Office of the Chief Inspector

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

Name of designated centre: Rosses View
Name of provider: Health Service Executive
Address of centre: Sligo

Type of inspection: Unannounced
Date of inspection: 09 April 2019
Centre ID: OSV-0003368
Fieldwork ID: MON-0024094
About the designated centre

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

Rosses View is a centre run by the Health Service Executive. The centre is located a short distance from a town in Co. Sligo and provides residential care for up to 28 male and female residents, over the age of 18 years who have an intellectual disability and associated health care needs. The centre is located in a campus setting and comprises of six separate units, which provide residents with their own bedroom, some en-suite facilities, shared bathrooms, kitchen and dining areas, sitting rooms and recreational spaces. Each unit opens out onto the grounds of the campus, which provides residents with access to various garden spaces and walk-ways. Staff are on duty both night and day to support the residents who live in this centre.

The following information outlines some additional data on this centre.

<table>
<thead>
<tr>
<th>Current registration end date:</th>
<th>09/05/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>19</td>
</tr>
</tbody>
</table>
How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (hereafter referred to as 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:

<table>
<thead>
<tr>
<th>Date</th>
<th>Times of Inspection</th>
<th>Inspector</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>09 April 2019</td>
<td>09:30hrs to 16:10hrs</td>
<td>Anne Marie Byrne</td>
<td>Lead</td>
</tr>
</tbody>
</table>
Views of people who use the service

The inspector met with two residents who live at the centre; however, neither resident spoke with the inspector about the care and support they receive. The inspector observed staff to engage respectfully with residents and some staff spoke with the inspector about the plans residents had that day to attend day services and to access the community. The inspector also observed displayed photographs of residents participating in club activities and of various seasonal events that they attended.

Capacity and capability

The inspector found this centre was well-resourced and effectively managed to ensure residents received a good quality of service. Since the last inspection of this centre in November 2017, the provider had made improvements to the overall arrangements in place for staffing and safeguarding of residents from harm. Although improvements were also made to the fire safety and risk management systems, these systems were still found to require further review to ensure compliance with the requirements of the regulations.

The person in charge held the overall responsibility for this service and he was supported by two clinical nurse managers in the management of this centre. He was present at the centre on a regular basis to meet with staff and residents and also met frequently with the clinical nurse managers to discuss operational issues arising within the service. He was unable to attend the centre on the day of inspection, but was represented by both clinical nurse managers.

Since the last inspection, the provider had increased the number of nursing staff working at the centre to ensure the assessed clinical needs of residents were at all times met. In addition to this, additional staffing resources were also allocated to the service to support the social care needs of residents during the week and at weekends. Staff who met with the inspector spoke of the positive impact these additional staffing resources had on providing residents with a good quality of life. A well-maintained roster identified the names of staff and their start and finish times worked both day and night. Effective training arrangements ensured that all staff received regular mandatory training and staff also continued to receive regular supervision from their line manager.

Regular staff meetings and management meetings were also conducted, which ensured all staff were facilitated to regularly discuss areas concerning the safety and welfare of residents. The annual review and six monthly provider-led visits were
occurring in-line with the requirements of the regulations and where improvements were identified, time bound action plans were put in place to address these. The provider's monitoring systems also included the regular review of incidents occurring at the centre, which had a positive impact on ensuring trends were identified and responded to, as required.

**Regulation 14: Persons in charge**

The person in charge was unable to be present at the centre on the day of inspection. However, he was found to have the qualifications and experience required to fulfill his duties as person in charge at this centre.

Judgment: Compliant

**Regulation 15: Staffing**

The number and skill-mix of staff was adequate to meet the assessed needs of residents. Staff rosters were found to be well-maintained and clearly identified the names of staff on duty and their start and finish times worked at the centre.

Judgment: Compliant

**Regulation 16: Training and staff development**

All staff received mandatory training and a refresher training programme was also available to them, as required. Staff also received regular supervision from their line manager.

Judgment: Compliant

**Regulation 23: Governance and management**

The provider had ensured effective monitoring systems were in place to oversee and regular monitor the delivery of care to residents. The annual review and six monthly provider-led visits were conducted in-line with the requirements of the regulations.
Judgment: Compliant

**Regulation 31: Notification of incidents**

The person in charge had a system in place to ensure incident were recorded, responded to and reviewed and notified to the Chief Inspector, as required.

