Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Windemere, Balbriggan
Name of provider:	Praxis Care
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	20 January 2020
Centre ID:	OSV-0006374
Fieldwork ID:	MON-0027411

About the designated centre

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

Windemere is a large eight bedded detached home set in its own grounds in a town in Co. Dubllin. The home is in walking distance to many local amenities and public transport links. Windemere can accommodate six adult service users in total, four of these adults share a group living arrangement within the house and two adults avail of self-contained apartments that are attached to the group living home. In the group setting the residents have a shared kitchen, large dining room, sitting room, sun room and further quiet room. Each resident has their own individual bedroom. A further two residents can be accommodated in additional self-contained apartments complete with own kitchen/living space, bathroom, and sitting room. All placements are on a full time permanent basis. Windemere aims to provide appropriate support to individuals over the age of 18 years with a diagnosis of intellectual disability, mental ill health and assessed medical needs. The staffing compliment includes a person in charge, team leaders, and support staff. There is one waking night staff on each night as well as one sleep over staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Monday 20 January 2020	09:30hrs to 18:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

On the day of inspection two residents were residing in the centre, one resident lived in the main house and the second resident lived in one of the self-contained apartments. The inspector had the opportunity to interact and briefly observe both residents at different times throughout the course of the day. During this time residents were enjoying some time outside or completing their favourite activity. Residents used different forms of communication including verbal communication or gestures, signs and choice boards to indicate what they needed. The inspector interacted with each resident in line with their assessed communication needs.

Observations of the residents, indicated they both frequently smiled and seemed comfortable in staff presence. Interactions from staff indicated care was provided in a patient and kind manner, however limited conversation with residents was noted at times.

Transition notes, residents' personal plans and notes with their keyworker were also utilised to obtain an overview of what the residents were experiencing on a day to day basis. These documents noted that residents were settling well into their new home. Residents had been introduced to activities in their local community and were becoming familiar with their local area. One resident had recently commenced and settled into their new day service, and the other resident was in the process of being introduced to suitable day service. Residents had frequent family visits and contact was encouraged and maintained.

Capacity and capability

The inspector found that the registered provider and the person in charge were striving to assure a good quality service was provided to the residents. The residents had both recently transitioned into this service from children's residential settings. Overall positive outcomes for residents were noted since their transition to adult services. The service provided was in accordance with the stated purpose and function. Systems were in place to provide consistent and appropriate oversight of the service.

The provider had ensured that there were clear management arrangements to ensure appropriate leadership and governance. There were three team leaders permanently based in the centre with support from a person in charge. The team leaders worked a variety of shifts, including a sleep over shifts seven days a week. Direct care workers reported to the team leaders who were directly supported by

the person in charge. The person in charge directly reported into the Head of Operations. Staff were aware of their individual responsibilities and the relevant reporting structures.

There were appropriate systems and processes in place that underpinned the safe delivery and oversight of the service. As this was a new service the annual review had not taken place as of yet. Monthly monitoring visits were completed by the Head of Operations. In addition to this, one unannounced visit, in the form of a self assessment judgement framework directly related to regulations, was also completed in September 2019. These visits audited a number of elements of service delivery including person-centred service, admissions, compliments and complaints, and medications to name a few. A Quality Improvement Plan (QIP) was developed following these visits. It was found that in December the QIP identified 22 actions, on the day of inspection only two actions were remaining to be completed. This indicated that identified improvements were being completed in a timely manner. Residents contribution to these visits was noted through observations. The improvements identified in these reviews were beginning to impact positively on the level of care and support afforded to residents.

The staffing compliment was sufficient to meet the care and support needs of the two residents currently residing in the centre. A sample of staff rosters over a four week period were reviewed and found that a consistent staff team were in place which utilised regular relief staff when needed. However, agency staff were being used occasionally, in order to ensure that staffing support was adequate for the transition process of the next new admission into the service. The inspector reviewed the agency staff files and found that information in relation to Schedule 2 was available in the centre. Other control measures employed by the person in charge to ensure continuity of staffing included, individual interviews of agency staff to ensure their suitability to the role, and having the same two agency staff to cover identified shifts. The decision to use agency staff was only made after concerted efforts by the provider and person in charge to recruit permanent staff. To date four recruitment drives had been completed and an open recruitment day. Recruitment continued to be an ongoing process.

The staff training needs and development was organised and managed in a way to ensure that staff had the required skills, experience and competencies to respond to the individual needs of the residents. Staff had received training in areas specific to providing evidence-based, quality and safe care. Staff had completed training in areas such as safeguarding, fire safety, safe administration of medication, behaviour support and de-escalation techniques to name but a few. In addition to this staff had received specific training to meet the individual healthcare needs of residents.

