Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Bethel House - Sonas Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	06 June 2019
Centre ID:	OSV-0003728
Fieldwork ID:	MON-0021826

About the designated centre

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

Bethel House is an 11 bedded unit for adults with an intellectual disability. The aim of the centre is to provide specialist convalescence care, palliative care and care and support for residents with high medical care needs. The centre is located within a large building within a campus based service located in North Dublin. The centre comprises of two dormitory style bedrooms catering for four residents in each, three single bedrooms two of which are ensuite, a medical supplies room, a visitors room, staff room, four bathrooms and shower areas and a laundry and sluice room. Residents are supported 24 hours a day, 7 days a week by a staff team comprising of a person in charge, clinical nurse manager, staff nurses, care staff and household staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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:

Date	Times of Inspection	Inspector	Role
06 June 2019	09:30hrs to 17:30hrs	Marie Byrne	Lead
06 June 2019	09:30hrs to 17:30hrs	Sarah Barry	Support

Views of people who use the service

The inspectors had the opportunity to meet and briefly engage with nine of the 10 residents living in the centre on the day of the inspection. The inspectors' judgments in relation to the views of the people who use the service relied upon observation of residents, a review of documentation, brief interactions with residents and discussions with staff. Throughout the inspection residents appeared comfortable in the presence of and with the level of support offered by staff.

The inspectors had the opportunity to speak with one of the residents in relation to their experience of the care and support in the centre. They were complimentary towards the staff in the centre but stated they required more staff to support the person in charge to ensure residents were kept safe. They stated that they were not happy to share her bedroom and would like their own bedroom. The inspectors reviewed complaints records in the centre and this resident had logged a complaint in relation to noise levels and sharing their bedroom. The provider had taken actions to resolve this complaint and one resident had transferred to another room within the centre. On reviewing one residents' personal plan in the centre the inspectors viewed a compliment from a family member in relation to the care and support provided by staff in the centre for their family member.

Through observation and by reviewing documentation the inspectors noted that many residents remained within the campus for much of the day, with limited opportunity to access the community individually. The centre had a vehicle; however, it was not meeting the needs of the majority of ladies in the centre, as it was not suitable for wheelchair users.

Capacity and capability

Overall, the inspectors found that the registered provider was not providing full oversight of the centre due to the fact that an annual review of quality and safety of care and support had not been completed in the centre since 2016. Areas for improvement were identified during the inspection. These improvements included; ensuring the premises was meeting the number and needs of residents, ensuring residents' had opportunities to engage in meaningful activities and access to their local community, staff access to refresher training in line with residents' needs and in ensuring residents were in receipt of continuity of care while the provider was in the process of recruiting to fill staffing vacancies in the centre.

There were clear management systems and structures in place and staff had clearly defined roles and responsibilities. The staff team reported to the person in charge

who in turn reported to the person participating in the management of the designated centre (PPIM). The person in charge, clinical nurse manager 1 and PPIM facilitated the inspection. Staff meetings were occurring approximately every three months and agenda items were found to be person centred. The staff team were completing audits including; medication audits, care plan audits, residents' private property audits, infection control audits. There was evidence that there were actions developed following these audits and that these actions were leading to some improvements in relation to care and support for residents in the centre. The provider was completing six monthly reviews of the quality of care and support in the centre in line with the requirements of the regulations. There was evidence that some of the areas for improvement identified, were in line with the findings of this inspection. There were timeframes identified for the completion of these actions and evidence of completion of most of these actions. The annual review of care and support completed in the centre in 2016 identified a number of recommendations which were similar to areas for improvement identified on this inspection. However, a number of these recommendations had not been completed at the time of the inspection. These included; actions relating to the premises and supporting residents to carry out social activities.

Throughout the inspection, residents appeared comfortable with the level of support offered by staff. Staff who spoke with the inspector were knowledgeable in relation to residents' specific care and support needs. Planned and actual rosters were available and maintained in the centre. There were a number of staff vacancies in the centre and the provider was in the process of recruiting to fill these. However, in addition to the 1.5 staffing vacancies there were a number of staff on leave which was leading to a heavy reliance on agency staff. This was impacting upon the continuity of care provided to residents in the centre. The inspectors were informed at the feedback meeting at the end of the inspection that a staff nurse had just been recruited to fill one of the staffing vacancies.

