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:	Pinegrove
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Unannounced
Date of inspection:	28 July 2022
Centre ID:	OSV-0002605
Fieldwork ID:	MON-0036766

About the designated centre

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

Pinegrove is a centre run by the Health Service Executive and is located on a campus setting a few kilometres from a town in Co. Sligo. The centre provides residential care for up to 8 male and female residents, who are over the age of 18 years and have a moderate to profound intellectual disability. Each resident has their own bedroom. There are shared bathrooms and communal areas and access to a garden area. Staff are on duty both day and night to support the residents who live there.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 (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
Thursday 28 July 2022	10:00hrs to 17:15hrs	Alanna Ní Mhíocháin	Lead

What residents told us and what inspectors observed

There was a good quality service in this centre that addressed the needs of the residents and supported them to engage in activities that they enjoy. Residents received good quality care from staff and appeared very comfortable in their home.

The centre was part of a congregated setting on a large campus located a few kilometres outside of a town. The designated centre was located over two floors in a large building that also housed another designated centre and offices. The residents' bedrooms and two shared bathrooms were located on the upper floor. Two sitting rooms, a small relaxation room, two dining rooms, two shared bathrooms, a store room with sluice and the nurses' office were located on the ground floor. There was no kitchen in this centre. Residents' meals were prepared in a central kitchen and delivered to the dining rooms during the day. However, there was a small kitchenette off one of the sitting rooms. The centre also did not have its own laundry facilities as there was a central laundry on the campus where residents' clothes and bedlinen were washed. Outside, residents had access to the large grounds of the campus that were well maintained. The centre also had access to its own transport for use by the residents.

The previous inspection in this centre had occurred in January 2022 and had focussed on infection prevention and control. A number of actions had been identified from that inspection in relation to cleaning in the centre and the need to replace damaged furniture. On this inspection, it was noted that all of these issues had been fully addressed. The centre was clean, tidy, warm and comfortable. Each resident had their own bedroom. Bedrooms were decorated in different styles in line with the residents' tastes and preferences. Some bedrooms were also personalised with the residents' photographs. When required, residents had profiling beds. The shared rooms in the centre were nicely decorated and the furniture was clean and in a good state of repair. The person in charge reported that some of the armchairs and sofas had recently been purchased to replace damaged items of furniture. The bathrooms were also clean and equipped with hand soap and paper hand towels. Residents' personal equipment, for example, shower chairs and wheelchairs, were clean and free from any damage. Hand sanitiser and pedal bins were located at various points throughout the centre.

The inspector had the opportunity to meet with all eight of the residents living in the centre. Residents engaged with the inspector on their own terms and staff were available to offer support to residents with their communication. Some residents left the centre at various points during the day to attend day services or social outings. Residents also spent time in the sitting rooms or dining rooms in the centre. Residents appeared relaxed and at ease in the centre. Staff were available at all times to offer assistance to residents when required. They interacted with residents in a friendly and caring manner. Staff were knowledgeable on the needs of residents and were respectful when they spoke about residents.

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

Capacity and capability

There was good oversight and governance arrangements in the centre. There were clear management structures and lines of accountability. Staffing arrangements and training were suited to the needs of residents. However, some improvement was required to ensure that audits were completed in line with the provider's schedule.

There were clear lines of management and accountability in the centre. Staff were knowledgeable on who to contact if there were any issues and there were clear escalation procedures. The records of incidents that had occurred in the centre were reviewed by the inspector. Incidents were recorded, escalated and reviewed. Learning and control measures to prevent the reoccurrence of incidents were outlined and implemented.

The provider maintained oversight of the service through the implementation of a number of audits. The audits covered a broad range of areas of service delivery. There was a schedule that outlined when certain audits should be undertaken throughout the year. It was noted that audits had not always been completed in line with this schedule. For example, the provider had completed an audit on safeguarding in January 2022 and it was due to be repeated in March 2022. However, this had not occurred. The person in charge reported that a new schedule of audits and new audit tools were due to be implemented in the centre commencing 01 August 2022.

Issues that were identified on audit were included in the centre's quality improvement plan. This plan listed the actions that were required to address issues identified on audit. A named individual who was responsible for their completion was identified. There were also specific timelines set out for their completion. The quality improvement plan was reviewed and updated monthly. The quality improvement plan also included actions that had been identified through previous inspections by the Health Information and Quality Authority (HIQA), self-assessments by the person in charge, risk assessments, and the provider's six-monthly unannounced audits and annual reviews into the quality and safety of care of support in the centre. There was evidence that service improvement issues were progressed and completed in line with the timelines set out by the provider.

