<table>
<thead>
<tr>
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<th>Helensburgh</th>
</tr>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001703</td>
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<td>Centre county:</td>
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<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<td>Registered provider:</td>
<td>Sunbeam House Services Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>John Hannigan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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**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, 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 02 September 2016 10:30  
To: 02 September 2016 21:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 14: Governance and Management</td>
<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

**Background to the inspection:**

This was the second inspection of this designated centre. This inspection was to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**How we gathered our evidence:**

The inspector visited the designated centre, met with seven residents and four staff members and the person in charge. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs and policies and procedures.

One resident provided a tour of the designated centre to the inspector, this included the history of the building. This resident stated "I love living here staff are good to me and I have my own office in my room to do my paper work". Other residents identified challenges within the living environment these related to behaviours of others. Staff acknowledged this challenge, while also identifying the designated
centre as a great place to work.

Description of the service:
This designated centre was operated by Sunbeam House Services (SHS) Limited and based in Greystones, County Wicklow. There were seven residents living in the designated centre. The designated centre consisted of a three story house. The provider had produced a document titled the statement of purpose, as required by regulation, this described the service provided. The designated centre aimed to provide residential support for both male and female adults over the age of 18 with intellectual disabilities. Residents with mild to moderate support needs were accommodated within the designated centre to live as independently as possible within the community as outlined in the statement of purpose.

Overall judgments of our findings:
Eleven outcomes were inspected against, one outcome was compliant and four outcomes were found to be substantially compliant. Six outcomes were found to be of moderate non-compliance. Areas of improvement included the complaints procedure, information contained within residents’ files including behavioural support plans and the monitoring of the designated centre.

The person in charge facilitated the inspection.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.
### 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, 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.

### Outcome 01: Residents Rights, Dignity and Consultation
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector reviewed this outcome in respect of the action identified in the previous inspection. The inspector found the action remained outstanding.

There was a complaints policy and procedure in place, however, it was unclear within the complaints policy who was the nominated person independent of the person nominated to deal with complaints was within the organization. This was to ensure all complaints were appropriately responded to and records were maintained as specified under paragraph 34(3) of the regulations.

**Judgment:**
Substantially Compliant

### Outcome 04: Admissions and Contract for the Provision of Services
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services
**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector reviewed this outcome in respect of the action identified from the previous inspection and found the action was achieved.

Residents now had written agreements in place.

**Judgment:**
Compliant

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**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

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**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Resident’s social care needs were identified and residents had the opportunity to participate in activities appropriate to their interests and preference. These included areas such as, holidays and community activities such as, shopping and visiting family members. Improvements were required in the review of resident's personal plans.

The system of personal social plans within the designated centre involved personal outcome measures encompassing 23 quality of life indicators as an assessment completed once every three years. The information gained during the process contributed to the development of a personal plan. This plan was to be completed annually and reviewed every six months. The inspector viewed seven residents' plans.

The inspector found all residents did not have an up-to-date personal plan reviewed within the last 12 months. For example, one plan viewed was dated 28 July 2015 another plan was dated 18 July 2015 other plans dated in 2016 were not updated since 2014. Therefore, the inspector was unable to see evidence of resident's person plans being reviewed annually as required by regulations. Staff members were unable to provide this information to the inspector when asked.
Personal plans contained goals, these included areas such as, holidays and clear collaboration with resident’s day service in relation to attending musicals. Residents also spoke with the inspector about their goals and were very knowledgeable in relation to what goals were identified in their plan and how these were progressing.

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence for this maintained within the resident's files.

**Judgment:**
Substantially Compliant

### Outcome 06: Safe and suitable premises

*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The inspector reviewed this outcome in respect of the action identified from the previous inspection and found the action remained outstanding.

Renovations to the large bathroom on the first floor remained outstanding since the previous inspection in July 2014, this room contained a disconnected shower. There was a bath used by some of the residents however, the inspector viewed documentation where a resident had difficulty in getting in and out of the bath. Staff members also identified issues with the floor surface being slippery when attending to residents. The inspector viewed documentation involving the person in charge and management in relation to the upgrade of the bathroom however, similar discussions had occurred during the previous inspection without any changes to the environment.

