### Centre name: Hillview A
### Centre ID: OSV-0001515
### Centre county: Clare
### Type of centre: Health Act 2004 Section 39 Assistance
### Registered provider: Peter Bradley Foundation Limited
### Provider Nominee: Donnchadh Whelan
### Lead inspector: Anne Marie Byrne
### Support inspector(s): None
### Type of inspection: Unannounced
### Number of residents on the date of inspection: 3
### Number of vacancies on the date of inspection: 1
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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 30 May 2017 09:10  
To: 30 May 2017 16:20

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| 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

Background to the inspection:
The purpose of this unannounced inspection was to monitor the centre's on-going regulatory 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 met with two residents, two staff members, the team leader and the person in charge during the inspection. On the day of the inspection, all residents had opportunities to speak and meet with the inspector if they wished, and two residents chose to speak in private with the inspector.

The inspector reviewed practices and documentation, including residents' personal plans, incidents, policies and procedures, fire management related documents and risk assessments.

Description of the service:
This centre is located near Ennis, Co. Clare. It is managed by the Peter Bradley Foundation Ltd and comprises of a purpose built four bedded bungalow house, which is a 24 hour residential neuro-rehabilitation service. This service provides care to
male and female residents between 18-65 years of age, who are living with a primary diagnosis of an acquired brain injury from road traffic accidents, falls, assaults, stroke, brain haemorrhage, viral infections or anoxia. Residents may also have cognitive, physical, sensory or behavioural difficulties. Three male residents were residing in the centre, with one vacancy on the day of the inspection.

The person in charge had the overall responsibility for the centre. She is supported in her role by the team leader and by the national services manager. The person in charge had the capacity to be present in the centre two to three times a week to meet with residents and staff. Residents who spoke with the inspector said they felt supported and safe in the centre. The inspector found staff spoke respectfully of residents and were found to be very knowledgeable of residents' care and support needs. The centre is a bungalow dwelling and each resident has their own bedroom with individual or shared en-suite facilities. The house has access to a garden space to the rear of building and communal areas including a kitchen, dining and living spaces. In the main, the inspector found the centre provided a warm, pleasant and homely environment for residents.

Overall judgment of our findings:
The inspector found this centre provided a very individualised and person-centred service to the residents. During the last inspection of this centre, seven actions were identified. During this inspection the inspector found that six actions were satisfactory completed, with one action not fully completed. However, further improvements were also identified in relation to residents' rights, dignity and consultation, social care needs and health and safety and risk management.

This inspection identified that of the eight outcomes inspected, four outcomes were found to be compliant, one outcome substantially compliant and three outcomes in moderate non-compliance.

These findings are discussed further in 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, 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:
Overall the inspector found residents were consulted with, and participated in decisions about their care and about the running of the centre. One action required from the previous inspection was not fully completed. The inspector found the complaints procedure "Your Voice Matters" did not reflect changes to the nominated complaint officers for the centre and further improvements were required to the arrangements for supporting residents to manage their financial affairs.

Residents' meetings were held on a regular basis and residents were involved in the scheduling of their weekly activities and general routines. Minutes of these meetings were reviewed by the inspector and were found to offer residents an opportunity to discuss topics such as complaints, up-and-coming social events, maintenance works required and general information. The inspector observed staff interacted with residents in a respectful manner, and residents who spoke with the inspector said staff regularly engage with them about their care and social needs. Evidence of residents' involvement and consultation in personal plan development and annual reviews, was also available to the inspector on the day of the inspection. Advocacy services were available to residents if they wished to access them.

Residents were supported to manage their own finances. Where residents' money was maintained by the centre, the centre had records in place to show all transactions and lodgements made to residents' personal accounts. All transactions and lodgements made by residents were witnessed and signed by two staff members, and the balance of residents' personal accounts was being 'spot checked' on a regular basis by the team.
leader. However, the inspector found the centre did not have adequate capacity assessments, risk assessments or protocols in place for some residents who required support with accessing their bank account. This was not in line with the centre's policy on personal finances.

Since the last inspection, the person in charge had put measures in place to ensure all complaints received were recorded, including the details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied with the outcome. The inspector reviewed the complaints register for the centre and found no gaps in the recording of complaints received. The complaints procedure had been updated since the last inspection and this was found to now include the name of the person nominated to deal with complaints. Staff who spoke with the inspector were knowledgeable of their responsibility in the local management of complaints. However, the complaints procedure for the organisation, 'Your Voice Matters', had not been updated with the names of those nominated to deal with complaints.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Each resident had opportunities to participate in meaningful activities that were appropriate to their interests. The inspector found the action from the previous inspection was satisfactorily completed. However, improvements were required to the recording of residents' personal goal progression.

Residents were supported to participate in a variety of activities, with some residents attending weekly social groups and education and training workshops. Residents were encouraged and supported by staff to engage in activities of interest to them. Residents who spoke with the inspector said that staff had assisted them to create a workshop space to the rear of the centre, which they regularly use for skill based activities. Other residents who spoke with the inspector said they don't like to engage in group events,
but are facilitated by staff to attend any event they requested to go to. Where residents wished to have regular home visits, they were supported by the centre to do this. The inspector found staff were very familiar with residents' likes and dislikes and residents' preferences were well-documented. The centre had access to a full-time vehicle which was used to transport residents to various activities.

