Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Ltd
Centre ID:	ORG-0007947
Centre county:	Wicklow
Email address:	
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Ltd
Provider Nominee:	Martina Byrne
Person in charge:	Martina Byrne
Lead inspector:	Julie Pryce
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 February 2014 14:30	12 February 2014 18:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This monitoring inspection of this centre was the first inspection by the Health Information and Quality Authority. As part of the inspection, inspectors met with residents and staff members. Inspectors observed practices and reviewed documentation such as personal plans, medical records, risk assessments, policies and procedures and staff files.

As residents are out during the day, part of the inspection took place in the late afternoon and evening, when residents had returned from their daily activities.

Overall, inspectors found that residents received a good quality service in the centre. Staff interacted with residents in a respectful and caring way. The centre was well resourced and the inspector found that the residents appeared to be comfortable and content. The provider had put arrangements in place to ensure that the premises were maintained to a good standard, met the needs of residents and ensured the safety of residents, staff and visitors.

While evidence of good practice was found across all outcomes, areas of non-compliance with the Regulations were identified. These included the management of risk, staff training records and the content of personal plans. These non-compliances are discussed in the body of the report and included in the Action Plan at the end of this report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Findings:
Overall the inspector found that residents' wellbeing was maintained by a high standard of evidence-based care and support. Staff were knowledgeable about the residents' needs and how these needs were met, and there was evidence of the involvement of families or representatives in the planning process.

Personal plans were well developed and showed evidence of multi-disciplinary input into the planning of care. However, some improvements were required in order for the plans to direct staff in the maintenance of the residents' wellbeing.

There was evidence of appropriate assessment and health and wellbeing plans, each resident had a safety assessment, and any rights restrictions were referred to the Rights Review Committee.

However, there was insufficient evidence in residents' personal plans to direct the delivery of person-centred care. For example, while staff could describe residents' communication needs and clearly demonstrate effective communication, there was no evidence of communication profiles or strategies in the personal plans.

Plans included health plans, risk assessments and intimate care plans. However, the intimate care plans were insufficient to direct staff in the delivery of care. For example, staff were aware that one of the residents required the assistance of two staff members in intimate care, one of whom must be of the same gender as the resident, but this was not documented in the intimate care plan.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Findings:
The inspectors were satisfied that there was evidence of a commitment to risk management and health and safety within Sunbeam House Services. The provider had introduced a new corporate risk register. However, this had yet to be fully implemented locally. There was evidence of adverse incident analysis in the centre and trend analysis conducted centrally, and of centre specific risk assessments.

Inspectors read a comprehensive risk management policy which had recently been drafted and found that it clearly identified the roles, responsibilities and reporting arrangements for managing risk. However, it did not include guidance in relation to the specific risks outlined in the regulations, for example the risk of self harm.

Inspectors were satisfied that there was an effective fire management system in place in the designated centre. Regular service checks of alarms and lighting systems were carried out by a suitable qualified person, fire drills were completed regularly and staff and residents were knowledgeable in the local procedures for evacuation in the event of an emergency. Inspectors found evidence of individual personal evacuation plans for residents, which outlined any specific supports they would need to safely evacuate the building.

Not all the risks in the centre had been risk assessed, for example the doors to the centre were kept locked to ensure the safety of some of the residents, and while there was a protocol in place there was no risk assessment.

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Judgement:
Non Compliant - Minor

Findings:
Inspectors found that there was evidence of good practice in regards to safeguarding residents' money. For example, each resident had a money management assessment outlining the level of support required from staff. Each resident had a financial folder in which all financial transactions were recorded and countersigned, and which contained receipts for all purchases.

The inspector found staff to be knowledgeable in the management of challenging behaviour of residents, and that steps were being taken to reduce the level of restrictive interventions for some individuals. However, these strategies were not documented in the personal plans, there was no evidence of evaluation of the effectiveness of the strategies or plans to maintain consistency of implementation amongst staff.

External doors were locked to ensure the safety of five of the residents, and while this had been discussed at a recent nurses meeting, no risk assessment was in place and there was no evidence of all alternatives having been attempted or considered and ruled out.

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Non Compliant - Minor

Findings:
Overall the inspector found that residents were well supported to achieve and maintain best possible health, although some improvements were required in relation to updating healthcare plans in relation to changing conditions.

The inspector found that residents were supported to access health care services relevant to their needs. The inspector reviewed the personal plans and for three residents and found there were health assessments and plans developed in conjunction with the resident's general practitioner (GP) on an annual basis. There was evidence of the input of healthcare professionals relevant to the residents' needs, including speech and language therapist and consultant neurologist.

While there was evidence of appropriate staff response to changing needs and adverse events, there was no documentation in the personal plans to reflect this. For example, the personal plan was not updated to reflect an acute medical condition for one resident, or an adverse incident for another, as discussed under Outcome 5.

Residents returned from their daily activities to a prepared evening meal when they returned to the centre. There was evidence of a nutritious diet with menus having been reviewed by a dietician, and of a variety of foods and snacks being available. Staff were aware of some of the residents' likes and dislikes, and explained that if a resident did not eat a meal an alternative would be offered. However, there was little evidence of proactive choice being offered to residents.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Compliant

Findings:
The inspector found that arrangements were in place to support the person in charge in protecting residents in relation to medication management. Medications were stored safely and appropriately, prescriptions were clear, individually signed by the prescriber and where transcription had been carried out two nurses signed the transcribed prescription and the prescriber also signed each prescription.

PRN (as required medication) prescriptions included the circumstances under which the medication was to be administered, and when these medications were administered this was recorded on the medication administrations sheet, in the resident's personal plan and an incident form was completed.