The staffing arrangements in the centre were reviewed. The number and skill-mix of staff were adequate to meet the assessed needs of residents. Nursing support was available at all times in the centre. There was a consistent team of staff. Annual leave could be covered from within the existing team. The person in charge maintained an accurate planned and actual staff roster. Senior management support

was available out of hours. Staff in the centre received supervision from the person in charge in line with the provider's time frames. The inspector viewed the schedule and the standard agenda for supervision meetings. The meetings covered issues relating to the care of the residents, for example, person centred planning. They also covered issues relating to the staff member's own professional development, for example, training. The person in charge reported that they received supervision from their own line manager. Staff meetings occurred every one to two weeks in the centre. The inspector reviewed minutes from recent staff meetings. The agenda covered a range of issues relating to the care of residents and operational issues in the centre. Meetings were attended by the staff who were on duty and minutes were available in a folder. However, there was no formal procedure to ensure that staff read the minutes following meetings.

Staff training was also largely up to date in the centre. The provider had identified a number of mandatory modules for all staff and specific training for this centre. Staff were fully up to date on all training modules in relation to infection prevention and control. Where staff required refresher training, this had been identified by the person in charge and staff were booked on training courses. For example, two staff were due to attend a training course in supporting residents manage challenging behaviour one week after the inspection. The person in charge had also accessed manual handling training for all staff in August 2022.

Overall, there was good leadership and management in this centre. The provider maintained oversight of the service and addressed service improvement issues that were identified. The staffing arrangements met the needs of residents and staff had received appropriate training. Some improvement was needed to ensure that staff were informed of issues discussed at staff meetings and that audits were completed in line with the provider's schedule.

Regulation 15: Staffing

The staffing arrangements in the centre were suited to the needs of residents. Nursing support was available at all times. There was a planned and actual staff roster in place. The team of staff in the centre was consistent and leave could be covered from within the existing team without the need for agency staff. This ensured continuity of care to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were mostly up to date with training in the mandatory modules that had been identified by the provider. Where refresher training was required, this had been

identified by the person in charge and staff had been booked on relevant courses.

Judgment: Compliant

Regulation 23: Governance and management

There were clear management structures and lines of accountability in this centre. Senior management cover was available at all times. The provider maintained oversight of the service through a suite of audits. Service improvement issues identified on audit were added to the centre's quality improvement plan. This ensured that issues were addressed within a specified time frame. However, some improvement was required in order to ensure that audits were always completed in line with the provider's schedule and that information from team meetings was shared with all staff.

Judgment: Substantially compliant

Quality and safety

Residents in this centre received a good quality service. Their health, personal and social needs were identified and staff provided appropriate support to meet those needs. Residents were kept safe from the risk of infection and fire. Risk assessments were in place to guide staff on how to reduce risks to the residents.

The centre itself was suited to meet the assessed needs of residents. The provider had made good attempts at making the building as homely as possible. As mentioned, residents' bedrooms were decorated in different styles and there was adequate storage for residents' personal items. Artwork and comfortable furnishings were located throughout the centre. There was enough space for residents to spend time together or alone, if they wished. It was noted that a closed circuit television (CCTV) system had recently been installed on the campus for security purposes. The CCTV covered the grounds and areas external to the building and therefore, did not impact on the privacy of residents. Residents had been informed of these cameras at resident meetings and provided with easy-to-read information about the new system. The use of CCTV was audited annually by the provider. The person in charge reported that the decongregation plan for the service was in process and that two houses in the community had been identified for the residents. Refurbishment of these houses had not yet occurred.

As discussed previously, the centre was last inspected by HIQA in January 2022 with a focus on infection prevention and control and a number of issues had been identified on that inspection. On this inspection, it was noted that all of the issues

had been addressed. The centre was clean and in a good state of repair. Damaged items of furniture, drug trolleys and residents' personal equipment had been replaced. Sharps bins were labelled and stored appropriately. Hand hygiene facilities were located at suitable points throughout the centre. The hand sanitisation station at the entrance to the centre was equipped with hand sanitiser, face masks and an appropriate bin. There was a sheet for staff to sign-in and ensure that they were hand hygiene ready and free from symptoms of COVID-19. All staff on the day of inspection had completed this sign-in sheet. The sluice room was clear of clutter and was clean. New cleaning checklists had been developed and provided assurance that rooms were suitably cleaned.

The inspector reviewed a sample of the residents' personal files. Residents had an assessment of their health, social and personal needs completed within the previous 12 months. Care plans and risk assessments were developed based on this assessment. Care plans gave clear guidance to staff on how to support residents with their identified needs. The care plans were regularly reviewed and updated. In addition to the assessment of need, residents' personal plans were also reviewed annually in line with the regulations. There was evidence that members of the multidisciplinary team and family members were invited to attend the residents' annual review meetings. The residents' previous personal plan was reviewed and new goals were set for the coming 12 months. The care plans indicated that the residents' health needs were well managed. Residents had an annual medical check-up and they had access to various healthcare professionals, as required. There was evidence of follow-up on medical and health appointments.