**Judgment:**
Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found the designated centre was suitable and safe for the number and needs of residents. Improvements were required in the area of safety plans, sharps management and risk assessments.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced by an external company as required by regulations. An annual service completed in December 2015 and the previous quarterly completed in June 2016. Staff members also completed checks on the exits, alarm panel and equipment.

Fire drills had taken place and documents recorded the time taken to evacuate and any issues identified along with residents who had participated in the drill within the designated centre. The inspector viewed a drill dated 27 August 2016.

The inspector viewed residents PEEPs (personal emergency evacuation plans) these were up-to-date and reflective of fire drills completed.

The inspector found the sharps container was unlabelled and untagged and no guidance was available for staff within the designated centre in relation to the safe disposal of this container.

The designated centre had an organizational risk management policy in place this included, the specific risks identified in regulation 26. The designated centre had a risk register and this recorded a number of risks within the house and the controls in place to address these. On the day of inspection the inspector found the temperature of the hot water was not regulated nor was this identified within the risk register.

There were individual risk assessments for residents in place these included fire, aggression and violence and trips and falls. The inspector found this system required improvement for example, a smoking risk assessment was not completed for one resident.

The inspector also viewed resident's safety plans these were present in several formats for example, my safety plan, safety plan and another in-depth document. Some of these were not maintained up-to-date for example, one of the versions of safety plans identified progress was to be documented on a quarterly basis. The inspector found this was dated 16 April 2014 and reviewed 19 September 2015.
The designated centre had a health and safety statement dated May 2016 this outlined the responsibilities of the various post-holders within the organization. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as fire, adverse weather conditions, flooding, power failure and possible gas leakage. The plan identified specific alternative accommodation to be provided in the event residents could not return to the designated centre.

There was a system in place for recording accidents and incidents occurring in the designated centre. The person in charge outlined the process for dealing with these and ensuring learning from any adverse incidents or accidents occurred.

**Judgment:**
Non Compliant - Moderate

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**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

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector found appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans.

The inspector viewed behavioural support plans and protocols in place however, the inspector found these documents were inconsistent and did not guide staff effectively.

Improvements were required in the following areas:

- One plan viewed was dated 29 March 2012 and reviewed 18 October 2012. The inspector was informed the plan was not currently in use, however, the plan was within the resident's active file.

- Another plan viewed was dated 29 July 2014 and reviewed 17 May 2016 no evidence of review in 2015.
Another plan viewed was dated 25 July 2014 with no evidence of review; however, handwritten on to the plan was a note suggesting the plan was no longer required.

Overall the inspector found the behaviour support plans were not kept under review and did not guide staff effectively and consistently in both verbal de-escalation and the use of chemical restraint.

There was a policy in place on the prevention, detection and response to abuse this was for review on 27 July 2017.

Staff members had received training in the area of prevention, detection and response to abuse. Some staff members spoken with by the inspector were unclear in relation to the management of an allegation of abuse and were unclear of the reporting structure. However, this aspect of training was not fully completed by the staff member during the training session.

The inspector found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 11. Healthcare Needs**

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Each resident was supported to achieve the best possible health. However, improvements were required in the information contained in resident's healthcare plans and annual reviews.

The healthcare needs of residents were completed via a plan entitled 'my health and wellbeing plan'. From this a care plan and/or support plan was developed.

The inspector viewed healthcare plans and found some of these were not reviewed at a minimum on an annual basis. For example, some plans were dated 11 May 2015 and June 2015. Another plan was dated 19 May 2016; however, the information contained within the plan was inaccurate.
Residents had access to allied healthcare professionals, the inspector viewed evidence of this including dietician and dentist. The inspector requested to see evidence of mental health reviews and there was clear evidence of resident's receiving regular reviews.

Residents had access to a general practitioner (GP) however, not all residents had received an annual medical review. Despite this being identified in the statement of purpose and within a document contained in residents files stated "My key worker helps me arrange my annual medical every year". The inspector found residents were not provided with an annual medical review for example, one resident's records identified their annual review was completed in 2012. Four residents had their reviews completed in 2014. The inspector found the health and wellbeing policy dated April 2015 identified all SHS clients must have an annual medical form completed, if clients had no contact with G.P./specialist or who have undergone tests in hospital or GP. However, within another part of the document it identified a decision as to whether the client requires an annual medical e.g. for clients who attend their G.P./ specialist or who had under gone tests in hospital or GP. The inspector found this document was unclear and had the potential to misguide staff for example, if a resident had undergone a test for one specific area this could replace a resident undergoing an annual medical.