There was a clear and planned approach to admissions and the residents had opportunities to visit the centre prior to admission. Notes on visits to the centre were reviewed and the notes indicated that the needs and wishes of the resident were considered during this process. For example one resident initially visited the centre with the support of their team from the children's residential service to ensure familiar faces were present for the resident when they visited their new

home.

Regulation 15: Staffing

Staffing levels took into account the statement of purpose and size and layout of the building. There was an actual and planned staff rota.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supervised appropriate to their role. Staff received mandatory and ongoing training that was relevant to the needs of the residents.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was up to date with all the required information.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clearly defined and identified the lines of authority and accountability, specified roles and detailed responsibilities for all areas of service provision.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The centre's admission process considers the wishes, needs and safety of the individual and the safety of other residents currently living in the centre.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider and person in charge were endeavouring to ensure that the quality of the service provided for residents was person centred and suitable for the assessed needs of the residents. As residents had recently transitioned to the service, both residents and staff were still becoming familiar with each other. There were systems in place to keep the residents safe. The residents appeared very content and happy on the day of inspection. Improvements were required in healthcare in relation to documentation and also implementation of plans. In addition to this, improvements were required in relation to the identification, review and rationale of the use of some restrictive practices.

The inspector completed a walk around of the premises and found it to be warm, bright, clean and maintained to good structural and decorative repair. One resident resided in the main home, while the other resident was living in one of the self-contained apartments. There was more than adequate communal space available for both residents. There was a large back garden with good space. This area needed some further development in terms of purchasing relevant outside furniture and the person in charge discussed that this would be completed by the summer months.

The communication style and ability of each resident varied, some residents used verbal language to communicate and other residents used gestures, facial expressions, body position and some sign language to indicate items they wanted or needed. Each residents' communication method was documented in their personal plan. Relevant strategies from allied professionals were in place, for example the use of picture choice board for activities and meal times. This board was on display in the kitchen and available for use when needed. Good visual supports were also utilised to help residents understand different aspects of systems in the centre, such as fire safety and the use of environmental restrictive practices. However, communication systems were in the early stage of development for one resident. This had been recognised by the person in charge and they discussed the steps that were currently in place to potentially develop and build on skills for this resident. Continued development of communication plans would ensure the provider was following best practice and achieving positive outcomes for residents.

The residents' personal plans were reviewed by the inspector. 'Everyday living plans' reflected the assessed needs of the individual residents and outlined the supports required to maximise their development in accordance with their individual health needs, personal needs and choices. A monthly review of the effectiveness of this plan was completed by the team leader and/or person in charge. Multidisciplinary reviews of the plan also occurred on a regular basis and plans were updated to reflect any change in needs. The resident had access to a key worker and meetings with the residents' keyworkers occurred on a regular basis. A sample

of keyworking notes were reviewed. Key working meetings covered a range of different aspects pertaining to the resident's care including some social care goals and relevant aspects in relation to the running of the designated centre. These notes were very detailed and also provided a very good overview of how the resident was responding to different activities introduced to them.

Overall, healthcare was delivered to a good standard. Residents had access to a range of relevant professionals such as GP, psychiatry, neurology and chiropody to meet their assessed needs. 'Everyday living plans' were reviewed in each residents file and were found to be sufficiently detailed to guide staff practice in the management of health related care needs. However, a resident's care plan in relation to a specific need did not contain all the required information as stated in the 'Everyday living plan'. This care plan was kept with the resident's medication management plan and staff would refer to this on a frequent basis. This gap in the documentation potentially could lead to incorrect care when managing the resident's specific need. Assurances were provided that this had not occurred as the staff team were familiar with the protocol. In addition to this, during an observation period, a resident's healthcare plan was not followed as stated. This was immediately brought to the attention of the Head of Operations.

A sample of positive behaviour support plans were reviewed. Residents had access to relevant allied professionals, such as psychiatry, and behaviour support specialists in order to help address any specific needs. Positive behaviour support plans were developed in line with a function based approach to managing behaviours that challenge. Detailed proactive strategies were described, in addition to reactive strategies in line with a 'traffic light' based approach to topographically defined behaviours. This enabled clear guidance to staff on how to address specific needs. A number of environmental restrictive practices were in place for both residents. Following the walk around of the premises, discussions with relevant staff and review of documentation it was evident that a small number of restrictive practices were in place that had not been recognised as such. Therefore, best practice in relation to following evidence based practice and relevant policies had not been applied in relation to their use. In addition to this, the review process of the identified restrictive practices needed improvement. Although restrictive practices were reviewed on a regular basis, the evidence for continued use of practices was not always adequately in place. It must be noted that the majority of environmental restrains had a clear rationale in place with associated risk assessments.