In addition to the residents' health needs, the personal plans also indicated that residents' personal and social needs were addressed. Residents were supported to maintain contact with family and friends. A review of daily notes indicated that residents were supported to engage in activities that were in line with their interests. In addition to attending their day services, they also availed of activities in the wider community. This included horse riding, swimming, seaweed baths, meals in restaurants, social outings and visiting religious sites. Residents were able to access their personal funds for these activities when required. The inspector met with a financial officer who outlined the process in place for residents to be able to access their personal funds in a timely manner. The financial officer outlined how residents' monies could be accessed without delay when they were requested. A member of senior management also outlined ways in which residents could access funds for personal spending outside of office hours, if required. The financial officer explained how residents' financial statements could be requested and accessed by the resident. The residents' personal money was included in the centre's audit schedule and reviewed by the inspector. It was noted that residents could access their own funds and that receipts were available to account for all spending.

Residents' personal plans contained behaviour support plans when required. These plans had been devised with input from appropriate healthcare professionals, for example, behaviour support therapists. The plans were regularly reviewed and staff were knowledgeable of their content. They were knowledgeable of the strategies that should be used to support residents manage their behaviour. The person in charge reported that the provider had recently completed a quality improvement

project in relation to restrictive practice. They reported that learning from this project had been shared between centres and that the policy on restrictive practice was updated as a result.

The arrangements for risk management in the centre were reviewed. The person in charge maintained a risk register that outlined the risks to the service as a whole. Risks and control measures to reduce the risk had been identified. Risk assessments were regularly reviewed and kept up to date. In addition, residents had individual risk assessments. Again, risks were identified and appropriate control measures put in place to reduce the risk to the resident. In some cases, where specific actions was required to reduce risks, this had been added to the centre's quality improvement plan and given a target date for completion.

The inspector reviewed the fire arrangements in the centre. Fire alarms and emergency lighting were checked and serviced by an external fire company every three months. A weekly check was completed by staff of fire detection, containment and firefighting equipment in the centre. Staff maintained records of these checks. Fire drills were completed routinely under different conditions. Records of these drills indicated that they were completed in a timely fashion. Staff had received training in fire safety and specific evacuation procedures for the centre. There was an evacuation plan for the centre and each resident had an individual evacuation plan that informed staff of any supports that residents required to leave the building in case of emergency.

Overall, residents received good, safe, person-centred care. Their care needs were identified and they were given appropriate supports to meet those needs. They were supported to engage in activities that they enjoyed.

Regulation 12: Personal possessions

Residents had access to their personal possessions. They had adequate space to store their clothes and personal items. Residents were supported to manage their financial affairs. They had timely access to their personal funds when required.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to engage in activities of their choosing that were in line with their interests. They were supported to engage in activities in the wider community. They were supported to maintain their personal relationships with their family and friends.

Judgment: Compliant

Regulation 17: Premises

The premises were suited to the needs of residents. There was adequate space for residents to spend time together or alone. The centre was in good decorative and structural repair. The centre was fully accessible to all residents. The centre was clean and tidy.

Judgment: Compliant

Regulation 26: Risk management procedures

There were good systems in the centre for the identification, assessment and management of risks. The person in charge maintained an up-to-date risk register for the centre. Individual residents also had risk assessments that guided staff on how to reduce risks to residents.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had taken steps to protect residents from the risk of infection. The provider had introduced new cleaning checklists and replaced damaged furniture. The centre was clean and tidy. Sharps bins were labelled and stored appropriately. There were adequate hand hygiene facilities in the centre. Infection prevention and control measures were included in the provider's audit schedule.

Judgment: Compliant

Regulation 28: Fire precautions

There were effective fire safety management systems in the centre. Fire detection, containment and firefighting equipment was regularly checked. An external fire company completed checks of the fire alarm system and emergency lighting every three months. Fire drills were completed routinely under differing conditions. There was an evacuation plan for the centre and individual residents had evacuation plans.

Staff had received fire safety training.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident's health and social care needs were assessed within the previous 12 months. A corresponding care plan was devised to address any of the needs identified. Residents had personal plans that identified their personal and social goals. The plans were reviewed annually.

Judgment: Compliant

Regulation 6: Health care

The provider had made arrangements to meet the health needs of residents. Residents had access to appropriate healthcare professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had behaviour support plans that clearly outlined the supports required to assist them manage their behaviour in response to challenging situations. Staff were knowledgeable on the contents of these plans and how to support residents. The plans were devised with input from appropriate healthcare professionals.

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 (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 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Pinegrove OSV-0002605

Inspection ID: MON-0036766

Date of inspection: 29/07/2022

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to comply with Regulation 23 the following actions will be completed;

• An annual schedule of audits for CHO1 has been reviewed and circulated. The Person in Charge has implemented the schedule within the centre and staff have been updated in relation to same. Audits will be undertaken in line with the revised schedule. Complete 01/08/2022 and ongoing.

• As audits are completed all actions identified will be transferred to the centers Quality Improvement Plan.

• To ensure compliance with this audit schedule the Person in Charge will monitor the schedule on a monthly basis.

• Team meetings occur weekly. To ensure all staff are aware of the minutes of meeting a signing sheet has been implemented for staff to sign.

• The PIC will monitor the signing sheets on a weekly basis.

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 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	10/08/2022