The inspector viewed phlebotomy results as required for some residents due to their diagnosis or their medication prescribed.

Regarding food and nutrition the inspector found residents participating in mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices. Residents participated in cooking in accordance with their own preferences.

The inspector viewed user-friendly menu selection refreshments and snacks were available for residents outside mealtimes within the designated centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector found policies and procedures were in place for the safe management of medications.
The inspector crossed checked the balances of some medication including p.r.n. (a medicine only taken as the need arises) and found these to be accurate.

The inspector viewed p.r.n. guidelines to assist staff in the administration of these medications. The inspector found one p.r.n. medication required clarity either through the development of a guideline or through the administration sheet. The document identified "pre appointment anxiety only if absolutely necessary" the inspector found this required further clarity as staff informed the inspector it was only used prior to dental treatment. The person in charge also identified this medication was not held on the premises as this was obtained when required.

The inspector viewed medication plans, these contained person-centred information in relation to residents medication needs. Accessible information relating to each medication the resident required was also included. This was present in both written and pictorial format.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines dated 01 September 2014. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received. On the day of inspection the local pharmacist came to the designated centre to deliver medications. The pharmacist was also available to take questions from staff members if required and completed and audit on the storage and stock balances from time to time. Every day medication was supplied in individual pre-formed plastic packaging with p.r.n. medication in containers.

Administration sheets were in place for each resident, a number of these were viewed by the inspector. These were found to be up-to-date and showed staff administered and signed for medication.

Staff signatures were present within the signature bank.

The inspector observed all medication was stored in a secure, locked cabinet and the keys to access the medication cabinet were held securely by staff.

There was a system in place for recording, reporting errors and reviewing medication, the person in charge presented some of these to the inspector. Clear learning was evident in relation to the errors within the designated centre in order to mitigate future risk of reoccurrence.

**Judgment:**
Substantially Compliant
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

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found improvements were required in the monitoring and follow up of the quality of care and experience for residents. The completion of annual reviews and enhancement of staff supervision was also required.

There was no annual review of the quality and care completed in this designated centre for 2014 or 2015.

There was a person nominated on behalf of the provider to carry out an unannounced visit of the designated centre on a six monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. The inspector viewed one completed on the 17 July 2015; however, no action plan was developed for areas required. There was no other record of any other unannounced visits available within the designated centre.

The inspector observed very limited auditing of areas within the designated centre. The person in charge identified a checking process however, no formal schedule of audits were available within the designated centre.

Staff supervision records viewed by the inspector identified the person in charge provided supervision, support and leadership to the staff team however, this was not consistent across all staff members.

The inspector found the needs for some residents were impacting on the overall care delivery to all residents within the designated centre. Staff members were required to meet the changing needs of some residents in relation to ageing and displays of behaviours however, this was impacting upon the lived experience for all residents. The person in charge was spending the majority of their time frontline within this location due to these issues. This impacted on other aspects of the person in charge's role such as, completing staff supervision and audits aspects of service delivery within the designated centre as required by regulations.
The inspector viewed minutes of staff meetings within the designated centre. The inspector viewed minutes dated 16 February 2016 and 15 March 2016 areas discussed included changes in residents assessed needs, funding issues and residents plans.

The inspector viewed a monthly updates from the person in charge to management these outlined areas in relation to staffing issues and increased residents needs dated January 2015. The renovation of the bathroom was also highlighted with the need for an alternative bath to meet the needs of the residents. The inspector found no follow of the issues with the exception of the person in charge spending more time frontline in the designated centre to assist staff in the delivery of care to residents.

The person in charge met with the senior service manager along with other persons in charge within the region (cluster meetings) dated 16 July 2016. Issues relating to transport, safeguarding incidents and staffing were areas discussed during this meeting.

The inspector viewed minutes of the person in charge attending the senior management team meeting dated 26 July 2016. Areas discussed related to the whole organization including training, budgets and safeguarding and protection.