Judgment: Compliant

**Quality and safety**

The provider had improved systems in place to ensure residents were supported to have a good quality of life. Adequate staffing and transport arrangements supported residents to engage in regular activities, to regularly access to the community and to avail of day services, if they wished. Residents participated in various club activities offered within the service and were supported to choose how they wished to spend their time each day.

The centre comprised of six separate units where residents had access to their own bedroom, some en-suite facilities, shared kitchen and dining areas, shared bathrooms and all units had access to the surrounding campus gardens and walkways. With the de-congregation of residents from this centre to the community, additional living spaces were now available within the centre for residents to avail of. For example, residents identified with changing needs were supported by the provider to have larger bedrooms with en-suite facilities to accommodate their increased mobility and health care needs. In addition to this, the provider also put in place additional recreational rooms for residents with assessed sensory needs to use. Residents’ bedrooms were found to be comfortable, spacious and decorated to each resident’s preferred taste. Due to an infection control risk identified by the provider in the days prior to this inspection, the inspector did not access all units within this centre on the day of this inspection.

Residents with assessed health care needs were appropriately supported by staff and had access to a variety of health care professionals, as required. Improved arrangements were in place for residents with assessed neurological needs and personal plans were found to clearly guide staff on the care and support required by residents with assessed health care needs. Similarly, where residents required behavioural support, clear behaviour support plans were in place to guide staff how they were required to support residents' assessed needs. There were some restrictive practices in use at the centre and prior to this inspection, the provider had identified that improvements were required to the system in place for the management and review of restrictive practices within the service. In response to this, the provider was in the process of reviewing these systems at the time of this
Since the last inspection, the provider had improved the systems in place for the identification and response to risk at the centre. However, some improvements were still required to ensure that identified risks were appropriately assessed. For example, falls risk assessments reviewed by the inspector, did not always record the correct information required to provide an accurate risk rating. In addition to this, some assessed risk ratings did not specifically identify or consider the impact control measures implemented by the provider had on mitigating the risk, which had a negative impact on the provider’s ability to monitor escalation and de-escalation of risk at the centre. The inspector also observed that the provider's response to identified organisational risk was not always supported by a risk assessment. For example, in the days prior to this inspection, the provider implemented various infection control precautions in response to an identified infection control risk; however, these measures were not supported by a risk assessment to monitor the overall effectiveness of these measures.

Fire safety precautions were in place including fire containment and detection systems, clear fire exits, emergency lighting arrangements and regular maintenance of fire equipment. The provider had reviewed the displayed fire procedure since the last inspection; however, the inspector found it required further review to provide clarity on the procedure staff were to follow in the event of a fire at the centre. The procedure was satisfactorily reviewed prior to the close of the inspection. Although regular fire drills were occurring, these drills did not consider the evacuation of residents in-line with the guidelines set out in the centre's fire procedure or with the use of minimum staffing levels. Furthermore, residents' evacuation plans required review to ensure they provided staff with accurate information on the level of support each resident would require to effectively evacuate.

**Regulation 13: General welfare and development**

The provider had ensured adequate transport and staffing arrangements were in place to support residents to have opportunities to engage in a variety of activities, in accordance with their wishes and developmental needs.

Judgment: Compliant

**Regulation 17: Premises**

The centre was found to be clean, spacious and residents were supported to decorate their bedrooms as they wished.
Judgment: Compliant

**Regulation 26: Risk management procedures**

Since the last inspection, the provider had made improvements to the systems in place to identify and respond to risk. However, further improvements were required to ensure that assessed risk ratings considered the impact of control measures in mitigating the risk. Furthermore, improvements were required to ensure risk assessments included accurate resident information and identified the specific measures put in place in response to the risk identified.

Judgment: Substantially compliant

**Regulation 28: Fire precautions**

The provider had effective fire safety precautions in place, including, fire detection and containment systems, up-to-date staff training in fire safety and emergency lighting arrangements. Although regular fire drills occurred in each unit within the centre, the provider had not assessed the effectiveness of the centre's fire procedures in the event of the need to evacuate the whole centre and in the event of only minimal staffing levels being available.

