Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children)

Name of designated centre:	Cliff House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 3
Type of inspection:	Announced
Date of inspection:	26 July 2018
Centre ID:	OSV-0003257
Fieldwork ID:	MON-0022064

About the designated centre

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

The designated centre consists of two houses with the capacity to provide full-time residential care and support for four children with an intellectual disability and autistic spectrum disorder. Residents are supported with their positive behaviour support needs, augmentative communication needs, emotional support needs, and physical and intimate care support needs. The centre is situated in a suburban area of Co. Dublin with access to a variety of local amenities such as shops, train stations, bus routes, churches and the city centre. There are vehicles available to enable residents to access school and local amenities. There are two premises in the designated centre the first of which is a three-bedroomed, split level, terraced home. Each resident has their own bedroom all of which are single ensuite rooms. Each resident is actively encouraged to personalise their own bedroom. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, person participating in the management of the centre, and healthcare workers. Staffing numbers are adjusted as the dependencies of the residents change.

The following information outlines some additional data on this centre.

Current registration end date:	06/12/2018
Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
26 July 2018	08:15hrs to 17:00hrs	Marie Byrne	Lead
26 July 2018	11:30hrs to 17:00hrs	Ciara McShane	Support

Views of people who use the service

During the inspection, the inspectors had the opportunity to meet and speak with three of the four residents living in the centre. The inspectors observed residents spend time in their preferred spaces and to engage in activities of their choosing during the inspection.

During the inspection the inspectors observed residents in the centre being supported to communicate their needs and wishes, and to receive the support they required to make decisions in relation to their day-to-day lives. This was facilitated through the use of pictures and easy read information for some residents.

The residents who spoke with the inspector described their involvement in the running of the centre including how they decided how they would like to spend their time including what activities they wished to engage in. One resident showed the inspectors their plans for the day through the use of pictures and another described their plans for the day and described how they fit into one of their goals for the future.

During the inspection residents appeared happy and comfortable with the support offered to them by staff in the centre. The inspector reviewed a number of satisfaction questionnaires which had been completed by residents' family members and spoke to one family member. The feedback indicated that overall they were happy with the care and support offered to their relatives in the centre and that there had been a number of recent improvements made in the centre which were leading to improved outcomes for their relatives.

Capacity and capability

Overall, the inspectors found that management structures and systems in the centre had been further strengthened since the last inspection and that these changes had resulted in improvements to the care, support and lived experiences of residents in the centre. However, continued improvements were required in relation to staffing numbers, governance and management arrangements, the maintenance of complaints in the centre and staff knowledge of the Health Act and Regulations.

While the inspectors found that governance and management arrangements had been strengthened and that systems implemented were proving effective in improving care and support for residents in the centre, these arrangements were still at their infancy and further strengthening was required. Inspectors found that while there was improvement it remained that one key person was the driver of this

and a heavy reliance was on this member of the management team to monitor the care and support and implement the new systems in the centre. This over reliance on one key member was not sustainable. It was evident that the director of quality and compliance was supporting middle management to build capacity since January 2018 by completing weekly objective setting with key members of the team, by completing increased supervision sessions and by meeting monthly to review incidents, complaints, notifications, near misses and safeguarding. However, at the time of inspection improvements were still required in relation to middle managements' capacity to monitor the effectiveness of care and support in the centre.

There was an annual review of the quality and safety in the centre and six monthly visits by the provider or their representative were also completed. The director of compliance and quality improvement and the person in charge were closely monitoring the progress of actions from these reviews. Audits in the centre were recognising required areas for improvement and there were clear plans in place to complete required actions within specified timeframes. There was evidence that these actions were leading to improvements in care and support for residents. The provider had recognised that there was a requirement for increased oversight in the centre at weekends and plans were in place for senior social care worker and social care leaders to work weekends to monitor the quality of care and support for residents.

Changes had been made in relation to the staffing recruitment and retention strategies in the centre. These changes were leading to improvements in relation to continuity of staffing support for residents in the centre. A number of staff had secured internal promotions including senior social care workers and social care leaders. Their roles and responsibilities were clearly defined and they were in receipt of support to fulfill their additional responsibilities.