The inspector found there was a clearly defined management structure with lines of authority and accountability identified. The designated centre was managed by a suitably qualified, skilled and experienced person in charge with authority, accountability and responsibility for the provision of the service. The person in charge facilitated this inspection. From speaking with the person in charge in length over the course of the inspection it was evident they had an in-depth knowledge of the individual needs and support requirements of each resident. The person in charge was supported in their role by senior service manager. The person in charge was aware of their statutory obligations and responsibilities with regard to the role of person in charge, the management of the designated centre and the remit of the Health Act (2007) and Regulations. Throughout the course of the inspection the inspector observed all residents knew the person in charge and were very comfortable in approaching and speaking with them as residents requested to meet with the person in charge regularly throughout the day of inspection. The person in charge worked on a full time basis between the designated centre and a day service.

Judgment:
Non Compliant - Moderate

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
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector found there were improvements required in relation to the staff numbers with the right skill mix, qualifications and experience to meet the assessed needs of the residents.

The inspector met and spoke with four staff members, each staff member was very complementary of the person in charge. Morning routines were identified by staff and residents as particularly difficult despite two staff members being present. Older residents had to be up at 07:30hrs and out of the designated centre at 09:00hrs on many days in order to get to their day service. The inspector acknowledged some residents had been provided with a day off from day service once a week.

The person in charge informed the inspector all staff had completed mandatory and relevant training in line with regulation. Eleven staff training records were reviewed, staff had up-to-date training in safeguarding training prevention, detection and response to abuse, manual handling, fire safety and medication management.

The inspector viewed the proposed and actual staff rota and found when gaps were evident these were for the most part replaced. The inspector found there was a coding system required in order to fully comprehend the rotas in place.

Staff files were not reviewed as part of this inspection as these are held within the organizations head office off site these were reviewed as part of the previous inspection.

The inspector observed residents received assistance in a respectful manner.

These were no volunteers within the designated centre.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspector viewed this outcome in respect of the action identified from the previous inspection and found the action was achieved. However, over the course of the inspection the inspector found the retrieval of schedule 3 documents difficult. Some documents were present in duplicate versions for example, guidelines in relation to the management of behaviours was present in different versions and safety plans for residents were also present in differing versions.

Schedule 5 documents were now available within the designated centre.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
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<td>Centre ID:</td>
<td>OSV-0001703</td>
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<tr>
<td>Date of Inspection:</td>
<td>02 September 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>31 October 2016</td>
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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, 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

It was unclear who was the nominated person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
The SHS policy has been updated and rolled out on 26/10/16.

**Proposed Timescale:** 31/10/2016

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**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:**
Some resident’s personal and social plans were not reviewed annually.

2. **Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
Personal and Social planning files will be reviewed, updated and supplemented (if necessary) and continue to be reviewed.

**Proposed Timescale:** 19/12/2016

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The bathroom on the first floor was in need of renovation the shower was not functioning, the walls and floor required attention.

3. **Action Required:**
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

**Please state the actions you have taken or are planning to take:**
The required number of quotes for the works have been received and one has been chosen. The renovation is due to start in the next number of weeks with a completion
date before the end of the year.

**Proposed Timescale:** 31/12/2016

| **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 hot water in the designated centre was not regulated nor was this identified within the location risk register

Individual risk assessments were not completed in required areas

Individual safety plans were not reviewed annually.

4. **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:**

a) There is a plan of works being developed following Environmental Services Ireland auditing of Sunbeam House locations. Recommendations have been made about Sunbeam House Services locations. These works include the fitting of individual temperature regulation modules at sinks in Helensburgh. The plan of works will be finalised by 31/12/16.

b) The danger of hot water will be included in the location risk register. Individual risk assessments will be completed in required areas and the individual safety plans will be reviewed, updated and supplemented using the new safety plan documentation. Specific safety plan mentioned during the report will be completed. 19/12/16

**Proposed Timescale:** 31/12/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The procedure for the management and disposal of sharps was not available within the designated centre nor were staff aware of the process.

5. **Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections.
Please state the actions you have taken or are planning to take:
Local procedure for sharps management and disposal will be developed, implemented and shared with staff team.

**Proposed Timescale:** 01/12/2016

### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not equipped with up-to-date behavioural plans nor did the plans viewed guide staff effectively to respond to consistently to behaviours displayed.