Judgment: Substantially compliant

**Regulation 5: Individual assessment and personal plan**

A system was in place to ensure residents' needs were regularly assessed and that personal plans were in place to guide staff on how to support residents' with specific needs. A number of residents had transitioned from this centre to the community since the last inspection and a system was in place to support other residents to also transition to the community.

Judgment: Compliant

**Regulation 6: Health care**

Where residents presented with assessed health care needs, the provider had ensured that these residents received the care and support they required. Residents
also had access to a variety of allied health care professionals as required.

Judgment: Compliant

<table>
<thead>
<tr>
<th>Regulation 7: Positive behavioural support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where residents required behavioural support, the provider ensured that resources and supports were in place to meet these residents’ needs. There were some restrictive practices in place; however, the provider was in the process of reviewing these at the time of this inspection.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation 8: Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were no safeguarding plans in place at the time of this inspection. All staff had received up-to-date training in safeguarding and the provider had procedures in place to support staff to identify, report and respond to any concerns regarding the safety and welfare of residents.</td>
</tr>
<tr>
<td>Judgment: Compliant</td>
</tr>
</tbody>
</table>
Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

<table>
<thead>
<tr>
<th>Regulation Title</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Views of people who use the service</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 14: Persons in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 15: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 16: Training and staff development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 23: Governance and management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 31: Notification of incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td><strong>Capacity and capability</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 13: General welfare and development</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 17: Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td>Regulation 28: Fire precautions</td>
<td>Substantially compliant</td>
</tr>
<tr>
<td><strong>Quality and safety</strong></td>
<td></td>
</tr>
<tr>
<td>Regulation 5: Individual assessment and personal plan</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 6: Health care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 7: Positive behavioural support</td>
<td>Compliant</td>
</tr>
<tr>
<td>Regulation 8: Protection</td>
<td>Compliant</td>
</tr>
</tbody>
</table>
Compliance Plan for Rosses View OSV-0003368

Inspection ID: MON-0024094

Date of inspection: 09/04/2019

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. Specific to that regulation, Measurable so that they can monitor progress, Achievable and Realistic, and Time 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:

<table>
<thead>
<tr>
<th>Regulation Heading</th>
<th>Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26: Risk management procedures</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with regulation 26:
To ensure the safe and effective delivery of care and support the provider adheres to and is guided by the following policies, legislation and guidance documents;
*Safety Health & Welfare at Work Act 2005
*HSE National Integrated Risk Management Policy 2017
*Health and Safety at Work guidance produced by the Health and Safety Authority.
*Schedule 5 - Risk Management & Emergency Planning Policy
*Schedule 5 - Policy on When a Resident Goes Missing.
*Safeguarding Vulnerable Persons at Risk of Abuse 2014.
*HSE National Incident Management Framework 2018
The provider ensures that the following robust practices are implemented to ensure all incidents and identified risks are effectively managed;
> National Incident Management System.
> A Health & Safety Risk Management System - which includes the corporate, organisational and centre specific safety statements, a risk register to manage the identified physical, biological and chemical risks. The plans in place to respond to emergencies that may arise.
> A schedule of audit which is completed throughout the year.
> All vehicles provided by the registered provider to transport residents, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.
> An incident review group is in place to review incidents at the end of each month and identify areas for improvement and share learning to prevent reoccurrence.
The provider respects the rights of residents to take positive risks in their everyday lives and has the following in place to support and safeguard residents;
> A comprehensive assessment of need and person centred planning process developed with the maximum participation of the resident and his/her representative where appropriate.
> The personal plan reflects the resident’s needs, wishes and preferences and outlines the supports required to maximise the residents’ personal development. Positive risk taking is encouraged, supported and risk assessed to ensure residents have opportunities in everyday life similar to their peers.

Response:

• The risk of falls has been reviewed, updated, and existing controls have been revised. Arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident’s quality of life have been considered.
• In consultation with the CNS in Infection Control the risk assessment in infection control was revised and the additional existing controls were reviewed, and the risk rating was revised and updated. This will be reviewed as necessary.
• The fire risk assessment was reviewed and additional existing controls were added following consultation with the Health and Safety Officer CHO1 and an external fire protection agency.
• The above risks were updated and inserted in the Health and Safety and Risk system throughout Rosses View.