An assessment of need was completed on an annual basis for all residents. Assessment findings were used to inform the development of residents' personal plans. The inspector found that personal plans clearly outlined the care and support required by residents. Each resident had a nominated key-worker, who supported them to develop and work towards their personal goals. Personal goals were reviewed annually and involved residents, key-workers and family members. On the day of inspection, some residents informed the inspector that they were currently in the process of reviewing their personal goals with their key-worker. The inspector reviewed a sample of personal goals and these were found to be varied and appropriate to the residents' expressed interests. The progress made by residents to achieve their goals was reviewed with their keyworkers every three months. However, the inspector found the progression made by some residents in achieving these goals was unclear in some progress reports. In addition, the names of those responsible for supporting residents to achieve their personal goals was not clearly documented.

There were no residents transitioning to or from the centre at the time of inspection.

Judgment:
Substantially Compliant

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

Findings:
The actions required from the centre's last inspection were found to be satisfactorily completed. However, further improvements were identified in relation to fire and risk management.

Incident reporting was promoted within the centre. All incidents were recorded on an electronic database and were reviewed by the team leader and person in charge. The team leader demonstrated to the inspector various trends identified through the review of incidents and informed of the corrective actions taken following these incidents. Staff meetings were conducted on a regular basis and the agenda for these meetings consistently included the review of incident trends.
There were risk management systems in place within the centre for the assessment, management and on-going review of risk. A health and safety statement was in place and the team leader was the nominated health and safety representative for the centre. Residents' specific risk assessments were in place and these were reviewed on a minimum annual basis. However, the inspector observed some gaps in the assessment of residents' specific risks. For instance, the centre had not risk assessed the safety of residents who wished to smoke, which was not in line with the centre's risk management policy.

A risk register was in place for the management of organisational risks. This was reviewed on an annual basis by the person in charge and the team leader. However, the inspector found gaps in the risk management practices within the centre to include: - not all organisational risk assessments clearly identified the additional control measures required to mitigate risk. For instance, where the register identified and rated as medium, specific risks associated with medication administration practices, the register did not identify the additional controls required to mitigate this risk. - where bedrails were in use by some residents, the inspector also found that the control measures identified in the risk assessment did not adequately demonstrate what measures the centre had in place to mitigate against the hazard associated with using these bedrails. - some risks on the register did not identify a person responsible for the review of these risks within measurable timeframes. - the risk management policy failed to guide on the measures and actions in place to control risks identified.

Since the last inspection, the person in charge had updated the emergency plan to provide clear guidance for staff of their roles in the event of an emergency. Fire drills were occurring in the centre, these were noted to involve all residents and staff. Records of these drills were reviewed by the inspector, which demonstrated residents were successfully evacuated during the day and at times of minimum staffing levels. Fire detection systems and fire fighting equipment were maintained on a regular basis. Residents had personal emergency evacuation plans in place and these were found to reflect the support needs of residents during an evacuation. Staff who spoke with the inspector were aware of how to respond to a fire, how they would alert the emergency services and of how they would support residents to safely evacuate from the centre. The fire procedure was displayed in the hallway of the centre; however, the inspector found it required updating to provide clarity on who was responsible for notifying the emergency services in the event of a fire in the centre.

All staff had received up-to-date fire training at the time of inspection.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
No actions were required from the previous inspection.

There was a restrictive practice in place at the time of inspection. This restrictive practice had been risk assessed and its use was reviewed on a regular basis by the team leader and staff. Staff who spoke with the inspector demonstrated their knowledgeable of the appropriate application of this restrictive practice.

There were no safeguarding plans in place at the time of this inspection, and all staff had received up-to-date training in safeguarding. There were no residents residing in the centre at the time of inspection who presented with behaviour that challenges. All staff had received up-to-date training in the management of behaviour that challenges.

Judgment:
Compliant

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:
No actions were required from this centre's last inspection.

Residents' healthcare needs were met, with timely access to healthcare services and appropriate treatments. Residents had access to local General Practitioner's (GPs) of their choice. Residents also had access to healthcare specialists, as required, and the centre maintained good communication with these specialists in the management of
residents' specific healthcare needs.

Where residents presented with specific healthcare needs, personal plans were in place to guide staff on the care and support required by these residents. These plans were found to be reviewed on a minimum annual basis. Staff spoken with were aware of residents' specific healthcare needs and had a clear understanding of how they were required to support these residents.

Residents were supported by staff to assist in meal preparation if they wished to do so. Menu planning was found to be resident led and residents were facilitated to dine out if they wanted to. A spacious kitchen and dining area was available in the centre for residents to enjoy. No residents were assessed as requiring modified diets at the time of inspection.

Judgment:
Compliant

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:
No actions were required from the centre's previous inspection.

