Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	The Grove
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	08 February 2018
Centre ID:	OSV-0004889
Fieldwork ID:	MON-0021188

About the designated centre

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

The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The overall objective of the service was to provide support and services to four residents both male and female on a full-time basis and a day service to one further resident. The inspector found that the service provided was as described in the statement of purpose.

The centre was purpose built; the location, design and layout were suited to the individual and collective needs of the residents. All of the amenities of the busy local town were within a short walking distance; given residents needs transport was provided.

The following information outlines some additional data on this centre.

Current registration end date:	20/12/2018
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
08 February 2018	09:15hrs to 17:30hrs	Mary Moore	Lead

Views of people who use the service

Four residents live in this designated centre on a full-time basis and the inspector met with all of the residents throughout the day as they went about their daily routines in their home. The inspector also met with the resident who attends for day service in the house.

Residents welcomed the inspector to their home and as residents grew accustomed to the presence of the inspector in their home a natural conversation developed. Some residents engaged through verbal communication while others communicated effectively using non-verbal tools such as gestures and facial expressions. Residents shared their personal items of interest with the inspector, their completed artwork and told of recent refurbishment works that had been completed to their bedrooms.

Residents chatted about their plans for the day, activities that they liked doing and those that they did not like as much but participated in as they knew that they were good for them; for example exercise programmes. The inspector noted that there was a relaxed atmosphere in the house and that residents were familiar with all of the staff on duty including a relief staff and the incoming person in charge. Residents were seen to seek out staff with confidence and ease; staff responded in a timely and respectful manner.

Capacity and capability

The inspector found that the centre was effectively governed and that there were systems for monitoring on a consistent basis the quality and safety of the care, support and services provided to residents.

The provider was aware of its regulatory responsibility to ensure that a clearly defined and effective management system was in place in the designated centre. For example the provider had made arrangements for the running of the designated centre during the planned absence of the person in charge.

The management team consisted of the lead social care worker, the person in charge and area manager. There was clarity on roles, responsibilities and reporting relationships.

The inspection was facilitated by the lead social care worker and the incoming person in charge who was completing induction in the centre. Both worked full-time

and were suitably qualified; both had a sound understanding of the governance, operational management and administration of the designated centre.

Consistent governance was supported by an out-of-hours on-call system the details of which were made available on a weekly basis to staff.

Staff described the formal systems of communication that functioned within the organisation from the designated centre-based team meetings to the monthly residential services meetings and how these supported the flow of relevant information between all grades of staff.

The inspector was advised that the annual review for 2017 was currently being compiled and questionnaires had been forwarded to families to ascertain their feedback. The reports of completed reviews for 2017 were made available to the inspector. Staff were consulted with during these provider reviews and were supported to raise any views or concerns they had as to the quality and safety of the service.

The inspector saw that these reviews led to service developments and incremental improvement. For example the lead social care worker had been appointed and allocated protected administration time as a support to the person in charge. Additional staff supports had been allocated at weekends given the shortfall identified during the June 2017 review.

There was evidence that the provider kept staffing numbers, skill-mix and staffing arrangements under review. There was evidence that the provider had put additional staff resources in place in response to the assessed needs of the residents and the findings of its own reviews.

An additional staff had been allocated once a week to facilitate protected administration time and at the weekends to facilitate individual resident choices.

There was a team of regular staff; if there was a requirement for relief staff these were sourced from within the providers own resources to ensure that residents received continuity of care and supports. This was evidenced on inspection.

However, there was one environmental restriction that was required when there was only one staff on duty if that staff was engaged in other duties such as attending to another resident. Also it had taken one staff 10 minutes to evacuate all residents to safety during a simulated evacuation drill. Therefore while there was evidence that the provider monitored the adequacy of staffing levels and did take action in response, further review of staffing levels was required to ensure that staffing numbers and arrangements were at all times appropriate to the number and assessed needs of the residents.

The provider facilitated staff with training that ensured that mandatory training requirements were met but also that staff had the skills and knowledge to respond to residents needs. All staff working in the centre had attended safeguarding training, training in responding to behaviours of concern including de-escalation and

intervention techniques, fire safety, manual handling and medicines administration.