<table>
<thead>
<tr>
<th>Regulation 28: Fire precautions</th>
<th>Substantially Compliant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</td>
<td>To ensure compliance with regulation 28: The provider ensures that;  &gt; Effective fire safety management systems are in place in the centre and adheres to and is guided by the following;  *Safety Health &amp; Welfare at Work Act 2005  *Health &amp; Safety Authority Guidance on Fire Prevention and Fire Safety.  *Code of Practice for Fire Safety in New &amp; Existing Community Dwelling Houses 2017  *HSE Fire Safety and Risk Management Policies and Procedures  *Schedule 5- Risk Management &amp; Emergency Planning Policy.</td>
</tr>
</tbody>
</table>

> The centre has a Fire Safety Statement, Fire Precautions and Emergency Evacuation Procedures in place which have been drawn up in consultation with the HSE Fire Officer and Estates Department and are reviewed annually or sooner if required.  > Easy read emergency evacuation procedures are available for residents.  > Staff receive fire training on an annual basis which incorporates evacuation procedures and the use of fire fighting equipment.  > The centre is equipped with suitable fire safety equipment, including a fire alarm system which are routinely checked and serviced according to safety requirements.  > Emergency lighting is in place to clearly identify means of escape.  > Fire safety checks are completed and recorded in the Fire Register, faults noted are reported immediately.  > The centre is well maintained, free from clutter with cleaning schedules in place.  > Electrical equipment is maintained in good working order, a night time safety check is completed to ensure all electrical appliances are switched off.  > Fire drills and evacuations are conducted monthly with residents and staff, details are recorded in the Fire Register. Drills include night time simulation & minimum staffing.  > Each resident has a personal emergency evacuation plan in place which is reviewed on
a six monthly basis or more frequently if there is a change in need or circumstances.
> The provider has a schedule of audit in place which includes audit of fire safety and health & safety.
> The centre has a health and safety risk management system in place which includes;
* A safety statement which is reviewed annually,
* A risk register which includes risk assessments for fire safety & electrical appliances.
* The fire precautions & evacuation procedures.
* Emergency plans in the event of major emergencies.

The person in charge ensures that;
> The procedures to be followed in the event of fire are displayed in a prominent place.
> Fire checks are conducted according to the Fire Register and records are maintained.
> Fire drills are conducted monthly, the learning is shared with both residents and staff and relevant fire safety information is updated if required.
> Random questionnaires are completed with staff to consolidate knowledge of fire procedures.
> Fire safety audits are completed on a quarterly basis.
> The staff training matrix is monitored on a monthly basis to ensure fire training is completed within the required timeframes.
> Each resident’s personal emergency evacuation plan is reviewed at six monthly intervals or in the event of a change in need or circumstances.
> All identified risks within the centre are kept under review.
> The centre is well maintained, repairs and faults are promptly addressed and the centre is free from clutter ensuring escape routes are unobstructed.
> Cleaning schedules are completed.
> All staff adhere to the Risk Management & Emergency Planning Policy.
> All staff have read and signed the Health & Safety Risk Management system.
> Fire safety is a standing agenda item on both staff and resident meetings.

Response:
• The Nurse Managers carried out a Fire Drill in Rosses View on the 12/04/2019. The outcome resulted in an action plan which recommended a visit from an external fire protection agency to carry out an assessment. This took place on the 16/04/2019.
• The Health and Safety Officer (CHO1) was also consulted and completed a desktop assessment to ensure they met the required compliance. The updated risk assessments were rolled out across Rosses View, and information shared at monthly team meetings. Further training in fire was rolled out by an external fire protection agency on the 26/04/2019 to all staff on duty on the day in Rosses View including Nurse Managers – this included fire drills, fire evacuation, review of PEEPS, review of fire notices and updating the fire register.
• Management will continue to have ongoing reviews of fire risk, including systems for responding to emergencies.
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).

<table>
<thead>
<tr>
<th>Regulation</th>
<th>Regulatory requirement</th>
<th>Judgment</th>
<th>Risk rating</th>
<th>Date to be complied with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulation 26(2)</td>
<td>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.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>01/05/2019</td>
</tr>
<tr>
<td>Regulation 28(4)(b)</td>
<td>The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.</td>
<td>Substantially Compliant</td>
<td>Yellow</td>
<td>01/05/2019</td>
</tr>
</tbody>
</table>