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:	Tús Nua
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	16 April 2018
Centre ID:	OSV-0005415
Fieldwork ID:	MON-0021388

About the designated centre

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

Tús Nua designated centre is located in County Wicklow and provides residential services with a maximum capacity for four male or female residents at any one time. It operates on a 24 hour, seven day a week basis. The property provides residents with adequate sized single bedrooms which are decorated in line with their personal tastes and interests. The premises presents as a modern and tastefully decorated property. Communal spaces in the property include one living room spaces and a kitchen/dining area. The property also provides residents with a well-maintained garden space to the rear of the property that incorporates a small patio area with garden furniture. The centre also provides a staff office which also incorporates a sleep over staff facilities.
The person in charge works in a full time capacity and manages this designated centre and one other designated centres within Sunbeam House Services. A deputy manager also forms part of the management team of this centre and is also assigned responsibility of the other designated centre. A staff team of social care workers and nurses work in the centre. There is a high resident to staff ratio in this centre and some residents receive one-to-one supports currently. The centre is resourced with one transport vehicle to support residents' participation in activities.

The following information outlines some additional data on this centre.

Current registration end date:	19/10/2019
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
16 April 2018	10:30hrs to 17:30hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

The inspector met with all four residents living in the centre on the day of inspection. As part of the inspection, some of the residents' daily routines were observed.

The residents who chose to speak to the inspector said they were happy living in the centre. Residents were also observed to be comfortable and relaxed in their home and appeared at ease in the presence of staff members. Residents smiled and appeared content during the inspection. Throughout the inspection staff members were seen to offer residents support in a pleasant and dignified manner.

During the course of the inspection, the inspector spoke with a family representative. They spoke positively of the service provided in the centre, the quality of supports which their relative received and the support provided by staff. They told the inspector that management and staff of the centre were approachable and that they could speak with them at any time about issues they may have. They also said that they had noticed some recent improvements for example, better communication between them and the centre and an increase in meaningful activities each day for their relative.

Capacity and capability

The provider demonstrated the capacity to respond to and address failings identified at previous inspections. This resulted in a good level of compliance on this inspection which had translated into an improved service for residents.

Previous inspections of the centre had found non-compliance across a range of regulations reviewed. An inspection carried out September 2017 had found residents were poorly safeguarded from peer-to-peer assaults and risk management systems were ineffective to ensure residents' care and welfare on a consistent basis. Staff workforce in this centre was inconsistent and there was an over-reliance on agency workers for the centre. A notice of proposal to cancel registration of this centre was issued to the provider in November 2017.

In line with the Health Act, 2007, the provider made a written representation to the Chief Inspector in response to the Notice of proposal to cancel registration, which also included a revised governance and management improvement plan. This inspection assessed the provider's implementation of their representation and governance improvement plan. Overall, the inspector found the provider had implemented the plan effectively and was now bringing about improvements in the

centre which were having a considerable positive impact on residents and their quality of life.

The registered provider, the person in charge and persons participating in management of the centre were now effectively ensuring each resident received an improved quality service. This inspection found evidence, across all regulations reviewed, of a service that supported and promoted each resident's care and welfare and social care needs to a better standard than found on previous inspections.

Improved quality systems in place included the introduction of an audit and risk sub-committee to the board of Sunbeam House Services. Their responsibility was to oversee internal and external control processes and provide quality assurance reports to the board. In order to improve governance, the provider had made appointments to a number of key roles within Sunbeam House Services, through recruitment or 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, an increased number of service manager(s), contracted specialist services for example, a clinical psychologist and increased psychiatry services.

The provider had also organised an external consultancy company to carry out staff training and annual provider reports to improve regulatory compliance and objective reporting to the provider on designated centres where previously persons in charge had only completed them.

