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:	Grange Apartments - Sonas Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	05 March 2019
Centre ID:	OSV-0003745
Fieldwork ID:	MON-0021829

About the designated centre

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

Care and support is provided in Grange Apartments for up to six residents with an intellectual disability, both male and female, from the age 17. The aim of grange apartments is to provide a supportive, individualised and low arousal residential environment, specifically tailored to each individual's needs. Each resident has their own apartment with a bedroom, bathroom and kitchen/living/dining area. The long term objective of the centre is to support the individual to develop the tools and skills required for their discharge to live in/or engage in their community at a level that best suits them. Residents usually transition to the centre from within the service. The primary focus in grange apartments is to support each resident to engage in meaningful activities of their choice, with a strong emphasis on community integration. The centre is situated near many local and public amenities including good public transport links and there are a number of vehicles in the centre to support residents to engage community activities. Internally, there are a variety of activities the residents can avail of including a gym, a number of garden areas, and a number of multifunctional rooms. Staffing support is provided 24 hours a day, seven days a week by a person in charge, clinical nurse manager, staff nurses and care staff.

The following information outlines some additional data on this centre.

Current registration end date:	27/11/2020
Number of residents on the date of inspection:	6

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
05 March 2019	09:00hrs to 17:00hrs	Marie Byrne	Lead
05 March 2019	09:00hrs to 17:00hrs	Sarah Mockler	Support

Views of people who use the service

The inspectors had the opportunity to meet five residents living in the centre on the day of the inspection, and to engage briefly with them. Throughout the inspection each of the residents appeared comfortable in the presence of, and with the levels of support offered by staff.

In line with their needs and wishes, staff were supporting residents to engage in meaningful home and community based activities. The inspectors had the opportunity to communicate with a number of residents who indicated that they were happy and felt safe in their home. Some of the residents did not express their opinions verbally to the inspectors but they appeared happy and comfortable throughout the inspection.

There were policies and procedures in place for residents to raise their concerns including the complaints procedure. These procedures were available in a format which was meeting residents' communication needs. There was accessible information available throughout the centre to facilitate residents to make choices in relation to activities, meal times and other day-to-day activities. In addition, staff were meeting residents regularly to discuss their rights and other aspects of care and support in the centre. Residents had access to advocacy support if they so wish. Information relating to the confidential recipient were also on display throughout the centre.

Capacity and capability

Overall, the inspector found that there were systems in place to monitor the quality of care and support for residents. The provider and person in charge were completing regular audits including the six monthly visits by the provider. These reviews were identifying areas for improvement in line with the findings of this inspection. However, the annual review of the centre for 2017 was not fully completed or available in the centre. The 2018 annual review was in progress.

There were clearly defined management structures that identify lines of authority and accountability. Staff had specific roles and responsibilities for aspects of residents' care and support. The staff team reported to the person in charge who in turn reported to persons participating in the management of the designated centre. In addition the service manager was visiting the centre regularly and providing support to the staff team. Staff meetings were held regularly and agenda items were found to be resident focused. They were identifying areas for improvement which were leading to improvements in the quality of care and support for residents.

There was evidence of follow up and completion of actions following audits which were positively impacting on the residents' home and the quality of care and support in the centre.

Staff were suitably qualified and competent and residents were observed to receive assistance in a kind, caring, respectful and safe manner throughout the inspection. Planned and actual rosters were maintained in the centre. There were a number of staff vacancies in the centre and the provider was in the process of reviewing staffing requirements in line with residents' needs. They were in the process of recruiting and in the interim were providing continuity for residents through staff completing extra hours and the use of regular agency staff. There was a robust induction process in place for new and agency staff.

Throughout the inspection residents appeared happy, relaxed and to be engaging in activities of their choosing. Staff members who spoke with the inspectors were knowledgeable in relation to residents' care and support needs and committed to providing person-centred care in line with residents' needs and wishes. They had completed mandatory training and refreshers in line with the organisations' policy and procedures and had also completed additional training in line with residents' needs. However, a number of staff required refresher training in areas such as fire training, safeguarding training and managing behaviour that is challenging. The person in charge showed the inspectors dates identified for staff to complete these courses. Staff who spoke with the inspectors stated they were supported in their roles and there was evidence that the person in charge, persons participating in the management of the designated centre and the service manager were meeting with them regularly and supporting them to carry out their roles and responsibilities to the best of their abilities. However, the staff team were not in receipt of regular formal supervision.

There were clear admission policies and procedures in place in the centre. Residents had written contracts of care in place which contained the information required by the regulations.

Overall, the residents were protected by appropriate policies, procedures and practices in the centre. However, a number of policies required under Schedule 5 of the regulations had not been reviewed in line with the time frame identified in the regulations.