The incoming person in charge confirmed that there was a formal system of staff supervision and all staff had an annual appraisal.

During this inspection staff knowledge of the requirements of the standards and regulations was evident in their practice and in their engagement with the inspector.

Staff were observed directly and indirectly interacting with residents; these interactions were noted to be timely, respectful and equitable and based on the guidance of the resident's personal plan.

Regulation 15: Staffing

There was evidence that the provider monitored the adequacy of staffing levels and did take action in response. However, based on these inspection findings further review of staffing levels was required to ensure that staffing numbers and arrangements were at all times appropriate to the number, assessed and evolving needs of the residents

Judgment: Substantially compliant

Regulation 16: Training and staff development

Centre specific records were maintained of staff attendance at training; attendance was monitored to ensure that refresher training was attended within the required mandatory time frame.

Judgment: Compliant

Regulation 23: Governance and management

There was a definitive management team consisting of the lead social care worker, the person in charge and area manager. There was clarity on roles, responsibilities and reporting relationships. There were effective systems for monitoring on a consistent basis the quality and safety of the care, support and services provided to

residents; these resulted in service developments and incremental improvement. Staff were supported to raise any views or concerns they had as to the quality and safety of the care and support provided to residents

Judgment: Compliant

Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent

The provider had made arrangements for the running of the designated centre during the planned absence of the person in charge. The required notification was submitted to the Chief Inspector.

Judgment: Compliant

Quality and safety

The inspector found that the care, supports and services provided in the designated centre were focused on residents and their needs and preferences. Resident's individual needs had been holistically assessed; plans of support were in place based on the findings of these assessments.

The inspector saw that the completed assessment was comprehensive; the personal support plan presented a clear picture of each resident, their strengths, needs, choices, visions and their required supports. Staff spoken with had sound knowledge of each resident and their personal plan.

There was evidence that residents were consulted with and participated in the development and review of their plan. The person in charge described how each personal plan was reviewed in turn at the monthly team meetings, six- monthly and annually. These reviews and any required changes were recorded in detail.

Each personal plan incorporated the plan for the progression of resident's personal goals and objectives. While some goals were related to activities of daily living and general well-being as was seen at the time of the last inspection, based on the records seen a good balance was achieved between what might be described as functional goals and those goals that sought to support ongoing personal and social development, for example securing voluntary roles in the community and access to educational programmes.

Residents had access to meaningful engagement and community access on a daily basis. This was confirmed from records seen and residents and staff spoken with. For example, residents attended a local community day service and a local gym and swimming pool. On arrival at the centre the inspector had met a resident collecting

the delivered post; the inspector saw later from the personal plan that this was an identified goal.

Staff spoken with and records seen provided evidence that the provider had arrangements in place to support residents to maintain and enjoy good health. Overall there was solid evidence of good care and practice.

Staff consistently monitored resident well-being and sought medical advice and review from the general practitioner (GP) when necessary; this was evidenced on inspection. Staff on behalf of residents liaised with two different GP practices as was their choice.

Staff maintained comprehensive records of referrals, reviews, recommended treatments and the care delivered to residents.

Overall as appropriate to their needs, inspectors saw that residents had ready access to other health care services; staff also sought advice from healthcare professionals to ensure that the care provided was evidenced based. For example, falls prevention practice was informed by occupational therapy assessment and recommendations and, by the review of medicines by the prescriber. The inspector saw that residents had access to neurology, psychiatry, psychology, behaviour specialist, dental care and chiropody. Nursing care, if required, was available from community nursing personnel. Health was promoted by access to screening programmes, regular blood-profiling and preventative treatment, for example for maintaining bone density.

Staff spoken with described strategies that had been devised with success to help residents overcome their fear and disquiet of medical personnel and interventions.

However, records seen stated, staff spoken with said and it was confirmed at verbal feedback that residents did not have timely access to a service to which they had a statutory entitlement. Access to dietetic services had not been facilitated by the Health Service Executive (HSE) Community Services though the provider had requested access on the residents' behalf.

Further to the previous inspection findings the provider had reviewed its policy and procedures for the management of medicines including the use of medicines and products available without prescription; the practice described by staff was as detailed in the revised policy and procedures.

