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>Orchid Lane</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005052</td>
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<tr>
<td>Centre county:</td>
<td>Wicklow</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Sunbeam House Services Company Limited by Guarantee</td>
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<tr>
<td>Lead inspector:</td>
<td>Ann-Marie O'Neill</td>
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<tr>
<td>Support inspector(s):</td>
<td>Gary Kiernan</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>7</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 08 March 2018 10:30  To: 08 March 2018 17:00

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

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Summary of findings from this inspection

Background to the inspection:
This was the fifth inspection of this designated centre formally known as Vevay Close. An initial inspection occurred in 2015, with subsequent inspections carried out in 2016 and 2017 in response to the provider's application to register 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 to grant registration.

An inspection of this centre in July 2017 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. A follow up inspection occurred in October 2017 where inspectors found significant non compliance which necessitated the issuing of a number of immediate actions to the provider to ensure a safe service.
Subsequent to the findings of the October 2017 inspection the Chief Inspector issued the provider with a notice of proposal to refuse and cancel registration of the centre. The provider responded to HIQA with a representation to the notice of proposal which set how the provider would address all deficits and bring the centre into compliance. 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 previous inspections and ascertain if the matters as set out in the provider’s representation response were bringing about improvements and 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 spoke with and spent time with one resident. Inspectors also met with the newly appointed person in charge, senior services manager and recently appointed CEO. Inspectors also met staff members on duty on the day of inspection and spoke more in depth with one staff member in relation to the key working process for residents, medication management, staffing arrangements and safeguarding reporting systems. Inspectors reviewed documentation such as, personal plans, person-centred support plans, recording logs, risk management systems and documentation and complaints management documentation and systems.

Description of the Service:
This designated centre is operated by Sunbeam House Services (SHS)Company Limited by Guarantee and is based in County Wicklow. Seven adult residents live in the designated centre. The provider had produced a document called the statement of purpose, as required by regulation, which described the service provided. The service was delivered in accordance with this document. The designated centre aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities. Overall, residents living in the centre were reasonably independent in their everyday lives but required varying support needs related to healthcare, personal risks, safeguarding issues and mental health.

Overall Judgments of our findings:
Nine outcomes were inspected against with eight outcomes found to be compliant or substantially compliant. One outcome met with moderate non compliance. 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.

Improved governance and management system were in place. Risk management, analysis and reporting had improved and this provided residents with a safer service and environment. 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.

Operational management and 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 monitoring systems had also improved and mandatory training in complaints management was to be rolled out for all staff.

Issues found on the previous inspection in relation to medication management and medication errors had been addressed effectively. Some improvement was required in relation to one aspect of medication management.

Improvement in the audit and review arrangements for restrictive practices had occurred also. A restrictive practices register was now in place which outlined the date the restriction had been put in place, review by a human rights committee date, rationale for it's use and control measures in place to ensure it was used for the least amount of time as necessary. Some slight improvement was required to ensure all restrictive practices were identified in the restraint register.

The provider had made good progress in ensuring a more consistent and adequately resourced staff team were in place to support residents. During the course of the inspection the provider outlined plans for review and configuration which would result in some residents receiving a more individualised and targeted service to meet their needs through home care support hours provided by Sunbeam House Services.

Overall, the provider was now demonstrating improved governance and oversight of the centre and an improvement in the quality of service provided to residents. A resident spoken with told inspectors that they were happier with the service they were now being provided with. Their complaints were being managed better and they had better support with regards to managing their day-to-day life in the areas of medication, buying groceries and engaging in activities they liked.

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. It was found that they had and further initiatives by the provider would continue to improve complaints management in the centre going forward.

Previously it had been found that complaints were not effectively managed and residents had expressed to inspectors their dissatisfaction with how their complaints were managed and followed up on.
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.

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.

Some improvement was required in the recording of the complainant's satisfaction with regards to the outcome of the complaints process as is required in the regulations.

**Judgment:**
Substantially Compliant

### Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Effective Services

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

**Findings:**
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 were bringing about improved incident analysis and overall reporting as part of a revised risk management procedures.

Since the October 2017 inspection the provider had instated a 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 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.

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. However, at the time of inspection the policy was out-of-date and also was not reflective of the new improved systems in place and therefore could not guide staff in appropriate risk management.

The risk management policy required some improvement. The provider was required to update this policy to meet the specific requirements of the regulations in relation to risk management and to incorporate guidance for staff on the new improved risk management systems within the organisation.

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. However, some improvement was required as risk of self harm, which was identified as a specific personal risk for a resident necessitating some restrictive practice measures, had not been identified on the risk register. This required improvement.

Fire safety measures had improved since the previous inspection. Fire drills now occurred monthly to ensure all staff had the necessary knowledge and experience of supporting residents to evacuate in the event of a fire occurring in any part of the centre. Fire drill records indicated as more drills now occurred some residents, who had not been co-operative previously, were now engaging better in the process.