Regulation 15: Staffing

Staff were suitably qualified and knowledgeable in relation to residents' care and support needs. There were a number of staff vacancies and the provider was in the process of reviewing staffing requirements in the centre in line with residents' needs. They were in the process of recruiting and in the interim were providing continuity for residents through staff completing extra hours and the use of regular agency staff.

Judgment: Substantially 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 refresher training. Dates had been identified for these courses to be completed. Staff were supported in their roles but they were not in receipt of regular formal supervision.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents in place which contained all the information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures which identified the lines of authority and accountability for each staff member. A suite of audits were being completed regularly and there was evidence that the actions completed following these reviews were positively impacting on residents' lives and their home. However, the annual review for 2017 was not fully completed or available. The annual review for 2018 was in progress.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspectors reviewed a number of residents' contracts of care and they contained all the information required by the regulations.

Judgment: 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 time frame identified in the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of policies required under Schedule 5 of the regulations had not been reviewed in line with the time frame identified in the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that the provider and person in charge were monitoring and reviewing the quality of the service provided for residents to ensure it was of a good quality and that people were safe. The centre was well managed and residents were being supported to gain independence and make choice in their daily lives. They had opportunities to be involved in the day-to-day running of their home. One resident was supported to transition from the centre since the last inspection, and another resident had been supported through the admissions process.

Residents had an assessment of need in place and personal plans were found to be person-centred. Residents' personal plans were detailed and clearly guiding staff to support residents in line with their needs and wishes. There was evidence of regular review and update of residents' personal plans in line with their changing needs. Residents had access to a keywoker to support them to develop their goals and their personal plans were available in a format accessible to each resident.

There were a number of restrictive practices in the centre and there was evidence that these were assessed and reviewed regularly. Staff had the up-to-date knowledge and skills to support residents to meet their assessed needs. The inspectors spoke to a number of staff who were knowledgeable in relation to each residents' specific support needs. Residents had access to the support of relevant allied health professionals in line with their needs, and their plans were reviewed and updated regularly.

The premises was specifically designed to meet the number and needs of residents.

There was adequate private and communal space for residents and each resident had their own apartment which was decorated in line with their individual needs and preferences. There were several areas for residents to meet visitors in private. Each of the residents' apartments had their own garden area and there was also a number of communal garden areas, one of which was a vegetable garden where residents were supported to grow their own vegetables. Residents had access to areas for other activities such as a trampoline area, a gym area and other multifunctional rooms.

The inspectors reviewed a transition plan for one resident. This plan was detailed and it was clearly evidenced what supports were put in place to support the resident through the transition process. There was evidence that the resident and their representatives were supplied with information relating to the services, facilities and other aspects of care and support prior to their admission.

Residents were protected by appropriate risk management policies, procedures and practices. There was a system for keeping residents safe while responding to emergencies. There was a risk register in place and evidence that it was reviewed and updated regularly. General and individual risk assessments were in place for all identified risks and there was evidence that they were reviewed and updated regularly. There was evidence of incident review and the sharing of learning following incidents.

Residents were assisted and supported to communicate in line with their needs and wishes. They had access to the necessary supports and aids. Residents' preferred methods of communication were detailed in their personal plan. Staff were aware of residents' preferred methods of communication and half of them had completed additional training in relation to two residents' preferred communication methods, and the other half were booked onto this training.

Regulation 10: Communication

Each resident was assisted and supported to communicate in accordance to their wishes and needs. Staff were aware of the different communication needs and supports of residents and ensured that these needs were met.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre was in line with the statement of purpose. The physical environment was clean. The premises met the needs of all residents and the design and layout promoted residents' safety and dignity.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transition plans were developed as required. There was evidence that relevant members of the multidisciplinary team supported residents through the transition process and that residents and their representatives were provided with relevant information prior to and during the transition process.

Judgment: Compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified. Arrangements were in place for identifying, recording, investigating and learning from serious incidents and adverse events involving residents.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment and personal plan in place for each resident. There was evidence of multidisciplinary team review to ensure they were effective and evidence of review of documentation in line with residents' changing needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in place due to the assessed needs of the residents. These practices were applied in accordance with evidence based practices and national policy. Staff had received training to support residents in line with their assessed needs.

Judgment: 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Grange Apartments - Sonas Residential Service OSV-0003745

Inspection ID: MON-0021829

Date of inspection: 05/03/2019

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Ongoing recruitment process in place. PIC and provider have carried out interviews on the 12th March 2019 and three candidates were successful from interviews. These are currently been processed through the HR department. HR recruitment process will continue until all vacant posts are filled.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Dates have been scheduled for refresher training which is required for identified staff members. Formal supervision template devised by PIC and to be implemented during staff supervision for 2019.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Email sent to Quality and Risk Officer to: 1.Obtain completed annual review for 2017. 2.Review due for 2018.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Action plan in place for policies which require update.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/08/2019
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	31/08/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately	Substantially Compliant	Yellow	31/05/2019

	supervised.			
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	31/12/2019
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	31/12/2019