The management structure had been reviewed and staff understood what they were responsible for. There was a clear definition and identification of the lines of accountability and authority for governance of the centre. Staff were accountable for the quality of their work as reflected in an improved performance management and accountability meeting structure between the senior services manager and person(s) in charge. Meetings between the senior services manager and person in charge now occurred within the centre at least once a quarter with evidence that this had occurred in Tús Nua designated centre in the first quarter of 2018. Specific key quality indicators were reviewed at this meeting. Senior services managers were now required to review a sample of information in the designated centre to evidence and check the work of the person in charge, resulting in improved accountability and performance management initiatives taking place at an operational level.

Since the previous inspection, the provider had also appointed a new person in charge for the centre. The person in charge presented as a competent, pleasant and effective manager who understood their regulatory role and responsibilities to a good standard. This included knowledge of notifications to the Chief Inspector required by the regulations. The inspector reviewed incident recording systems in the centre and noted all required notifications had been submitted to the Chief Inspector within the time-lines stipulated in the Regulations.

The person in charge had maintained her continuous professional development and at the time of inspection was in the process of completing a course in business

management. She had also completed a supervisory management course and management essentials training.

The provider was gathering and using information well to bring about ongoing improvement. Ongoing operational management audits were now in place and there was evidence that staff were encouraged to take responsibility and be accountable through improved governance arrangements in the centre.

The provider had also ensured there were sufficient numbers of consistent staff with appropriate qualifications, experience and skill mix to meet the assessed needs of residents. Previous inspection findings had noted an over-reliance on agency workers in the centre which was having a negative impact on residents and consistency and quality in service provision. This inspection found the whole time equivalent numbers of agency workers had reduced considerably to the extend that there would be no agency workers required in the centre in the weeks following the inspection as all staffing positions in the centre were now filled with permanent workers. This was a considerable, positive workforce initiative taken by the provider and having a positive impact on residents with feedback from family members also positive in this regard.

All staff had now completed necessary mandatory training in management of behaviours that challenge, fire safety and safeguarding vulnerable adults. Staff had also completed training in other areas such as safe administration of medication and administration of emergency medication for the management of seizures. A training needs analysis for the centre had been revised and refresher training was also available and scheduled for staff.

Staff supervision meetings were ongoing and most staff had received a supervision meeting since January 2018 with dates for further supervision meetings scheduled.

The inspector reviewed the statement of purpose during the course of the inspection. Inspection findings and observations made during the course of the inspection indicated the service was being operated in line with the matters set out in the statement of purpose.

In general appropriate arrangements were in place to ensure the care provided to residents was recorded and guided by clear policies. Some improvement was required in relation to Sunbeam House Services safeguarding vulnerable adults policy to ensure it was up-to-date and reflected the improved reporting procedures within Sunbeam House Services.

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre.

They met the requirements of regulation 14 and its sub-regulations.

The person in charge had maintained their continuous professional development to a good standard and had completed a number of recognised management qualifications.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured there were sufficient numbers of staff with appropriate qualifications, experience and skill mix to meet the assessed needs of residents. A planned and actual staff rota was in place which was developed by the person in charge and deputy manager and reviewed and revised regularly. The rota identified staffing on duty for day and night time.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training records reviewed indicated that staff had received up to date training. Staff had also received training in supporting residents with acquired brain injury.

Staff knowledge audits were also carried out by the person in charge which reviewed staffs' understanding of safeguarding policies and procedures and fire safety, for example.

Judgment: Compliant

Regulation 21: Records

Fire safety documentation was now located in the centre as per the requirements of Schedule 4 of the Regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured robust governance arrangements for this centre. Provisions were in place for a six monthly provider led audit to take place and also the provider had identified persons to carry out the annual review of the centre.

Operational management auditing was also taking place in the centre and completed by the person in charge and deputy manager for the centre.

Improved governance and management initiatives had been implemented throughout all lines of accountability within Sunbeam House Services. This improvement was providing residents with a more positive quality of life since their implementation.

