**Health Information and Quality Authority**  
**Regulation Directorate**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Parkview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001689</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Wicklow</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Sunbeam House Services Company Limited by Guarantee</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Gary Kiernan</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
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 inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 22 February 2018 09:45  To: 22 February 2018 16:00

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

| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 04: Admissions and Contract for the Provision of Services |
| 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 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

Summary of findings from this inspection
Background to the inspection:
This was the fourth inspection of this designated centre. An initial inspection in 2015, with subsequent inspections in 2016 and 2017; were carried out in response to the provider’s application to register this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Previous inspections of this designated centre did not find sufficient compliance with the regulations for the Chief Inspector to grant registration.

The previous July 2017 inspection of this centre had found significant non compliance with the regulations and standards. Following the inspection the Chief Inspector issued the provider a warning letter outlining consequences that may be enacted in line with the Health Act 2007 (as amended) if improvements did not occur within a specified timeframe.

Since the previous inspection Sunbeam House Services appointed a new CEO and made changes to the constitution of the board. In light of this the Health Information and Quality Authority (HIQA) made the decision to allow the incoming CEO and
newly constituted board time to make necessary improvements within the service.

The purpose of this inspection was to follow up on actions from the previous 2017 inspection of this centre, evaluate evidence of the provider's governance and management improvement plan submitted to the Chief Inspector dated January 2018 and ascertain if these improvements were ultimately having positive impacts for residents. This inspection would also provide evidence for a decision on the registration of this centre.

How we gathered our evidence:
As part of the inspection, inspectors visited the designated centre and met with three residents and spoke more in depth with one resident. Inspectors also met with the person in charge, deputy manager and senior services manager. Inspectors also met staff members on duty the day of inspection and spoke more in depth with one staff member in relation to complaints management and the key working process for residents. Inspectors reviewed documentation such as, personal plans, person-centred support plans, recording logs, risk management systems and documentation and complaints management documentation and systems. Over the course of this inspection resident's communicated in their own preferred manner with the inspector.

Description of the Service:
This designated centre is operated by Sunbeam House Services (SHS)Company Limited by Guarantee and is based in Bray County Wicklow. Four adult residents live in the designated centre. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The designated centre, aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities as outlined in the statement of purpose. Residents living in this center presented with varying support needs related to healthcare, personal risks, safeguarding issues and mental health.

Overall Judgments of our findings:
Ten outcomes were inspected against with all outcomes found to be compliant or substantially compliant. Inspectors only reviewed if actions from the previous inspection had been addressed and compliance found on this inspection related to the actions taken by the provider and person in charge to address these. Overall, there were significant improvements in governance and management of the centre resulting in better outcomes for residents and improved compliance with the regulations and standards.

There was evidence that the governance and management improvement plan submitted by the provider to the Chief Inspector was being implemented and improvements in relation to risk management, analysis and reporting had improved. The electronic recording and reporting system for incidents had been reviewed and improvements made to ensure incidents were reported and escalated where required to both the person in charge and senior services manager. The system had also been reviewed to ensure data analysis and reporting systems were in place to inform the newly formed quality and risk sub-committee of the board. All staff in Sunbeam House Services were in the process of receiving mandatory training in incident and
risk management and three staff working in the centre had already completed this training.

This was a significant improvement in relation to risk management for Sunbeam House Services and provided for a safer service for residents.

Operational management accountability arrangements were now clearer with lines of reporting and responsibility established in line with each manager's regulatory responsibilities. Improved performance management systems had also been instated in the centre. A revised performance management process between the senior service manager and person in charge ensured continued monitoring of quality and compliance for the centre in a more effective and robust way.

Complaints management systems had also improved. A complaints and compliments manager had been instated by the provider for Sunbeam House Services. Complaints recording and management systems had also improved and mandatory training in complaints management was to be rolled out for all staff working in Sunbeam House Services.