A recent audit had been undertaken by the pharmacist, and internal audits also took place. These audits resulted in an action plan, and the actions of the most recent audit had been completed. Drug errors were well managed, and there was evidence of learning from any incidents in the minutes of the nurses meetings.

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Minor

Findings:
Sunbeam House Services is governed by a board of directors consisting of nine members, including the CEO, Mr Hannigan who is identified as the person nominated on behalf of the provider. Mr Hannigan is supported in his role by the senior management team which is made up of seven managers with a variety of roles and responsibilities. There are 18 client services managers (CSM) across the organisation who directly report to the senior management team. Members of the CSM team are the identified persons in charge for the designated centres within Sunbeam House Services.

The inspectors were satisfied that there was a clear governance and management structure within the service. During discussion the provider and senior management team demonstrated a commitment to providing a good quality service with clear reporting systems in place. There was evidence of regular staff meetings in the centre and biannual nurses meetings.

Whilst some audits had been conducted, including health and safety audits and an audit against the National Standards for Residential Services for Children and Adults with Disabilities, there was no system in place to monitor the action plans of the audits or to assess improvements or changes resulting from the audits.

The inspectors were satisfied that the person in charge was appropriately qualified and skilled. She had sufficient experience in supervision and management of the centre, and was knowledgeable about the requirements of the Regulations and the Authority's Standards. She also demonstrated a very clear knowledge about the support needs of each resident.

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Judgement:
Non Compliant - Moderate

Findings:
Inspectors found the staffing levels and skill mix to be adequate to meet the needs of the residents. Staff were knowledgeable and their interactions with residents were respectful and caring. There was evidence of annual appraisals, and actions plans

including the identification of training needs resulting from these appraisals.

Inspectors reviewed the records relating to staffing and found that they contained most of the information outlined in Schedule 2 of the Regulations with some exceptions. For example, photographic proof of Identify had been sought for all new staff since the introduction of the regulations but this had not been done retrospectively for staff employed before 1 November 2013.

Inspectors reviewed the training records which demonstrated that training was made available to staff with an extensive calendar of training for the year. However, inspectors noted some gaps in the mandatory training. For example, training in protection of vulnerable adults was not current for all staff working in the designated centre. Inspectors found that the provider had already put measures in place to provide this training with two to three days per month allocated in 2014. In general mandatory training in the area of fire safety and manual handling was updated in line with the organisations policies and guidelines. Some improvements were required in the training of de-escalation techniques for staff working with behaviours that challenge, and inspectors found that dates had been outlined during the training calendar to provide this.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Ltd
Centre ID:	ORG-0007947
Date of Inspection:	12 February 2014
Date of response:	13 March 2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Theme: Effective Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Personal plans did not reflect all resident's needs. **Action Required:** Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs. **Please state the actions you have taken or are planning to take:** Personal plans were all reviewed. Amendments were made where needed. Care plans were put in place regarding specific medical issues (Wound Care, Chest infection) and intimate care plans were amended to direct staff in providing care.
Proposed Timescale: 20/02/2014

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not reflect the changing needs of residents.

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
Care plans were put in place to reflect the changing needs of the clients. Staff were spoken to regarding the importance of this. Same to be further discussed at Team Meeting on Wednesday 12th March 2014 and at the Nurses meeting on 1st April 2014.

Proposed Timescale: 01/04/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the measures and actions in place for all the risks specified in the Regulations.

Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
SHS have a risk management policy and framework in place and a corporate risk register has been developed.

The missing person's guidelines are included in the Safety Statement as part of the Emergency/Disaster plan. The Risk Management Policy was amended on 1st April to reflect the recommendations made by HIQA Inspectors.

Proposed Timescale: 01/04/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy does not guide staff in the management of the specific risks required by the Regulations.

Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
A location specific risk register will be developed.

The risk assessments in the Safety Statement include measures and actions to control accidental injury to residents, visitors, & staff. The Risk Management Policy was amended on 1st April to reflect the recommendations made by HIQA Inspectors.

The Location Risk Register will be completed on 1st May 2014

Proposed Timescale: 01/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all risks within the centre had been assessed.

Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
The Emergency / Disaster Plan Safety Statement includes fire (including what to do if the building becomes unusable due to fire or other emergency), transport incidents, local flooding, severe weather and missing persons. Location specific risk registers will be in place.

Proposed Timescale: 01/05/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Therapeutic interventions were not reviewed as part of the personal planning process.

Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
All therapeutic interventions will be included in Personal Plans and will be reviewed as part of the clients individual planning process.

Proposed Timescale: 01/06/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the locking of doors was the least restrictive procedure to ensure the safety of residents.

Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
Risk assessments are to be completed for all service users with regard to the locking of the front door.

We will document the time, date and duration of when the door is locked. We will also provide documentary evidence of least restrictive measures being used.

Proposed Timescale: 31/05/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that residents were offered a choice of meals and snacks.

Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
Menu's are in place. Clients are always offered an alternative if they do not want something that is on the menu. The issue of how we demonstrate 'Choice to the clients' without it becoming a tokenistic gesture has been discussed locally since this inspection, and it is down for further discussion at the Team Meeting on Wednesday 12th March 2014.

Choice Cards will be introduced to clients as a support to making choices re meals etc.

Proposed Timescale: 30/04/2014

Outcome 14: Governance and Management

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence of an annual review of the quality and safety of care and support.

Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
An audit feedback report form has been developed and will be issued to all locations. All client files will be reviewed in the areas of Quality and Safety.

Proposed Timescale: 30/04/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not all up to date with mandatory training.

Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Staff have completed or are booked onto all the mandatory training throughout 2014.

Staff have been requested to forward photographic ID to HR.

Proposed Timescale: 20/12/2014