Medicines were supplied to residents by a community-based pharmacist. Medicines were seen to be securely stored and supplied on an individual resident basis.

Medicines were seen to be clearly labelled. Prescription records were clearly written and legible. The maximum daily dosage of PRN medicines (as required) was stated. Staff maintained a record of each medicine administered and the sample of medication administration records seen corresponded with the instructions of the prescription record.

Training records indicated that staff had completed recent training in the safe

administration of medicines. There was a low reported incidence of medication errors; there was a system for their recording and review.

Medicines management practice was the subject of regular audit. While actions did issue from these audits, no repeat or recurring failings were identified and actions that had issued form the most recent audit in January 2018 were seen to have been addressed by the time of this inspection.

Residents had where required, a plan for the administration of medicines to be administered in an emergency (in the event of seizure activity). The plan outlined clear guidance to staff on the administration of emergency medicine, recovery times, repeat administration and when and why the assistance of emergency services may be required.

Residents were supported to manage their own medicines. The inspector saw that this practice was supported on-going assessment of capacity and risk and monitoring procedures by staff to ensure ongoing resident compliance and capacity.

The inspector found that staff responded therapeutically to any behaviour of concern and risk. On speaking with staff it was clear to the inspector that staff did not have a problem based approach to such behaviours but sought to establish their meaning so as to support the resident in an evidenced based manner. For example staff spoke of current clinical referrals that were sought so as to explore possible clinical rationales for behaviours.

Relevant plans were compiled by the behaviour support specialist in consultation with staff; the plans were seen to be informed by preparatory groundwork that included the completion and analysis of ABC records (antecedent, behaviour and consequences). Analysis informed the response strategies and staff spoken with described how this evidenced based approach supported their understanding of the purpose and meaning of behaviours.

Overall residents enjoyed an environment and routines with minimal restriction:there was one environmental restrictive practice in use. Staff maintained a record of each time the restrictive practice was implemented. Staff sought to and did based on records seen, minimise the use of the restrictive practice.

However, the environmental restriction was required to ensure resident safety when staff were engaged in other duties and could not provide direct supervision for the resident; therefore this has been discussed in the context of Regulation 15: Staffing.

There were measures in place to protect residents from harm and abuse; these included organisational policies and procedures, a designated person, plans for the provision of personal care and staff training. The name of the designated person was prominently displayed.

The incoming person in charge had a sound understanding of what constituted abuse and her responsibility to safeguard residents including reporting and investigating any alleged or suspected abuse.

Residents' knowledge and awareness of self-protection was supported through regular discussion at house meetings. Staff gave examples of concerns raised at times by residents and the action taken in response. There was documentary evidence that staff also raised concerns and of the actions taken by the provider in response to ensure that there was no risk to residents and that they were protected. The inspector saw that residents were comfortable with staff and that staff responded to and spoke to and of residents with respect. Residents told the inspector that everything was good in the house.

Training records indicated that all staff had completed safeguarding training; the incoming person in charge said that all newly recruited staff had to complete safeguarding training as part of their induction.

The four residents living in the house were described as compatible and there was no evidence of negative peer-to-peer interactions.

The provider had itself identified deficits in the arrangements it had for ensuring effective fire safety managements systems were in place including the arrangements for the effective evacuation of residents. However while there was a plan to address these deficits, they were not satisfactorily resolved at the time of this inspection.

The inspector reviewed the records of simulated drills convened by staff in March, June and August 2017; the latter was convened to simulate the night-time scenario. The report of the March and June drills indicated that the time taken to evacuate all of the residents was outside of that recommended on both occasions. However, staff had recorded the time taken to reach the assembly point; the assembly point was some distance from the house and given the needs of the residents' additional time would have been required by them to reach this point as opposed to the actual time it took to vacate the house and reach a reasonable place of safety. The August 2017 time however was well above the recommended time with times of eight and ten minutes recorded by staff due to the assistance required by two residents; there is only one sleepover staff on duty each night.

