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:	Damien House Services
Name of provider:	Health Service Executive
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	17 August 2021
Centre ID:	OSV-0002442
Fieldwork ID:	MON-0033757

About the designated centre

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

Damien House is a designated centre operated by the Health Service Executive (HSE). The designated centre provides a residential service for up to twelve adults with a disability. The designated centre comprises of four houses and an apartment located in County Tipperary. One of the houses is based in a rural setting outside a small town. The other three houses and apartment are located on Health Service Executive grounds. The centre is staffed by the person in charge, clinical nurse managers, staff nurses and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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
Tuesday 17 August 2021	09:15hrs to 17:40hrs	Conan O'Hara	Lead
Tuesday 17 August 2021	09:00hrs to 16:15hrs	Conor Brady	Support

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic. As such, the inspectors followed public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspectors ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with the residents, staff team and management over the course of this inspection.

Overall, from what residents communicated with the inspectors and what the inspectors observed, it was evident that the residents were comfortable in their home and received a good standard of care. Over the course of the inspection, the inspectors had the opportunity to meet with the 11 residents, and visit the four houses and apartment that made up this designated centre. In addition, the inspectors had the opportunity to speak with 12 staff members and 3 members of management during the inspection. The staff members demonstrated a good knowledge of the residents' and their needs.

On arrival to the apartment, it was observed that the resident was out walking in the community as per their daily plan. When the resident returned, they welcomed the inspector and showed the inspector around their apartment. Their home consisted of two adjacent apartments where the bedroom was accessed through the connected garden. The apartment was decorated in line with residents preferences with pictures and personal possessions. The resident spoke positively about their life in the designated centre and was observed planning their day with staff which included meeting with family members for lunch in a nearby hotel.

In the three houses located on the health service executive grounds, the residents were observed being supported gardening, accessing the community, going for walks and interacting with staff and engaging in table top activities.

In the afternoon, an inspector visited the fourth house located in a rural setting. The inspector observed residents engaged in activities of daily living including preparing meals and reading the newspaper. In addition, during the visit, one resident was observed returning home from a visit with their family and another resident from a walk. Residents appeared content and relaxed in their home.

Overall there was a good level of care and support found to be delivered across this centre and inspectors found staff on duty who were very knowledgeable and caring for the residents in their care.

As noted the designated centre is located in County Tipperary and comprises of four houses and an apartment. The inspectors carried out inspection of each unit and found that internally they were clean and decorated in line with the residents needs. However, as identified on the previous inspection improvements were required in the upkeep of the premises. For example, in one unit, the inspectors observed

external painting was required and weeds were growing in the areas around the premises and in the gutters and uneven surfaces of the exterior paths. This had been previously identified but remained unaddressed. In addition, bin bags/refuse and old equipment (portable heater) were observed stored in areas around this unit. In another unit, as previously identified, the inspectors observed peeling laminate on a kitchen press and areas of painting and plasterwork requiring attention. While there was evidence of a premises review in May 2021 and plans in place, these issues this remained ongoing at the time of the inspection and negatively impacted on the homeliness and environment of the designated centre.

In summary, based on what the residents, staff and a management communicated with the inspectors and the care and support that was observed, the inspectors found that, while there were some areas for improvement, residents received a good standard of care in this centre. The areas for further improvement included staffing arrangements, staff supervision, governance and management, premises and fire safety.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, the inspectors found that there were management systems in place to ensure the provision of a good standard of care to the residents. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, improvement was required in the effective monitoring of the centre, staffing arrangements and staff supervision.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. On the day of the unannounced inspection, the person in charge was not on duty, so the inspection was facilitated by an experienced Clinical Nurse Manager and members of the staff team. There was evidence of quality assurance audits taking place including the annual review for 2020 to ensure the service provided was monitored. Inspectors were assured that the centre was safe and well governed and the residents in the centre were being appropriately supported.

However, some improvements were required in the effective monitoring of the centre. For example, an audit carried out in March 2021 identified a fire door in one unit as requiring a self-closing device which had not been fitted. Furthermore premises issues previously identified in audits and inspections had not been actioned by the provider. In addition, a report of the most recent provider unannounced six-monthly visit was not available on the day of the inspection for review.

On the day of the inspection, the inspectors observed that there was an appropriate

number of staff to support the residents' assessed needs. The inspectors spoke with a number of staff members who demonstrated a good knowledge of the residents and their needs. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

However, a review of a sample of staffing rosters demonstrated that the staffing arrangements required review to ensure they were appropriate to the needs of the residents and size and layout of the designated centre at all times. At the time of the inspection, the centre was operating with nine whole time equivalent vacancies. From a review of rosters, on occasion staffing levels in one unit fell below the assessed staffing complement. This meant that the unit did not have the required staffing complement or required a staff member from another unit to come and support the residents in particular regarding medication management. This had an impact on the care and support that could be provided to the remaining residents. The inspectors were informed that the provider had recently held interviews and was in an ongoing process of recruiting to fill these vacancies.In addition, the use of consistent relief staff meant that the impact on residents was being closely monitored by management to ensure the delivery of safe and quality care to residents.