There were written operational policies and procedures relating to the ordering, prescribing, storage and administration of medication to residents. Medicines were dispensed in blister packs, which were clearly labelled with residents' details. Staff had received training in the safe administration of medication. Each resident had a medicine management plan in place which guided staff on each resident's preferred way to take their medication. Protocols were also in place to guide staff on the administration of 'as required' medication. A number of medication records were reviewed by the inspector. These were found to be clear and informative, with no gaps in the documentation of medicine administration found. Each medication on prescription sheets was signed by the prescribing practitioner.

The centre had completed assessments of capacity to encourage each resident to take responsibility for their own medication; however, no resident was self-administering their own medication at the time of this inspection.
Judgment: 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:
No actions were required from the previous inspection.

The person in charge had overall responsibility for the centre. The organisation had made some changes to its governance structure since the last inspection and the person in charge was now supported in their role by the team leader, the provider and by the national service manager. The person in charge was found to have a good knowledge of each residents' needs, and of the operational management of the centre. The person in charge had the capacity to visit the centre regularly during the week to meet with residents and staff.

There were management systems in place to ensure the service provided to residents was safe and consistently monitored. The person in charge and team leader held regular staff meetings in the centre, where topics specific to the operations of the centre were discussed. An annual review of the service had been completed and unannounced visits to the centre were also conducted on a six monthly basis. An action plan was in place to address areas of improvement identified within these six monthly audits. The inspector found that actions which were due for completion, were satisfactorily completed.

Judgment: Compliant

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:
Actions required from the previous inspection were satisfactorily completed. However, upon this inspection some improvements were required to the maintenance of Schedule 2 documents.

Staff supervision was occurring in the centre on a three monthly basis. Since the last inspection, the inspector found changes were made to the roster to ensure it now detailed the full name of staff duty and identified the staff member in charge on each shift.

Training records demonstrated the nature of staff training conducted within the centre. Staff had received training and refresher training in areas such as infection control, manual handling and behaviour management.

The inspector reviewed a sample of staff files and found not all contained Schedule 2 documents to include:
- satisfactory history of any gaps in employment
- two signed written references

Judgment:
Non Compliant - Moderate

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:

Anne Marie Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Peter Bradley Foundation Limited</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0001515</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>30 May 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 June 2017</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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure adequate arrangements were in place to support residents to manage their financial affairs, in accordance with the centre's policy on personal finances.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**
- The agreement of supporting Person Served with their finances was updated, signed and will be reviewed every 6 months.

**Proposed Timescale:** 31/05/2017

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that the complaints procedure "Your Voice Matters" was updated to include the names of those in the organisation who were responsible for dealing with complaints.

2. **Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
- "Your Voice Matters" leaflets have been updated to reflect who is responsible for dealing with the complaints in the Organisation.

**Proposed Timescale:** 26/06/2017

**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:**
The provider failed to ensure the development and review of residents personal goals included:
- accurate records of the progression made by residents to achieve their personal goals
- identify the names of those responsible for supporting residents to achieve their personal goals

3. **Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.
Please state the actions you have taken or are planning to take:
• A clear follow through from the IRP goals, monthly goals, Progress Report and Annual Report is to be evident.

• A review sheet is now in place for reviewing of all goals for each Person Served.

• Where a goal has been identified for Person Served the name of the staff member that is responsible for supporting Person Served will be identified on the personal goals.

Proposed Timescale: 15/07/2017

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 provider failed to ensure that the risk management policy included the measures and actions in place to control the risks identified.

4. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
• This was discussed with the National Service Manager and the Quality Control Coordinator and the Risk Management Policy is to be reviewed.

• In relation to the measures and actions to control risk this will be disseminated to all staff so that the process is clear.

Proposed Timescale: 26/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to put systems in place in the designated centre for the assessment, management and ongoing review of risk to include:
- identify nominated persons responsible for the review of risks within the risk register within clear timeframes
- completion of smoking risk assessments in line with the centre's risk management policy
- risk assessments adequately identified the control measures in place for residents' in use of bedrails

5. 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 Local Risk Register will be a continual ongoing risk review document and will be reviewed every quarter.
- A nominated Person that is responsible for the ongoing risk reviews has been identified and includes the Local Service Manager and the Team Leader.
- As well as a smoking risk assessment in the Local Risk Register a personal risk assessment has been carried out for the two Person Served that smokes outside the house.
- A risk assessment has been carried out for Person Served that uses a bedrail.

**Proposed Timescale:** 15/06/2017

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure the fire procedures displayed in the centre provided clear guidance on who was responsible for alerting the emergency services in the event of a fire in the centre.

**6. Action Required:**
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

**Please state the actions you have taken or are planning to take:**
- The terminology “Person in Charge” that was used on the Fire Procedure Display has now been changed to the “Staff Member in charge on the day is responsible for alerting the Fire Emergency Service”.

**Proposed Timescale:** 31/05/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all information as outlined in Schedule 2 of the regulations was maintained for all staff.
7. **Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**
• The gap in the C.V that was identified for a staff member has been identified and has been written into the C.V and signed by the Local Service Manager.

**Proposed Timescale:** 31/05/2017