There was documentary evidence made available to the inspector that further to this drill the provider had commissioned a review of the existing fire safety features of the centre including the evacuation-escape routes. The review was completed with reference to relevant legislation and guidance on fire safety in community dwelling houses. Recommendations issued in December 2017 from this review to the provider as to a schedule of works required in relation to escape routes and exiting the building in the event of fire.

In addition deficits were identified during this HIQA inspection in the systems for reviewing fire safety precautions. The fire fighting equipment had not been inspected and serviced since September 2016; once brought to the attention of the incoming person in charge this was addressed prior to the conclusion of the inspection.

Staff completed visual inspections of fire safety precautions including the fire detection system panel, emergency lighting and final exits. The records for December 2017 and January 2018 were complete; however, there were unexplained

recording gaps in earlier records seen.

Regulation 28: Fire precautions

The provider had itself identified deficits in the arrangements it had for ensuring effective fire safety managements systems were in place including the arrangements for the effective evacuation of residents; however while there was a plan, the deficits were not satisfactorily resolved at the time of this inspection

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Further to the previous HIQA inspection findings the provider had reviewed its policy and procedures for the management of medicines including the use of medicines and products available without prescription; the practice described by staff and evidenced on inspection was as detailed in the revised policy and procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the care, supports and services provided in the designated centre was focused on residents and their needs and preferences. Resident's individual needs had been holistically assessed; plans of support were in place based on the findings of these assessments; needs and plans of support were subjected to regular review by staff

Judgment: Compliant

Regulation 6: Health care

Access to dietetic services had not been facilitated by the HSE Community Services though the provider had requested access on the residents' behalf

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff had a therapeutic approach to behaviours that challenged and sought to establish their meaning so as to support the resident in an evidenced based manner. There were plans of support specifically for responding to behaviours of concern and risk. These plans were compiled by the behaviour support specialist in consultation with staff; the plans were seen to be informed by preparatory groundwork that included the completion and analysis of behaviour records. There were procedures for the use of and the review of any restrictive practice: these included the input of the behaviour support specialist and the psychologist. Staff maintained a record of each time the restrictive practice was implemented. Overall the inspector saw that residents lived in an environment with minimal restrictions.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from harm and abuse.The incoming person in charge had a sound understanding of what constituted abuse and her responsibility to safeguard residents. Residents' knowledge and awareness of self-protection was supported through regular discussion at house meetings. The provider exercised its duty to ensure that there was no risk to residents and that they were protected.

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	Compliant
Regulation 23: Governance and management	Compliant
Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Grove OSV-0004889

Inspection ID: MON-0021188

Date of inspection: 08/02/2018

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 PIC will ensure the following actions are completed to ensure compliance with Regulation 15: • The PIC has completed a current assessment of needs for each individual residing in the designated centre. • Current staffing levels have been reviewed to ensure that appropriate staffing levels/ skill mix are identified. • Additional requirements will be discussed with the service provider with a view of increasing staffing levels to an appropriate level. [31/08/2018	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The PIC will ensure the following actions are completed to ensure compliance with Regulation 28: • In consultation with the service provider, an upgrade means of escape will be completed as per fire officer recommendations to ensure all individuals are provided with safe routes of escape in the event of a fire. • Following this; both individuals supported within the centre and staff will receive suitable site-specific training in fire prevention, emergency procedures, building layout and escape routes and arrangements for the evacuation of residents. • Regular fire drills and fire safety education will be undertaken with residents to ensure their awareness of the procedure to be followed in the event of an outbreak of fire. • Updated procedures to follow in the event of a fire will be displayed in a prominent place. [31/12/2018]	

In the interim; until these works have been finished, the following actions will be completed:

- Existing emergency evacuation routes, as described in updated central emergency evacuation plan, will be used to ensure the safe evacuation of residents in the event of a fire.

[29/05/2018

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

Dietician services have now been facilitated for all individuals who reside in the designated centre.

Furthermore, the PIC will ensure that all residents who require services provided by allied health professionals; as set out in their individual plan, will be supported to access such services by the registered provider, if not by arrangement with the Executive.

14/04/2018

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.	Substantially Compliant	Yellow	31/08/2018
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/12/2018
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the	Substantially Compliant	Yellow	14/04/2018

	registered provider or by arrangement with the Executive.			