There were systems in place for staff training and development. The inspectors reviewed staff training schedules and a training matrix and found that appropriate training was being provided and scheduled. However a sample of staff supervision records were reviewed and found that the staff team did not receive regular formal supervision in line with the provider's own policy with an inconsistent approach to staff supervision found in this centre which required further review. A number of staff did however compliment the support they received from management and highlighted there was always managerial support/supervision available to them when they required it.

Regulation 15: Staffing

On the day of the inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. There was a core staff team in place which ensured continuity of care and support to residents. The person in charge maintained a planned and actual roster. The inspectors reviewed the roster and this was seen to be reflective of the staff on duty on the day of inspection.

However, the staffing arrangements required further review to ensure they were appropriate to the needs of residents and the size and layout of the centre. The designated centre was operating with nine whole time equivalent vacancies in place. A review of the roster demonstrated that at times the staffing levels in unit may fall below the assessed staffing complement. This had an impact on the care and support that could be provided to the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A clear staff supervision systems was in place and the staff team in this centre took part in formal supervision. The inspectors reviewed a sample of the supervision records which demonstrated that the staff team did not receive regular supervision in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to residents' needs. However, improvement was required in the effective monitoring of the service. For example, the report for the last six monthly provider visit was not available on the day of the inspection for review. In addition, an audit identified the need for a self-closure on a fire door in March 2021. This issue was ongoing on the day of the inspection. Further audits had been completed regarding outstanding premises issues that remained incomplete.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of adverse incidents occurring in the centre and found that the Chief Inspector was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the management systems in place ensured the service provided appropriate care and support to the residents. However, improvement was required in premises,

personal plans, positive behaviour support and fire safety arrangements.

The inspectors reviewed a sample of resident's personal files. Each resident had an up to date comprehensive assessment of their social, personal and health needs. The assessment informed the residents' personal plans which were found to be up-to-date and suitably guided the staff team in supporting the residents with their assessed needs. There were positive behaviour supports in place to support residents to manage their behaviour. The inspectors reviewed a sample of positive behaviour support plans and found that they were up-to-date and appropriately guided the staff team. Staff were very knowledgeable regarding residents and their personal plans.

In November 2019, the provider reviewed the compatibility and suitability of the living arrangements for each resident and identified two placements in two residences as not suitable. The provider outlined in their compliance plan to the previous inspection that the proposed transfer was postponed due to COVID-19 and will be completed by March 2022. This remained in process at the time of the inspection. Inspectors found that this remained a high priority based on the observations made on this inspection.

There were effective systems in place for safeguarding residents. The inspector reviewed a sample of adverse incidents occurring in the centre which demonstrated that incidents were reviewed and appropriately responded to. There were safeguarding plans in place to manage identified safeguarding concerns. The residents were observed to appear comfortable and content in their home.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including fire alarm, emergency lighting and extinguishers. For the most part, the equipment was serviced as required. The inspectors found that one fire extinguisher was in need of annual service. However, this had been self-identified by the provider and plans were in place to address same. There was evidence of regular fire evacuation drills taking place in the units. However, the arrangements in place for the safe evacuation of residents in one unit at night required review as it was not evident a drill (with lowest complement of staffing) had been completed in the last year. All residents had a personal emergency evacuation plan (PEEP) in place which guided staff in supporting residents to safely evacuate. The previous inspection identified improvement required in the arrangements for the containment of fire. While, this had been addressed, on the day of the inspection, one fire door located near a high risk area did not have a self-closing device. This had been identified by the provider and remained ongoing at the time of the inspection.

Regulation 17: Premises

The designated centre is located in County Tipperary and comprises of four houses and an apartment. All residents had their own bedrooms which were decorated to reflect the individual tastes of the residents with personal items on display. Overall,

the internal areas of the designated centre were clean and decorated in line with residents needs.

However, as identified on the previous inspection, improvements were required in the upkeep of the premises including:

- areas of peeling external paint,
- weeds growing in the areas around the premises and in the gutters
- upkeep of exterior paths.
- waste stored in areas around a unit
- peeling laminate on a kitchen press
- areas of painting and plasterwork requiring attention.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. General risks were managed and reviewed through a centre-specific risk register. The risk register was up-to-date and outlined the controls in place to mitigate the risks. The residents had number of individual risk assessments on file so as to promote their overall safety and well-being, where required. The individual risk assessments were also up to date and reflective of the controls in place to mitigate the risks.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance and protocols in place in the centre. The interior of the premises were observed to be clean and the inspectors observed cleaning schedules in place. There was sufficient access to hand sanitising gels and hand-washing facilities observed through-out the centre. All staff had adequate access to a range of personal protective equipment (PPE) as required. The centre had access to support from Public Health.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place and the residents had a personal emergency evacuation plan (PEEP) in place. However, the arrangements in place for the safe evacuation of a resident at night in one unit required review as it was not evident a night time fire drill had been completed in the last year. In addition, improvement was required in the fire containment measures in place in one unit. For example, on the day of the inspection, one fire door located near a high risk area did not have a self-closing device.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for each resident. These were reviewed each month and an annual 'Visioning' meeting was held with the resident. Residents had clearly identified roles which informed their goals. There were activity planners on file which were directly linked with their goals. All residents had an electronic tablet which had photographs of them doing different activities to progress and achieve their goals. While this had been a challenge during the COVID-19 pandemic, staff had made adaptations in-house in order to best support the residents