Judgment: Compliant

Regulation 3: Statement of purpose

The revised statement of purpose was found to be in line with the matters set out in Schedule 1 of the Regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to the Chief Inspector within the time-lines stipulated in the Regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The safeguarding vulnerable adults policy required updating to reflect the improved reporting and response mechanisms within Sunbeam House Services.

The risk management policy required updating to reflect the revised and improved risk management reporting systems with in Sunbeam House Services. The provider was also required to ensure the revised policy met the requirements of Regulation

26 and its associated sub-regulations.

Judgment: Substantially compliant

Quality and safety

The findings of this inspection demonstrated an overall improvement in the quality and safety of care provided to residents. The frequency and severity of peer-to-peer assaults had reduced significantly since the previous inspection. Residents were observed to engage in more meaningful and varied activities with some residents returning to activities that they had previously enjoyed but were unable to do so due to health-care issues which were a feature on the previous inspection.

All personal plans for residents had been reviewed since the previous inspection and now contained accurate and up-to-date information which would guide and support staff in implementing evidence based practice and recommendations to support residents. Personal plans incorporated allied health professional recommendations and daily notes of the implementation of residents plans were maintained electronically.

Residents health care needs were more comprehensively assessed and responded to now. There was evidence that residents had received reviews and allied health care assessments since the previous inspection and associated recommendations and care planning was in place to ensure each resident's specific health-care need was supported as much as possible. In some instances residents had experienced improved nutritional management and had progressed towards a more optimum weight resulting in them being able to participate in activities which they enjoyed.

Residents were now engaged in more physical pursuits such as swimming, walking and bowling. All these activities contributed to promoting residents' best possible health and encouraged fun and provision for a meaningful day.

Residents were also supported to experience best possible mental health and where required, had access to allied health care professionals such as psychiatry. Some residents had received psychiatry reviews and changes to their medications had occurred which appeared to have a positive impact on residents, for example, a lessening of obsession type behaviours and the frequency and intensity of some behaviours that challenge. Ongoing review and consistent liaison with psychiatry services were a feature for some residents and provisions were in place to ensure residents were supported where they had an identified need in this regard.

The provider had also improved psychology services within Sunbeam House Services. It was also observed that where required, residents had positive behavioural support plans in place.

Since the previous inspection there had been a reduction in restrictive practices in

the centre. Previously all storage cupboards in the kitchen were locked. This practice had been reviewed by the person in charge and persons participating in management for the centre and deemed no longer necessary as improved supervision arrangements were now in place. This was a positive outcome for residents and ensured a more homely, less institutional environment in the centre than had been noted previously. Further improvements had also occurred where some residents night time sedation had been discontinued as a regular nightly medication and now prescribed only as required or PRN. This was a positive improvement and it was noted that the resident had not required the medication since its prescription had been changed. A restraint register was also in place which identified the number of restrictions in the centre, the date they were initiated and control measures in place to ensure they were the least restrictive and used for the least amount of time necessary.

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 was evidence of a more comprehensive implementation of the National safeguarding vulnerable adults policies and procedures.

Since the previous inspection there had been a significant reduction in the number of peer-to-peer assaults in the centre. This was a significant improvement in the quality of life for residents living in the centre and evidenced an improved quality service.

The systems in place to ensure safe medication management practices were found to be adequate and all staff that administered medication had been trained to do so. Medication audits had taken place at an operational level by the person in charge on a monthly basis. There were also provisions being put in place for residents' pharmacist to carry out medication and pharmacy audits in the centre. This work had begun already where residents' pharmacist had carried out a therapeutic medicines audit for residents in the centre. This audit examined the therapeutic benefits and side effects of residents' medications with guidelines for staff to implement to promote positive health outcomes for residents.

Since the previous inspection the provider had revised Sunbeam House Service's 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.

The improved system could now also provide reporting and analysis data to the quality and risk sub-committee which in turn provided a mechanism for reporting to the board on how risk and incidents were managed in designated centres of

Sunbeam House Services. This was a significant improvement in the overall risk management system for Sunbeam House Services where this reporting mechanism and risk classification system was not previously in place.

