.</p>	

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 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	06/01/2021
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/01/2021

Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	31/01/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/01/2021