As identified on the previous inspection, the suitability of the centre to provide care for two of the residents and to address issues of compatibility remains outstanding. While, there is clear plans developed to transition these residents to a suitable placement, the transitions have yet to take place.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place which appropriately guided staff in supporting the residents. The residents were facilitated to access appropriate health and social care professionals including psychology and psychiatry as needed.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe. There was evidence that incidents were appropriately managed and responded to. Formal safeguarding plans were in place for identified safeguarding concerns. Staff were found to be knowledgeable in relation to keeping the resident safe and reporting allegations of abuse. The residents were observed to appear relaxed and content in their home.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Damien House Services OSV-0002442

Inspection ID: MON-0033757

Date of inspection: 17/08/2021

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: The designated centre was operating with nine whole time equivalent vacancies in place. The provider has identified and accepted the staffing vacancies for filling. A recent regional recruitment campaign in July 2021 did not identify any suitable candidates, 1 HCA position has been filled from the current panel and will commence late September 2021. The provider is putting in arrangements with recruitment department for a bespoke local recruitment campaign which is hoped will prove more successful in attracting suitable candidates, this will be completed by 30/11/21 There is a dedicated nurse manager leading on HR and recruitment matters and is actively driving on these matters. In the interim an identified core of agency relief staff are available and utilized by the service to maintain appropriate staffing levels. The provider has also agreed to the use of an additional agency provider in June 2021 with the availability of additional staff alleviating staffing issues in the main. Proactive recruitment with graduating student nurses and HCA's was discussed at senior nurse managers meeting for implementation in this college semester.	
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 inspectors reviewed a sample of the supervision records which demonstrated that the staff team did not receive regular supervision in line with the provider's policy.

The provider implemented a new/reviewed formal staff supervision policy in July 2021.

senior nurse managers meeting 8th September ; staff supervision was reviewed , all staff members to have 1 completed supervision meeting by 31st October 2021 with 2nd meeting planned within the next 6 months as per policy.

A provider audit on supervision policy will occur by 1st November 2021.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
the report for the last six monthly provider visit was not available on the day of the inspection for review

A draft 6 monthly provider visit and report was conducted on 9/9/21 we are currently awaiting return of family satisfaction surveys to finalise the report. To be completed by 24/9/21.

The responsibility for completion of 6 monthly and annual reports has been delegated to assistant director of nursing to prevent further omissions/delays in this process.

an audit identified the need for a self-closure on a fire door in March 2021. This issue was ongoing on the day of the inspection. Further audits had been completed regarding outstanding premises issues that remained incomplete.

Non closing fire door which had been reported initially in January 2021 to maintenance department was addressed promptly at that time and door was removed and shaved as it was catching on the door frame – these doors and frames were newly fitted in July 2021 when apartment was renovated and there appears to be warping occurring with the frame which resulted in ongoing issue.
This door was reviewed on 11/9/21 by maintenance manager, PIC and director of nursing with a commitment to have issue rectified by 11/10/21

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: improvements were required in the upkeep of the premises including: • areas of peeling external paint, • weeds growing in the areas around the premises and in the gutters • upkeep of exterior paths. • waste stored in areas around a unit • peeling laminate on a kitchen press • areas of painting and plasterwork requiring attention. A full review of issues identified will be undertaken by the unit manager in each house and plan of works will be devised with the maintenance manager by 31/9/21. Gardening service is provided by an external contractor who will address issues re weeds etc by 31/9/21. Funding has been secured and sanctioned for the replacement and repair of exterior ground works driveway/exterior paths, the tendering process is currently underway. It is proposed these works will be completed by 31/3/22. Additional funding for painting and décor improvements will be sought and identified issues addressed by 31/12/21.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: the arrangements in place for the safe evacuation of a resident at night in one unit required review as it was not evident a night time fire drill had been completed in the last year. A night-time fire drill will occur in all houses by 31/9/21 with ongoing bi annual drills scheduled as part of the fire drill schedule to be the responsibility of the Person in charge and audited monthly.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:	

As identified on the previous inspection, the suitability of the centre to provide care for two of the residents and to address issues of compatibility remains outstanding. While, there is clear plans developed to transition these residents to a suitable placement, the transitions have yet to take place.

The provider has identified this matter as a priority action for the service and is continuously monitored. The identified premises that is required to progress these transitions remains unavailable at present due to being designated as isolation facilities for disability services during Covid pandemic. It is proposed that this transition will be completed by 31/3/22-

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	30/11/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/10/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2021
Regulation	The registered	Substantially	Yellow	11/10/2021

23(1)(c)	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.	Compliant		
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	24/09/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	11/10/2021
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Substantially Compliant	Yellow	30/09/2021

	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.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2022