Issues found on the previous inspection in relation to inadequate food supplies in the centre had also been addressed.

Previously ineffective budget management systems had resulted in a lack of food and drinks for residents living in the centre necessitating them to purchase foods from their own personal monies. On this inspection it was found the provider had reviewed this and had identified issues with the budget allocation system for the centre. This had been addressed and the centre was now appropriately resourced with a budget to meet the needs of residents. The provider also had plans to further improve the system in place for designated centres' household budgets and a streamlining of the process for managers to ensure there were less steps required for application and receiving of household budget monies.

Some improvement was required in relation to the overall audit and review arrangements for restrictive practices. Improvements were also required in relation to workforce to ensure the centre was adequately resourced with a consistent staff team to meet the assessed needs of residents.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
In this outcome inspectors reviewed if actions from the previous inspection relating to complaints management had been addressed. On this inspection it was found they had and further initiatives by the provider would further improve complaints management in the centre going forward.

Previously it had been found that complaints were not effectively managed and staff did not demonstrate adequate knowledge and understanding of the complaints process and management of complaints.

On this inspection it was noted that the person in charge demonstrated a good understanding of complaints management and had followed up in a timely way to residents' complaints if and when they occurred.

The provider had instigated a revised and improved complaints management framework in the centre. This included a more responsive and comprehensive system for the management of complaints through an electronic recording system which generated an alert to the nominated person to manage complaints in the centre, the person in charge. This ensured where a complaint was logged the person in charge was alerted and was required to process the complaint in a timely way.

Documented meetings between the person in charge and complainant were maintained in residents' personal plans. It was also evident that key workers had supported residents to avail of the complaints process and had worked with some residents to develop an agenda prior to meeting the person in charge to ensure they effectively
brought forward their issue. This was evidence of supportive action taken by key workers on behalf of residents living in the centre.

Staff spoken with demonstrated a good understanding of the complaints process and residents' right to make a complaint.

The provider had also initiated further improvements at a governance level with regards to complaints management. This included complaints management training for all staff working in Sunbeam House Services which would be mandatory. This training incorporates role playing, instructions on how the electronic documentation system and ensuring all staff had a working knowledge of the organisation's complaints procedure and policy. The provider had also appointed a complaints manager for Sunbeam House Services. Their specific role would be to audit and analyse information gathered through the online complaints documentation system and respond to complaints that could not be resolved at a local level.

This improved provider led complaints management process provided inspectors with assurances that going forward complaints would be managed in a more effective way, be responsive to residents and families and ensure better compliance with the regulations.

Inspectors did not review any other aspects of this outcome.

**Judgment:**
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:**
Inspectors reviewed if actions from the previous inspection in relation to contracts of care had been addressed. It was found they had.

The provider had revised the contract of care for residents living in the centre. An inspector reviewed a sample of contracts during the course of the inspection. Contracts of care for residents had been devised in an easy to read format which included written text and colour pictures to represent and explain the services provided to them and the terms and conditions of their service. This was a good initiative implemented by the
provider as it evidenced their commitment to support residents in being fully informed of their rights and entitlements for the service they received.

Equally the provider had listed and documented in a transparent way each residents' weekly rental payment and what this covered. They had also listed fees the resident may be required to pay.

Each resident issued a contract of care had signed the contract.

**Judgment:**
Compliant

---

**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

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

**Findings:**
Not all aspects of this outcome were reviewed during this inspection. Inspectors reviewed actions taken by the person in charge to address non compliances found on the previous inspection were adequate and complete. Inspection findings indicated the recently appointed person in charge had addressed the actions to a good standard.

It was evident from reviewing a sample of residents' personal plans that they have been reviewed and updated. An assessment of needs had been carried out for each resident which identified areas of support and independence for each resident. Where a need was identified an associated up-to-date support plan was in place to guide staff.

Person centred planning meetings had occurred and a review of actions and goals from the previous year had also occurred. A number of goals for residents had been achieved such as going to a casino, going on a foreign holiday and an overnight stay in a hotel.