Keys were now available for all gates leading to and from the centre and all staff were aware of where they were maintained. Ongoing daily and weekly checks were now occurring and fire alarms had been serviced as required. All fire fighting equipment in the centre had also received an up-to-date service check from an appropriately qualified person. A discussion at the feedback meeting indicated the provider intended to invite the local fire brigade to visit the centre and carry out a review of the premises as part of an initiative to improve fire safety measures for the centre overall.

**Judgment:**
Substantially 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.

Theme:
Safe Services

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

Findings:
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 improvement had taken place. Restrictions had been reviewed and a restrictive practices register had been devised outlining an identification of all restrictive practices within the centre. There was some improvement required however, in relation to the number of gates leading into and out of the property and their recording within the register as a form of restraint and limiting freedom of movement for residents. The person in charge and provider were required to assess their requirement and rationale for their use with due regard to residents’ safety needs.

Of those restrictive practices identified they had been 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. A rationale for each restriction was documented, control measures to ensure they were used for the least amount of time was also recorded as was a review date for each restriction.

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 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.
All staff working in the centre had received training in safeguarding vulnerable adults and associated Sunbeam House Services reporting and recording procedures. A designated officer was now allocated for the centre and staff were knowledgeable of who that person was when asked by inspectors. Agency staff working within the centre were also familiar with safeguarding policies and procedures and reporting systems within the centre.

Behaviour support planning was at the time of inspection under review and updated on an on-going basis. Training in therapeutic management response systems to behaviours that challenge had also begun and the person in charge was also a qualified trainer in this system which ensured oversight and supervision of staff practice in the centre. There was evidence that this was already underway with documented evidence of the person in charge's review of instances where therapeutic reactive strategy responses had occurred including direction and feedback to staff involved.

Judgment:
Substantially Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
On review of the revised incident recording system inspectors determined that all required notifications had been submitted to the Chief Inspector in line with the regulations and associated timelines.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A sample of healthcare plans were reviewed. These were found to be person specific and no longer generic in format. Evidence of allied health professional reviews and recommendations, where 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.

Some improvement was required in relation to pain management support planning for residents prescribed a number of different PRN (as required) pain relief medications. Support planning was required to guide staff in what pain management medication to administer as a first line medication in response to a resident complaining of pain. Medications prescribed were of varying strengths and doses but it was unclear which was to be administered first.

Judgment:
Substantially 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 safe management of medication. The previous inspection had found there were a significant number of recorded medication errors in the centre.

On this inspection it was noted that residents were in the process of changing their pharmacy provider. Staff said that under the new system residents' medications would be supplied to the centre by their pharmacist in a pre-packed dosage system. When medication was delivered to the centre the pharmacist would carry out a stock check of medications each week. This system would provide a more robust stock balance check than had been found on the previous inspection.

Some improvement was required. Medication management audits carried out at the time of inspection were not comprehensive or robust enough to capture qualitative
information about medication management systems in the centre. For example, it was not clear what resident's medication had been audited and no actions for improvement were detailed following the audit. This required improvement. An action relating to this is assigned to outcome 14; Governance and Management.

The maximum dosage for each PRN medication was clearly indicated on residents' medication administration charts.

Where PRN (as required) medications were prescribed in most instances an associated protocol was in place setting out specific criteria for when and why they should be administered. However, some PRN (as required) medications did not have a clearly documented protocol in place for staff to follow. This required improvement.

Since the previous inspection there was an overall significant reduction in the number of medications errors that had occurred in the centre.

**Judgment:**
Non Compliant - Moderate

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### Outcome 13: Statement of Purpose

*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.*

**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 which now met the requirements of Schedule 1 of the regulations.

Some further revisions of the statement of purpose were necessary to reflect the change in capacity numbers for the centre in light of the provider's proposed reconfiguration of the service. The provider was required to submit the revised statement of purpose to the Chief Inspector. However, as the statement of purpose accurately reflected the centre on the day of inspection this outcome is deemed complaint.

**Judgment:**
Compliant

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### Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
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 a plan for improved governance and management submitted to the Chief Inspector in January 2018.

Since the previous inspection management systems had been enhanced to promote and monitor the effectiveness and safety of care to residents. 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 November 2017. The person in charge was responsible for Orchid Lane designated centre only. This addressed serious non compliance found on the previous inspection whereby there was no manager in the centre and inspectors were required to issue an immediate action to the provider to address the situation.

The person in charge in this centre was found to be suitably experienced and qualified in line with regulation 14 and associated 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. The person in charge was also a trained instructor in therapeutic management and response to behaviours that challenge and had also worked in a previous employment setting supporting and running a service for persons with similar assessed needs to those living in the designated centre referred to in this report.

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 Services 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.

The provider had put systems in place to monitor and audit key areas in the centre. However, improvement was required in relation to medication management audits in the centre to ensure they comprehensively reviewed the safety of medication administration and storage in an effective way with an associated action plan for quality improvement included.