The inspector reviewed a number of staff files and found that two of files did not contain all the information required by schedule 2 of the regulations. The provider provided documentary evidence that one of the staff files contained all the information required by the regulations at the end of the inspection and forwarded assurances to the Office of the Chief Inspector (OCI) in relation to the other staff file after the inspection.

Staff had completed a suite of training and refreshers in line with the residents' assessed needs. However, a number of staff required refresher training in safeguarding, and manual handling. A training needs analysis had been completed by the person in charge and they showed the inspectors evidence that they had contacted the organisations' education and training department to access this refresher training for staff. The person in charge had a schedule in place for formal staff supervision. The inspectors reviewed a sample of staffs' supervision records and found that agenda items were varied and areas of good practice and areas for improvement were identified with staff during the supervision sessions.

Regulation 15: Staffing

There were a number of staffing vacancies in the centre and the provider was in the process of recruiting to fill these vacancies. However, in addition to the staffing vacancies there were a number of staff on leave which was leading to a heavy reliance on agency staff in the centre, which was in turn leading to a lack of continuity of care for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs. However, a number of staff required safeguarding and manual handling refresher training. A schedule was in place for formal staff supervision.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider could not fully demonstrate that they were identifying and resolving areas for improvement in the centre. The annual review of quality and safety of care and support of the centre had not been completed since 2016 and a number areas for improvement identified in this review had not been completed at the time of this inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

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

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was good. Residents lived in a caring environment and were being supported to enjoy best possible health. However, the design an layout of the premises was not meeting the number and needs of residents or the requirements of schedule 6 of the regulations. In addition, residents had limited opportunities to engage in their local community.

The inspectors found that the premises was not meeting the numbers or evolving needs of residents' in the centre. The inspectors acknowledge that the premises was clean, spacious and well maintained. In addition, efforts were being made to make the centre more homely and comfortable for the ladies living there. However, there were two multi-occupancy bedrooms in the centre which were dormitory style in layout and design. Each of the two bedrooms had the capacity to accommodate four residents. There was evidence that attempts were being made to ensure residents' privacy and dignity through staff practices to respect residents privacy and dignity and through the use of curtains between each bed. During the inspection of the residents who spoke with the inspectors indicated that they were not happy to share their bedroom and stated that she would like to have their own bedroom. There were a number of bathrooms and shower rooms in the centre; however, there was only one bathroom which was fully accessible to meet the needs of nine of the 10 ladies living in the centre. There was limited storage for large items in the centre, resulting in storage of large items in bathroom areas. The provider had recognised the premises deficits in the annual review completed in the centre in 2016 and in their latest six monthly review of care and support in the centre. The person in charge informed the inspectors that a review of the premises had been recently completed by the management team. In addition, the service manager informed the inspectors that the they had met with the organisations director of logistics to review the layout and available space in the centre. They recognised that there was wasted space in the centre that could be better utilised to give residents more private space. They stated that a proposal was being put forward to the management team in relation to the findings of the review of the premises.

The inspectors reviewed a number of residents' personal plans. In line with residents' current care and support needs there were a number of different formats for residents' personal plans in the centre. Each resident had an assessment of need in place and care plans which were were detailed and clearly guiding staff to support them in line with their needs and wishes. Residents also had an accessible person centre plan in place which outlined their likes, dislikes and their goals.

Overall, residents were being supported to enjoy best possible health. They had access to allied health professionals in line with their assessed needs and staff were knowledgeable in relation to their care and support needs. Health action plans were developed as required and there was evidence of regular review and update of residents' personal plans in line with their changing needs. However, in a number of residents' personal plans reviewed, there was an absence of an assessment in relation to their healthcare needs. This was discussed with the person in charge and PPIM during the inspection and they showed the inspector and existing document

which they used in other parts of the service which they now planned to use in the centre. The provider had recently set up a committee to review health screening programmes to ensure residents were fully accessing these services and to set up various health promotion initiatives.

The inspectors found that residents had limited access to opportunities to participate in activities and link with their local community. The inspectors acknowledged that some efforts were being made to support residents to engage in meaningful home or campus based activities in line with their wishes and preferences and their assessed needs. Residents had person centred plans which identified their likes, dislikes and residents' preferred activities. However, due to lack of access to transport appropriate to meet residents' needs at times, residents' opportunities to engage in some activities or to link with their local community were limited. The inspectors reviewed a sample of residents' activity records and found that on average some residents were engaging in community based activities once per month.