At each residents' planning meeting they had identified goals they wished to continue to work on and new goals for the coming year. In some instances action plans were not in place for goals identified however, there was evidence to indicate that key workers were working towards developing action plans for goals identified through liaison with social
work and other key stakeholders and persons part of residents' circles of support.
Thereafter, action plans would be finalised.

It was noted that in some instances during the previous year that residents' goals could
not be fully achieved due to lack of staffing resources. This was documented in
residents' personal plans as a barrier to achievement. The person in charge and provider
representative discussed this issue with inspectors during the feedback meeting and
outlined some initiatives that were underway to improve staffing resourcing for the
centre.

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

**Findings:**
Inspectors reviewed if actions from the previous inspection in relation to risk
management and implementation of associated policies and procedures had improved.
Overall, it was found they had been addressed with evidence that improvement
initiatives by the provider were bringing about improved incident analysis and overall
reporting as part of a revised risk management policy for Sunbeam House Services.

The person in charge demonstrated to an inspector the revised electronic incident log
system which now provided a more robust incident monitoring, analysis and reporting
mechanism. Incidents could now be more accurately classified than previously. Incidents
logged by staff escalated to the person in charge who in turn was alerted that an
incident had been recorded for their designated centre. This in turn required the person
in charge to analyse the information logged and to risk rate it based on the information
entered. If the incident was not a high risk incident or was appropriately managed, the
person in charge closed the incident and it was then retained for information and risk
analysis data for the centre. If the incident was a high risk incident this created an alert
to the senior services manager to review how it was managed and in turn provide more
robust or comprehensive supports to the centre based on the risk or incident entered.

The improved system could now also provide reporting and analysis data to the quality
and risk sub-committee which in turn provided a mechanism for reporting to the board
on how risk and incidents were managed in designated centres of Sunbeam House
Services. This was a significant improvement in the overall risk management system for
Sunbeam House Services where this reporting mechanism and risk classification system was not previously in place.

The organisational risk management policy for Sunbeam House Services was also under review. The provider had requested an external consultant to review the policy to ensure it met the regulations and provided a robust and comprehensive framework for Sunbeam House Services risk management. The provider had also initiated mandatory training in risk and incident management for all staff working in Sunbeam House Services to ensure the revised and improved risk management policy was implemented correctly and comprehensively. Three staff working in the centre had completed this training and told the inspector they found it very interesting and had learned a lot on the training.

These improvements, initiated by the provider, evidenced their work towards actions identified in the governance and management improvement plan submitted to the Chief Inspector January 2018. This in turn provided inspectors with assurances that risk management for the designated centre would be more robust and could sustain consistent risk management improvement during the centre's next three year cycle of registration.

An up-to-date risk register was in place for the centre which included environmental hazard identification and specific control measures for each. Personal risks for residents had also been identified with associated control measures in place for each risk identified. Each risk had been analysed and a risk rating assigned to each risk.

During the course of the inspection, inspectors identified two risks which required improvement.

A fridge located under the stairs of the premises had been identified as a fire hazard. This had been identified through an annual review report for the centre commissioned by the provider to meet their regulatory responsibilities. However, at the time of inspection the fridge was still in place. Inspectors requested the person in charge to address this fire hazard risk before the close of inspection. Before the inspection closed inspectors observed the fridge being removed. Therefore, a non compliance was not found in relation to this.

Another hazard identified was the risk of scalds due to very hot water in hand washing sinks in the centre. Inspectors brought this to the attention of the person in charge and provider during the feedback meeting. The provider gave assurances that a thermostatic control mechanism would be installed to control the temperature of hot water. However, it was not possible for this to occur before the close of the inspection. Shortly following the inspection, inspectors received correspondence from the provider that thermostatic controls had been installed which mitigated the risk of scalds. Therefore, a non compliance was not required in light of the provider's timely and responsive actions.