There were a number of staffing vacancies in the centre. Three new staff had been recently recruited and were in the process of receiving a formal and then area specific induction. A recruitment drive was in progress to recruit a further three staff. The provider was attempting to minimise the impact of these vacancies on care and support for residents in the centre by offering additional hours to existing staff and using regular agency staff to the fill the required shifts. However, a review of the rosters demonstrated that the additional hours staff were completing was having an impact on them resulting in increased sick leave. Therefore it was important the recruitment was expedited where possible.

Staff in the centre had access to training and refreshers in line with residents' care and support needs. Plans were also in place for additional training which was facilitated quarterly and found to be in line with residents' assessed needs. The supervision process had been strengthened since the last inspection and staff were now in receipt of regular formal supervision to support them to effectively carry out their duties.

There was a complaints policy and procedures in place in the centre. Residents had access to advocacy services if they so wish and there was a local complaints officer

in place. The inspectors found that improvement was required in relation to recognising and recording complaints in the centre and in relation to recording the complainants satisfaction levels.

There was a written statement of purpose in place which was reflective of the care and support in the centre. It contained the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Regulation 15: Staffing

Improvements had been made to the recruitment and retention practices in the centre since the last inspection. However, there were not sufficient staffing numbers in the centre to meet residents' assessed needs due to a number of staffing vacancies. The provider was attempting to minimise the impact of these vacancies on care and support for residents by offering existing staff extra hours and by using regular agency staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff in the centre had access to education and training in line with the statement of purpose and residents' assessed needs. Staff were in receipt of supervision appropriate to their role. Staff competencies relating to residents' direct care and support were being reviewed as part of this supervision process. The inspectors found that improvement was required in relation to staffs' knowledge of the Health Act and Regulations.

Judgment: Substantially compliant

Regulation 21: Records

The information and documents in relation to staff specified in schedule 2 of the regulations were in place.

Judgment: Compliant

Regulation 22: Insurance

There was written confirmation of insurance cover in place in the centre which included details of insurance in place against risks in the centre, including accidents or injuries to residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspectors found that although the provider had strengthened governance and management arrangements in the centre concerns remained in relation to capacity and capability due to an over reliance on a key member of the management team. There was a annual review of quality and safety of care and six monthly visits on behalf of the by provider. There was evidence of actions following these reviews and other audits in the centre and clear timeframes identified for completion of these actions.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose in the centre contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were policies and procedures in place for the management of complaints including an appeals process which was fair and objective. Residents and their families were made aware of the complaints process and residents had access to advocacy services should they wish to access them. The inspectors found that improvement was required in relation to to recognising and recording complaints in the centre to the complainants satisfaction.

Judgment: Substantially compliant

Quality and safety

The inspectors found that the provider and person in charge had some systems in place to monitor the quality and safety of care in the centre. However, some improvement was required in relation to the the state of repair of the premises and control measures in place for identified risks.

Works had been completed to improve areas of the centre since the last inspection including works to the garden, new furniture and painting and decorating in both premises. Areas for improvement remained in relation to damage to the flooring in a number of areas in both premises and damage to fencing in the garden of one of the premises. The carpet in one unit was coming to the end of its life span and would require replacement in the not too distant future.

The health and safety of residents, visitors and staff was promoted in the centre. There was an updated risk management and policy in place and procedures for risk management and emergency planning. There was a risk register in place, and a log was maintained of any changes to this risk register. Corporate, environmental, and residents' individual risk assessments were reviewed and updated regularly. There were arrangements in place for identifying, recording, investigating, and learning from incidents. Regular incident review meetings were held and there was evidence of learning from incidents which were leading to improved outcomes for residents. Shared learning notices were developed and shared with the staff team following these and other reviews. The inspectors found that improvement was required in relation to control measures in place for the management of risk associated with a piece of furniture in the centre.

There was suitable fire equipment available throughout the centre. Works had been completed to install additional fire containment measures since the last inspection. Staff in the centre had completed suitable training in fire prevention and emergency procedures. An additional fire safety competency check was now being completed regularly with staff. There were evacuation procedures in place and fire drills were being completed regularly.