The organisational risk management policy for Sunbeam House Services was also under review. The provider had requested an external consultant to review the policy to ensure it met the regulations and provided a robust and comprehensive framework for Sunbeam House Services risk management. The provider had also initiated mandatory training in risk and incident management for all staff working in Sunbeam House Services to ensure the revised and improved risk management policy was implemented correctly and comprehensively.

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

An up-to-date risk register was in place for the centre which included specific control measures for each risk identified. 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. Some improvement was required to ensure the risk register captured hazards and environmental risks in the centre as well as person specific risks. The risk management policy also required updating to reflect the positive initiatives and improvements being implemented in Sunbeam House Services.

Regulation 26: Risk management procedures

The risk register required review to ensure it captured not only person specific risks but also hazard identification and environmental risks within the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Compliant fire management procedures were in place. Fire safety checks and equipment servicing records were maintained in the centre and were found to be up-to-date. Fire containment measures and compartmentalisation was also evident throughout the centre.

Fire drills occurred once a month and each resident had an up-to-date personal evacuation.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There was a policy on the management of medication available in the centre and was line with legislation and national guidelines.

The systems in place for the receipt of, administration and storage of drugs were found to be satisfactory. There were also appropriate documented procedures in place for the handling, disposal of and return of all medications.

Medications were routinely audited in the centre and it was found that they could be accurately accounted for at all times.

There were systems in place to manage a drug error should one occur.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date personal plan which outlined an assessment of residents needs incorporating allied health professional reviews and recommendations. Where residents needs were identified each resident had a support plan in place.

Residents person centred goals had also been identified and set for the coming year with evidence that some goals had been achieved for residents, for example seeing a show in a theatre and establishing better links with the community and re-engaging in preferred hobbies and interests which they hadn't done for a period of time.

Judgment: Compliant

Regulation 6: Health care

Each resident had received an annual review by their general practitioner. Residents

had also received review and assessment for other identified health care needs for example, some residents had received speech and language therapy reviews since the previous inspection and had been prescribed modified consistency diets based on their assessment.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required residents had a behaviour support plan in place. These plans had received a preliminary review by a psychologist and some recommendations with regards to the layout and person centred information in the plans had been recommended. The inspector noted that these recommendations would bring about improved behaviour support planning for residents.

The frequency and intensity of challenging behaviour incidents resulting in peer-to-peer assaults had reduced since the previous inspection.

The level of restrictive practice in the centre had reduced and had been discontinued in some instances. A restraint register had been devised which captured information with regards to all restrictive practices in the centre. All staff had received training in the management of potential and actual instances of aggression and/or behaviours that challenge. Refresher training was scheduled also as part of staffs overall training programme for the centre.

Judgment: Compliant

Regulation 8: Protection

The provider had improved safeguarding reporting and response systems within Sunbeam House Services and this was found on this inspection. Where required residents had a safeguarding plan in place.

All staff had received training in safeguarding vulnerable adults. A designated officer, a requirement of National Safeguarding Vulnerable Adults policy, was allocated to the centre and their photograph and contact details were located in the centre.

The frequency of peer-to-peer safeguarding incidents had reduced significantly since the previous inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
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 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tús Nua OSV-0005415

Inspection ID: MON-0021388

Date of inspection: 16/04/2018

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 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: SHS are currently following the HSE safeguarding national policy. All centers have guidelines in place. **Completed** The Risk management policy has been updated to reflect the revised and improved risk management reporting systems within the organization. **Completed** The above policies are in line with regulation 26 and associated sub regulations. **Completed**	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The risk register has been reviewed to ensure environmental risks and hazards are identified and appropriate measures have been put in place. The risk register format has been changed over to the HSE excel risk register format. **Completed**	

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 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	Completed 30/05/2018
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	Completed 30/05/2018