**Judgment:**
Compliant
### 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.*

<table>
<thead>
<tr>
<th>Theme: Safe Services</th>
</tr>
</thead>
</table>

#### Outstanding requirement(s) from previous inspection(s):

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

#### Findings:

Inspectors did not review all aspects of this outcome. The previous inspection had found that restrictive practices were not implemented in line with the regulations and National policy. It had also found there was a lack of evidence that the least restrictive option was implemented in all instances where restrictions were in place.

On this inspection it was evidenced that restrictions in place had been reviewed and in some instances had been discontinued with alternative options in place to manage personal risks to residents. By way of example, the person in charge had discontinued residents' restricted access to the fridge and food storage areas in the kitchen and had implemented a system whereby raw foods only were stored in a container unavailable to some residents. Food items for snacks and drinks were made available for residents that liked to have a snack at night time but could consume raw foods if unsupervised. This was a practical and least restrictive solution to manage a person risk for some residents and evidence and improved approach to the management of restrictive practices and personal risks for residents.

Restrictive practices were referred to a human rights committee for external review and feedback. These referrals and reviews were maintained in residents' personal plans and on the electronic system for the centre.

While these improvement initiatives were evident there was no overall restraint register in place which evidenced an overall recording and oversite of restrictions in the centre and control measures in place to ensure they were the least restrictive, when they were initiated and when they were reviewed. A restrictive practices register was required to ensure a comprehensive oversight of restraint in the centre, support auditing of such practices and evidence where they had been discontinued.

The provider had improved safeguarding allegation reporting mechanisms for Sunbeam House Services. Where issues of concern occurred staff logged them on the electronic incident recording system. On this system safeguarding allegations or concerns were then sent as an alert to the person in charge and also an assigned designated officer for the centre. This ensured where a safeguarding allegation was logged it was reviewed in
a timely way by a designated officer and ensured a preliminary screening was completed before moving on to the next stage of the process. This initiative by the provider would provide better safeguarding reporting systems for the designated centre and Sunbeam House Services and evidenced more comprehensive implementation of the National safeguarding vulnerable adults policies and procedures.

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

Findings:
The previous inspection had found healthcare planning for residents to be generic and not person specific. In addition serious findings in relation to lack of food available for residents in the centre had resulted in the provider being issued a warning letter in August 2017.

On this inspection it was evident the person in charge and provider had instigated improvements in healthcare planning and budget resourcing to ensure adequate quantities of food and drinks were available to residents on all occasions.

An inspector reviewed a sample of healthcare plans for residents. These were found to be person specific and no longer generic in format. Evidence of allied health professional reviews and recommendations, were required, were maintained in residents personal plans. Support planning had been updated since the previous inspection and there was evidence that residents had received an annual health check with their general practitioner and blood tests where required had been carried out with results maintained in residents' personal plans.

Poor budgeting and resource management of the household budget had previously resulted in negative impacts on residents where they were required to eat out and use their own personal funds to purchase foods due to lack of food provisions in the centre. These findings on the previous inspection, coupled with the poor compliance found in other outcomes, had resulted in the Chief Inspector issuing a warning letter to the provider outlining consequences that may be enacted, in line with the Health Act 2007 (as amended), if improvements did not occur.

On this inspection it was evident that food supplies were adequate in the centre. Fresh,
Frozen and dry goods for making nutritious meals were in good supply in the centre. Residents' personal preferences for meals and drinks were also available in the centre and in an adequate supply to ensure their food preferences were always met.

The provider and person in charge had also reviewed the household budget for the centre to ensure there was an adequate monetary resource at all times. The provider also outlined changes that were planned to ensure a more streamlined system was in place for allocating budget resources for the centre which in turn would ensure the household budget was always adequate to meet the assessed needs of residents.

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

**Findings:**
Inspectors reviewed the management of PRN (as required) medication. The previous inspection had found non-compliance in systems management of these types of medication.