**6. Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
Client Behaviour Support Plans will be updated and supplemented where necessary. Discussion about plans to happen at team meeting.

**Proposed Timescale:** 19/12/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff members were not aware of the reporting structure should an allegation of abuse arise.

**7. Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
PIC has met staff informally and gone through the process of reporting and recording, responsibilities and duties. PIC to meet all staff individually (formally) to go through the actions again that are required should there be a concern or disclosure of abuse. Also discussion at team meeting on 09/11/16.

**Proposed Timescale:** 14/11/2016
<table>
<thead>
<tr>
<th>Outcome 11. Healthcare Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Some residents did not have healthcare plans reviewed annually. The inspector viewed a healthcare plan reviewed this contained inaccurate information.</td>
</tr>
<tr>
<td><strong>8. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All healthcare plans to be to be reviewed, updated and corrected/supplemented if necessary. Plans to be reviewed annually from now on.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 19/12/2016</td>
</tr>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Residents did not have an annual medical review despite this documented within the residents personal planning documentation. The health and wellbeing policy dated April 2015 contained conflicting information pertaining to this aspect of care provision.</td>
</tr>
<tr>
<td><strong>9. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>All Clients will have an Annual Medical. And will continue to have annual medicals until the policy is reviewed and clarified.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 19/12/2016</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 12. Medication Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Health and Development</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The administration of one p.r.n. medication required clarity.</td>
</tr>
</tbody>
</table>
10. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
The details about the administration of the PRN medication for this client will be clarified so there is no doubt about when exactly the medication is required.

**Proposed Timescale:** 01/12/2016

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**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:**
An annual review of the quality and safety of care and support in the designated centre for 2014 and 2015 was not available.

11. **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:**
PIC will ensure that yearly reports will be completed.

**Proposed Timescale:** 31/12/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Unannounced visit to the designated centre at least once every six months were not available within the designated centre.

12. **Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.
Please state the actions you have taken or are planning to take:
An unannounced inspection had occurred on 7/4/16 with a follow up on the 15/04/16. These reports have been printed and are now available within the designated centre.

**Proposed Timescale:** 31/10/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Systems were not in place within the designated centre to ensure the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Issues with the bathroom were outstanding since 2014.

Staffing issues were identified in January 2015.

Residents needs in relation to the mix of residents within the designated centre and in relation to the aging profile of some residents were outstanding since January 2015.

13. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
Use of the resources of the day service the PIC also manages has restarted (this had been in place when there were staff who worked equally between the residential location and the day service for a period between inspections). This can facilitate a slower start to the day for some of the residents.

PIC plans to move back from the front line and regain a higher level view of the designated centre, implement regular formal monitoring, reviews and support of staff. This will be enabled when a new staff member starts work in the next number of weeks which should allow the PIC more flexibility.

There will be another needs review carried out by the PIC (with support) and following this, Business Proposals submitted to the HSE for the additional funding needed. The number of clients within the house causes some issues but because no client wants to move (they have made it very clear) the process of reducing the numbers of clients is complex.

The issues regarding the bathroom upstairs are being addressed and an updated quote has been received. PIC will continue to emphasise the need for the bathroom to be updated as soon as possible.

**Proposed Timescale:** 31/12/2016
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Effective arrangements to support, develop and performance manage all members of the workforce was not consistent across the staff team.

14. **Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
All staff will receive regular formal supervision. Every staff member will have received supervision by 16/12/16.

PIC plans to move back from the front line and regain a higher level view of the designated centre, implement regular formal monitoring, reviews and support of staff. This will be enabled when a new staff member starts work in the next number of weeks which should allow the PIC more flexibility.

**Proposed Timescale:** 31/12/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The ageing profile needs of residents and the increase in displays of behaviours were not reflected in the staff compliment.

15. **Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
There will be another needs review carried out by the PIC (with support) and following this, Business Proposals submitted to the HSE for the additional funding needed to allow a more flexible approach to the support of the clients.

**Proposed Timescale:** 31/12/2016
Outcome 18: Records and documentation

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The retrieval of schedule 3 documents difficult as some documents were present in duplicate versions.

16. **Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
Client personal and social planning files will be reviewed, updated, duplication removed, with files supplemented (if necessary) and will continue to be reviewed.

**Proposed Timescale:** 19/12/2016