Residents were protected by appropriate policies and procedures in relation to safeguarding. Staff spoken with were knowledgeable of their responsibilities under the relevant policies and knew the correct time lines and reporting structures. Staff had received relevant training in this area.

Staff had received suitable training in fire prevention and emergency procedures. The registered provider had ensured that all fire equipment was maintained and serviced at regular intervals. There was adequate means of escape, including emergency lighting. All escape routes were clear from obstruction and were sufficiently wide to enable evacuation, taking account residents' individual needs. The mobility and cognitive understanding of residents had been considered and

appropriate emergency plans had been developed and reviewed regularly. Fire drills were reflective of possible fire scenarios, as drills were taking into account times were minimum numbers of staff were present. Residents were provided with accessible information in relation to fire safety.

There was enough space for each resident to store and maintain clothes and other possessions. In each residents' personal plan there was an up-to-date inventory in relation to personal possession brought to their new home with them. At the time of inspection, neither resident had a bank account in their own name. The provider and person in charge discussed some of the steps they had begun to take in relation to this, including discussions with parents. This had been well documented in relevant meeting notes and would also form the agenda of upcoming review meetings. However, the relevant steps in relation to achieving this goal for residents required development.

The inspector found that residents were protected by appropriate risk management procedures and practices. There was a risk register in place and evidence that general and individual risk assessments were developed and reviewed as necessary. Risk control measures were relative to the risk identified.

The transition process for all residents was well planned. The residents had transitioned from other services and all necessary documentation and information was transferred to their new home. On the day of inspection residents appeared content in their new home.

Regulation 10: Communication

Staff were aware of the different communication needs and supports of residents. Individual communication requirements were documented in the residents' personal plans.

Judgment: Compliant

Regulation 12: Personal possessions

While residents had access and control of their property and possessions, residents did not have their own back accounts.

Judgment: Substantially compliant

Regulation 17: Premises

The premises, was bright, warms and in very good structural repair. There was more than adequate communal space

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Planned supports were in place then the residents moved into this new service.

Judgment: Compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced when required. There was adequate means of escape, including emergency lighting. The understanding of the fire evacuation procedure for residents had been adequately accounted for in the evacuation procedure.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment completed before the resident was admitted to the centre and was kept up-to-date as required. The personal plan was made available to the resident in an accessible format.

Judgment: Compliant

Regulation 6: Health care

Overall the health and wellbeing of each resident was promoted and supported accordingly. However, observations on the day of inspection indicated a specific healthcare plan was not being followed. In addition to this, there was a gap in the documentation process where a health plan described in the resident's personal plan did not correspond with the health plan detailed in the resident's medication management plan.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Some environmental restrictive practices had not been applied in line with the relevant policies and evidence-based practices. Although the restrictive practices that had been identified by the provider were reviewed on a regular basis, there was at time insufficient evidence in relation to supporting their rationale.

Judgment: Not compliant

Regulation 8: Protection

Residents were safeguarded because staff understood their role in adult protection and were able to put appropriate procedures into practice when necessary.

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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Windemere, Balbriggan OSV-0006374

Inspection ID: MON-0027411

Date of inspection: 20/01/2020

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 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: Person In Charge to draft an action plan with specific time frames in relation to steps to be achieved for residents to open bank accounts. Person In Charge to consult further with relevant persons to ensure that immediate action is taken to continue the process. The Person In Charge shall ensure that bank accounts are opened by 29.05.2020.	
Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The registered provider and Person in charge to ensure that all Healthcare plans in the service are followed at all times and that any failure to do so is managed effectively. The Person in Charge will ensure that all Health plans are communicated to staff by 07.02.2020. The Provider will update Epilepsy Management Plan template to ensure that it reflects all strategies considered and implemented for the management of medical diagnosis. The Provider will ensure that Epilepsy Emergency Protocol template is updated and re-named. The Provider will ensure that both templates are updated by 28/02/2020.	

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Person In Charge will ensure that a restrictive practice is only implemented in line with Praxis policy and regulations. Person In Charge will ensure that where environmental restrictions are in place that they are outlined in Positive Behaviour Support Plan and also documented in the Restrictive Practice register. The PIC will ensure that there is clear and documented evidence on file for the rationale for all restrictive practices including evidence of 'least restrictive and in best interests' of residents. Person in Charge will ensure restrictive practices are signed by a multi-disciplinary team. Person in Charge will ensure all restrictions in Centre are completed on register by 07.02.2020.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	29/05/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	28/02/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Not Compliant	Orange	07/02/2020

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			