On this inspection it was noted that residents had changed their pharmacy provider since the previous inspection. This change was now providing a more comprehensive pharmaceutical service to residents. Each week residents' medications were supplied to the centre by their pharmacist in a pre-packed dosage system. When medication was delivered to the centre the pharmacist carried out a stock check of medications each week. This system provided a more robust stock balance check than had been found on the previous inspection.

Audits were carried out by the pharmacist in the centre which incorporated a review of the types of medications residents were receiving, a categorization of their types and a review to ensure interactions and healthcare adverse effects, if any, were identified and brought to the attention of the person in charge.

The maximum dosage for each PRN medication was clearly indicated on both residents' medication administration charts and also their pre-packed dosage system.

Where PRN medications were prescribed an associated protocol was in place setting out specific criteria for when and why they should be administered. These were found to be
recently revised and an associated signature by the prescribing physician documented on each protocol.

No other aspects of this outcome were reviewed on this inspection.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 13: Statement of Purpose</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.</em></td>
</tr>
</tbody>
</table>

**Theme:**
Leadership, Governance and Management

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

**Findings:**
Since the previous inspection the provider had revised the statement of purpose to provide a clearer more comprehensive outline of the service the centre provided and to ensure the statement of purpose contained all the matters required in Schedule 1 of the regulations.

Some further review was required in relation to the whole time equivalent staffing arrangements for the centre.

The provider submitted a further revised statement of purpose to the Chief Inspector shortly after the inspection and therefore this outcome was found to be in compliance.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 14: Governance and Management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>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.</em></td>
</tr>
</tbody>
</table>

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors assessed if actions from the previous inspection in relation to governance and management had been addressed and for evidence of the provider implementing their governance and management improvement plan submitted to the Chief Inspector January 2018.

Since the previous inspection management systems had been enhanced to promote and monitor the effectiveness and safety of care to residents. Since the previous inspection changes had been made to the local and organisational management structures. A new person in charge had been appointed since the previous inspection taking up their position in October 2017, furthermore changes had been made to the deputy manager for the centre. The person in charge was responsible for Parkview designated centre and another designated centre both within walking distance from each other. This close proximity ensured the person in charge could visit and supervise in both locations during their working shift. The person in charge in this centre was found to be suitably experienced and qualified in line with regulation 14 and it's sub-regulations. On this inspection there was evidence to indicate they were involved in the governance, operational management and administration of the centre on a regular and consistent basis.

In addition a new CEO had been appointed to Sunbeam House Services since the previous inspection. The CEO had visited the centre on a number of occasions and was familiar with the residents and the key issues in the centre and outlined short and longer term plans to address these issues during the feedback meeting with inspectors. The structure of the board of management for Sunbeam House Services had also been finalised in recent months. The board constituted persons with expertise and knowledge in the areas of disability, healthcare, risk and the regulations and parent representatives, for example.

The board had also appointed a quality and risk sub-committee. This committee was responsible for reporting to the board on the internal audits for designated centres with Sunbeam House Servcies and also risk and compliance with the regulations. Health Information and Quality Authority inspection findings and reports were a fixed agenda on all board meetings. The provider had also made appointments to a number of key roles, through recruitment or through the appointment of external consultants in an effort to improve compliance with the regulations and to improve the quality of services provided. This included the appointment of a new complaints and compliments manager, service manager(s), contracted specialist services for example, a clinical psychologist and psychiatry services and an external company to carry out staff training and annual provider audits in regulatory compliance and the standards.

In accordance with a governance and management improvement plan submitted by the provider to the Chief Inspector January 2018, definition and identification of the lines of accountability and authority for governance and management structures within
Sunbeam House Services and this designated centre had begun. These included improved performance management and accountability meetings between the senior services manager and person in charge. Meetings between the senior services manager and person in charge would now occur in the designated centre. Specific key quality indicators would be reviewed at each meeting and the senior services manager would review a sample of information in the designated centre to evidence and check the work of the person in charge. This was a considered and effective governance improvement initiative by the provider to improve accountability and quality of work for both the senior services manager role and the role of the person in charge which in turn, if implemented consistently and effectively, would result in improved services for residents.