Residents were protected by suitable arrangements for ordering, receipt, prescribing, storage and disposal of medicines in the centre. Improvements had been made to medicines management in the centre since the last inspection which were resulting in improved outcomes for residents. There was evidence that medication incidents were being regularly reviewed and followed up upon. Staff competency assessments were in place and fully completed.

Each resident had an assessment of need in place and there was evidence of regular review and update of their personal plans. Keyworkers were completing monthly reviews of residents' personal plans and there were progress reports in place which reviewed their overall health and wellbeing. Residents' social goals were reviewed monthly including a review of progress and the development of new goals. Family

forum meetings were in place with resident focused agenda items including residents' health needs, education, behaviour, communication and social skills, home visits and incident review. Residents' family members and key members of staff and their multidisciplinary team were in attendance at these meetings.

Each resident had an updated behaviour support plan in place. Through review of documentation and discussions with staff in the centre there was evidence of consistency of implementation of residents' behaviour support plans which was resulting in a reduction of incidents and restrictive measures in place for residents. The behaviour specialist was regularly meeting with and supporting staff in relation to the implementation of residents' behaviour support plans. There was evidence of regular review of restrictive practices to ensure the least restrictive measures were used for the least amount of time.

There had been a number of safeguarding concerns in the centre since the last inspection. Following these concerns the provider had put measures in place to protect residents being harmed or suffering abuse in the centre. Safeguarding risk assessments and plans were developed for each resident and reviewed weekly. Staff had received additional training and there were plans in place for quarterly safeguarding training in the centre. The inspectors found that staff who they spoke with were knowledgeable in relation to residents' safeguarding plans and the types of abuse and the procedures to follow in the event of a safeguarding concern. Residents' intimate care plans had been recently reviewed and updated in line with residents' changing care and support needs.

Regulation 17: Premises

The inspectors found that the centre was clean throughout on the day of inspection. Improvements had been made to both premises since the last inspection. However, areas of the centre were in need of repair including flooring in two of the bedrooms and fencing in one of the premises.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The safety of residents, staff and visitors was promoted in the centre through risk management and emergency planning. However, improvement was required in relation to control measures in place for an identified risk relating to a piece of furniture in the centre. There was a risk register in place which was updated in line with residents' changing needs. There was a system in place for recording and learning from incidents in the centre which were leading to improvements to residents' safety.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors found that effective fire management systems were in place in the centre. Staff had completed suitable area specific fire training and residents' personal emergency evacuation plans were reviewed and updated regularly. There was evidence of regular fire drill and learning from these drills.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by appropriate policies and procedures relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines. Audits were completed regularly in the centre and there was evidence of learning and follow up from these audits.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which outlined their likes, dislikes, goals and care and support needs. Keyworkers were regularly reviewing residents' goals and there were regular family forum meetings in place. There was evidence of regular review to ensure residents' personal plans were effective.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' behaviour support needs were recognised and supported in the centre. Restrictive practices in the centre were regularly reviewed and a number of restrictive practice had been removed following these reviews.

Judgment: Compliant

Regulation 8: Protection

Safeguarding plans and risk assessments were in place to keep residents in the centre safe. Staff in the centre were found to be knowledgeable in relation to residents' safeguarding plans and could clearly identify their responsibilities in relation to managing and reporting allegations of abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cliff House OSV-0003257

Inspection ID: MON-0022064

Date of inspection: 26/07/2018

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

The registered provider is ensuring the number qualification and skill mix of staff is appropriate to the number and assessed needs of the residents by continuing the recruitment campaign for the centre:

- Two of the three social care workers have commenced on August's roster following local in house training in safeguarding, MAPA and positive behaviour support.
- One social care worker will commence in September 2018 following receipt of garda vetting, all mandatory training has been completed.
- Recruitment for 1 full time social worker and two part time health care assistants continues with shortlisting for interview underway.

The statement of purpose will continue to be updated by the person in charge as staff members commence employment in the centre.

The registered provider, PPIM and person in charge will continue to review monthly the staffing risk assessment to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents.