There was a residents' guide in place which clearly outlined the services and facilities provided for residents. It also detailed the terms and conditions relating to living in the centre, the arrangements for residents' involvement in the running of the centre, how to access any inspection reports, the procedure for complaints and the arrangements for visitors.

Residents were protected by appropriate risk management procedures and practices in the centre. There were systems in place for keeping residents safe while responding to emergencies. The centres' risk register, general and individual risk assessments were reviewed as required. Residents' individual risk assessments reviewed were found to be person-centred. There was evidence of regular review and update of these risk assessments in line with residents' changing needs and learning following incidents.

Residents were protected by appropriate policies and procedures relating to the ordering, receipt, storage and disposal of medicines. Audits including stock control were completed regularly and incidents were documented. Protocols for as required medicines and in relation to refusal of medicines were developed and reviewed as required.

Regulation 13: General welfare and development

The inspectors found that residents' opportunities to engage in activities or to link with their local community were limited. At times, this was due lack of access to transport appropriate to meet residents' needs. The inspectors reviewed a sample of residents' activity records and found that on average residents were engaging in community based activities once per month.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the premises was not meeting the number and needs of residents in the centre. There were two multi-occupancy bedrooms, with four beds in each these rooms. There was a lack of private space to meet residents' needs. There were insufficient bathing/showering facilities to meet the number and needs of residents and insufficient storage for large items in the centre.

Judgment: Not compliant

Regulation 20: Information for residents

There was a residents' guide developed which contained all the information required by the regulations. The residents guide was available in the centre for residents and their representatives if they so wish.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by appropriate risk management procedures and practices. There were systems in place for responding to emergencies and arrangements arrangements were in place for identifying, recording, investigating and learning from serious incidents and adverse events.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were appropriate practices in relation to ordering, receipt, storage and disposal of medicines in the centre. Protocols for PRN/as required medicines and in relation to refusal of medicines were developed and reviewed as required.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents' care and support needs were assessed and they had a personal plan in place. There was evidence of review to ensure they were effective and evidence that they were updated in line with residents' changing needs.

Judgment: Compliant

Regulation 6: Health care

Overall, residents were supported to enjoy best possible health. They had access to the support of relevant allied health professionals in line with their needs. Staff were knowledgeable in relation to their care and support needs. However, there was an absence of an assessment in relation to their healthcare needs in a number of residents' personal plans reviewed.

Judgment: Substantially compliant

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:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant

Compliance Plan for Bethel House - Sonas Residential Service OSV-0003728

Inspection ID: MON-0021826

Date of inspection: 06/06/2019

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. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is ongoing recruitment for staff nurse vacancies for the center. • Staff on long term sick leave has now reported to resume back to work by 19th July 2019. This will increase regular staff working with the service users and promote continuity of care. PIC/CNM1 discussed with PPIM/CNM3 to look at requesting regular Agency staff to cover the center to promote continuity of care when needed.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The schedules for the mandatory training and development are available until June 2019. The center is waiting for the autumn schedule. • PIC has completed a training list on the 14th June 2019 and forwarded to CNM3 in-charge of training and development for those requiring mandatory refreshers training for autumn calendar. • PIC will continue to meet individual staff for Formal staff supervision as per 2019 calendar. • Schedules for staff/team meeting are to continue as per 2019 calendar.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Schedule for the annual review by Quality and Risk Officer will commence on 1st August 2019.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• PIC will ensure service users to access the community more frequently.
• PIC will undertake activity audit and address findings with keyworkers.
• The Service continue to inquire about changing the service vehicle for the center, PIC will ensure residents access the community via other means of transport i.e. public transport and Service vehicles around the campus.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• PIC and Service manager will continue to link with the Director of logistics regarding designs and layout of the premises to meet individual needs and preferences of service users.

• The Service manager is awaiting reply from the Director of logistics and will refer back to the inspector in 2 weeks with compliant date.

The inspector has reviewed the provider compliance plan. This action proposed to address the regulatory non-compliance does not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations.

Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • PIC to complete audit on care plans to ensure they are maintained to high standard and meet requirements of regulation 6. • PIC to incorporate assessment of health care needs to a number of personal plans.	

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/12/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/12/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is	Substantially Compliant	Yellow	31/12/2019

	appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/12/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	14/06/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and	Not Compliant	Orange	31/08/2020

	laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/08/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30/08/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/12/2019