Training for person(s) in charge in relation to their regulatory responsibilities was underway with Sunbeam House Services. This training would support and update persons in charge of their regulatory responsibilities which in turn had the potential to improve regulatory compliance within designated centres and quality of service provided to residents. The person in charge and senior services manager demonstrated a clearer understanding of their regulatory and management roles and responsibilities. Their feedback to inspectors about the provider's recent governance and management improvement initiatives was positive.

There was an annual review of the quality and safety of care in the designated centre completed February 2018. The provider had assigned the responsibility of annual review to an external consultant on their behalf. Inspectors reviewed the annual review that had been recently carried out. It was found to be comprehensive and had identified a number of areas for improvement within the centre. Residents' feedback had also been sought in the audit.

An action plan had been created following the audit and the person in charge and senior services manager had begun addressing the actions identified. This was an improvement from the previous inspection and within Sunbeam House Services where previously persons in charge had carried out the provider's regulatory required annual review which impacted on the objectivity of the report.

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

Findings:
The previous inspection findings had found there were inadequate staffing resources to meet the needs of residents. Staff training also required improvement to ensure staff had appropriate skills and training to meet the assessed needs of residents.

On this inspection staffing resource issues were still ongoing but not to the same extent as previously found. The provider had attempted to improve staffing within the centre through recruitment initiatives. Two recently recruited staff had begun to work in the centre. Regular agency staff were also employed to fill staffing resource gaps. While this evidenced the provider and person in charge's efforts to address staffing issues at the time of inspection, improvements and review of current staff resources in the centre was required to ensure residents' needs were met. Inspectors did acknowledge the provider and person in charge's ongoing work towards addressing this issue.

The provider had ensured information with regards to agency staff vetting, qualifications and training had been provided to the human resources department. This information had been supplied to the person in charge and was available in the centre on the day of inspection.

A staff training matrix was also maintained in the centre and up-to-date. There was evidence that most staff had received mandatory training with training dates booked where staff required refresher training or newly recruited staff were scheduled to complete mandatory training in the areas of safeguarding vulnerable adults, fire safety and management of behaviours that challenge. Newly recruited staff that had not completed such training worked alongside staff that had received this training until such time as they had completed the training.

The provider had also increased the types of mandatory training for staff working within Sunbeam House Services to include training in complaints management and risk and incident management. Training dates were booked for risk and incident training for most staff and training dates for complaints management would be issued to the person in charge when the training course for complaints management was finalised by the provider. At the time of inspection the provider and complaints manager for Sunbeam House Services, were reviewing the content of the training to ensure it provided troubleshooting and practical elements.

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:**

Ann-Marie O'Neill  
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 Sunbeam House Services Company Limited by Guarantee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001689</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>22 February 2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>23 March 2018</td>
</tr>
</tbody>
</table>

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 08: Safeguarding and Safety

Theme: Safe Services

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

There was no overall restraint register in place which evidence and overall capture of restrictions in the centre and control measures in place to ensure they were the least restrictive, when they were initiated and when they were reviewed.

---

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 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
As of 16th March 2018 there is a register of restrictive practices in place which captures the restrictions in the centre and control measures in place to ensure they were the least restrictive, and evidence based, when they were initiated and when they were reviewed.

**Proposed Timescale:** 23/03/2018

### Outcome 17: Workforce

**Theme:** Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider was required to review staffing resourcing in the centre to ensure the needs of residents were met at all times.

2. **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:**
As of 6th March 2018, there are sufficient permanent staff, of suitable skill mix and qualification to meet the assessed needs of residents.

**Proposed Timescale:** 06/03/2018