The PIC/PPIM will review as part of the centre's weekly care and support report the staffing arrangements in place to ensure adequate oversight of staff supervision, sick leave and agency use. This report will continue to be forwarded to the registered provider.

Any agency staff members working in the centre will have completed the induction programme and work alongside staff members familiar with the residents care and support needs. Regular agency use will continue to be sought by the person in charge as a priority.

The new social care leaders in place will be guided by care and support checklists to ensure effective oversight of the centre in the absence of the PIC but in conjunction with the on call system.

October 1st 2018.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The current schedule for staff refresher training will continue as scheduled for quarters 3 and 4 2018. All current staff members remain up to date with all mandatory training.

Additional local training in positive behaviour support and safeguarding will continue for the staff team in September and December 2018.

Infection Control is scheduled for all staff members in quarter 4 of 2018.

A shared learning notice will be issued to all staff from the PPIM and person in charge to enhance knowledge of the regulations and standards.

Formal staff supervision sessions by the person in charge will also focus on knowledge of the Act, regulations made under it and standards set out by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act. These supervision sessions will be recorded and retained in each staff member's file.

December 14th 2018.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The lines of authority accountability and specific roles of the person in charge and senior social care leader will continue to be reviewed by the PPIM/Registered Provider to ensure expansion of these roles in line with the required initiatives outlined in the centre's quality improvement plan.

The management structure in place will continue to be reviewed by the PPIM in conjunction with the registered provider to ensure effectiveness of the new social care leader structure in place since July 2018.

The PPIM will continue to provide regular supervision sessions for the person in charge and senior social care leader (in conjunction with the weekly meetings) in areas such as governance and management, quality improvement, health safety and risk management.

The PIC will continue the weekly programme of formal staff supervision. Supervision sessions will be indicated at the start of each month on the roster.

The PPIM has commenced and will continue with external supervision from a suitably trained professional to act as a resource for the role considering the volume of quality improvement on going within the centre at present.

Quarterly Internal audit schedules will continue to be set and conducted by the PPIM, person in charge and senior social care leader in areas of regulation to ensure the Quality Improvement Plan of the centre identifies and addresses non compliances with regulations and standards.

December 14th 2018

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The registered provider in conjunction with the PPIM and PIC will review the complaints folder to ensure all information relating to complaints management is aligned in one location to monitor complaints effectively.

All concerns/complaints (verbal or written) will now be logged on the complaints log, this will include verbal concerns made and resolved at family forums.

The revised complaints folder will be reviewed monthly by the PPIM/Registered Provider to ensure compliance with regulation 34 (2).

13th of August 2018.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Registered Provider will ensure that the following maintenance work will be completed:

- The wooden floor in 2 resident's bedroom will be replaced.
- The wooden fence in the back garden of one house will be replaced.
- The carpeting on the landing/stairs of one house will be replaced

The PIC or PPIM will continue to conduct a weekly environmental walk round of the centre and escalate any on- going maintenance issues to the registered provider.

October 8th 2018.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

The coffee table identified as a risk during the inspection has been removed from the centre by the person in charge.

All new furniture/fittings will now be risk assessed by the person in charge prior to purchase to limit any safety risks to residents.

The PPIM, person in charge, senior social care leader and behaviour specialist in conjunction with the registered provider will continue the following risk management oversight in the centre to ensure compliance with regulation 26:

Monthly review of all risk assessments active in the centre.
Monthly reviews of the risk register, unless early review is warranted.
Daily review of all incidents by the person in charge with inputting and follow up documented on the risk log.
Weekly review of all behaviour incidents by the behaviour specialist.
Monthly incident review meetings.
Quarterly Restrictive Practice Meetings.
Monthly reviews of the Quality Improvement Plan.
Weekly safety checks of vehicles in use by the centre.

27th July 2018.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall 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.	Not Compliant	Orange	October 1st 2018
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	October 1st 2018
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations and standards made under it.	Substantially Compliant	Yellow	December 14th 2018
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	October 8th 2018

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	December 14th 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	27th July 2018
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	13th of August 2018