Judgment:
Substantially Compliant

**Outcome 17: Workforce**

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.
**Theme:**
Responsive Workforce

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

**Findings:**
Not all aspects of this outcome were reviewed on this inspection. Inspectors followed up on the previous inspection actions to ascertain the provider's progress in addressing non compliances found in during the October 2017 inspection.

A planned and actual staff rota was in place and provided staff with their rostered work hours/days a month in advance. The person in charge was responsible for managing the staff roster. This was an improvement from the previous inspection.

Since the previous inspection the provider had undertaken a recruitment drive to improve staffing levels in the staff and instate a more stable workforce in the centre. At the time of inspection the number of agency workers in the centre had reduced and some internal staffing moves had also occurred. This had reduced the whole time equivalent numbers of agency workers within the centre and was beginning to create a more stable and consistent workforce. However, improvements were still required with regards to staffing to further reduce the provider's reliance on agency workers and to strive towards a staffing resource of consistent regular staff.

While agency workers were still utilised in the centre the provider ensured they were regular staff and had received training in mandatory areas such as safeguarding vulnerable adults. An induction process for newly appointed staff was also in place. As part of the induction process recently appointed staff received mandatory training in safeguarding vulnerable adults, fire safety, manual handling and therapeutic management of behaviours that challenge. This provided assurances that the provider was actively working towards creating a stable and well informed workforce to support residents in this centre. The provider had addressed actions from the previous inspection to a good standard.

The recently appointed person in charge had begun a supervision process for staff within the centre and a number of staff had received a one to one supervision meeting with the person in charge. Informal supervision of staff also occurred on an ongoing daily basis. The person in charge was now only responsible for this designated centre which ensured staff supervision, support and guidance, by the person in charge, could consistently occur. This was an improvement from previous inspections.

Staff files were not reviewed during this inspection.

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

**Theme:**
Use of Information

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

**Findings:**
Not all aspects of this outcome were reviewed during this inspection.

The provider was required to review and update and disseminate to staff their safeguarding vulnerable adults and the risk management policies to ensure they met the requirements of the regulations and also reflected the improved procedures now in place in Sunbeam House Services.

**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

| Centre name: | A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee |
| Centre ID: | OSV-0005052 |
| Date of Inspection: | 08 March 2018 |
| Date of response: | 27 April 2018 |

**Requirements**

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

**Theme:** Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The complainant's satisfaction with the outcome of a complaint investigation was not consistently recorded.

**1. Action Required:**

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The nominated person will ensure that each complaint record states the outcome of the complaint and how it was resolved and the complainant’s satisfaction of the complaint outcome.

Proposed Timescale: 23/04/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required to the risk register to ensure all risks in the centre were identified, analysed and recorded, for example the risk of self harm.

2. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
A review and update of the risk register was conducted and the risk of self-harm is now included.

Proposed Timescale: 27/04/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider was required to update the risk management policy to meet the specific requirements of the regulations in relation to risk management and to incorporate guidance for staff on the new improved risk management systems within the organisation.

3. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
The Risk Management Policy has been revised and updated, this will be available to all
Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all restrictive practices had been identified in the restrictive practice register to include a rationale for their use, associated control measures to ensure they were the least restrictive option, referral to a human rights committee and review date.

4. **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:**
A review will be conducted on the requirement of some physical restrictive practices at this centre and the rationale for their use with the view to removing these.

**Proposed Timescale:** 01/05/2018

Outcome 11. Healthcare Needs

**Theme:** Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required in relation to pain management support planning for residents prescribed a number of different PRN (as required) pain relief medications.

5. **Action Required:**
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

**Please state the actions you have taken or are planning to take:**
A review was conducted and action taken to improve PRN pain management for one resident. Kardex has been revised to reflect these changes.

**Proposed Timescale:** 27/04/2018
### Outcome 12. Medication Management

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some PRN medications prescribed for the management of epilepsy did not have a protocol setting out criteria for administration guidelines.

6. **Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
A protocol to be implemented which sets out the criteria for administration guidelines for one residents epilepsy PRN Medication.

**Proposed Timescale:** 08/05/2018

### Outcome 14: Governance and Management

**Theme:** Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvement was required in relation to medication management audits in the centre.

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

**Please state the actions you have taken or are planning to take:**
The Medication Management Audit has been updated and now includes a section which identifies the residents name and action resulting from audit.

**Proposed Timescale:** 27/04/2018

### Outcome 18: Records and documentation

**Theme:** Use of Information

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider was required to review and update and disseminate to staff their

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safeguarding vulnerable adults and the risk management policies to ensure they met the requirements of the regulations and also reflected the improved procedures now in place in Sunbeam House Services.

8. **Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
The Safeguarding of vulnerable adult’s policy and the risk management policy have been reviewed and updated and available to all staff by 30th April 2018.

**Proposed Timescale:** 30/04/2018