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:	Florence House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	01 October 2020
Centre ID:	OSV-0002632
Fieldwork ID:	MON-0023546

About the designated centre

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

This centre provides a residential service for up to ten male and female residents. The profile of the residents that this centre caters for is set out as those with a severe to a profound level of intellectual disability. At the time of this inspection, there were eight residents living at the centre and the centre had a capacity of ten residents. The centre is located in a housing estate on the outskirts of a large town. This centre is open 24 hours a day and seven days a week. It is staffed with a person in charge, nurses and multi-task workers. The building consists of two floors, with the ground floor being open to residents and the upstairs floor used for office purposes. An outside area was available to residents and this had some recreational equipment used mostly in the summer months. Residents have access to facilities in the town and a nearby day service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Thursday 1 October 2020	10:00hrs to 17:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

This was a short term announced inspection and the inspector had the opportunity to meet with seven residents living in the designated centre on the day of inspection. All residents met with, used non verbal methods of communication.

The inspector observed residents during meal times, engaging in prescribed exercises and observed some residents watching television. The person in charge communicated that some residents had gone out for a walk on the morning of the inspection. Some warm interactions between staff and residents were observed and staff spoken with appeared familiar with the residents individual preferences and needs.

All residents presented with high levels of disabilities and high health care needs. At times, it appeared that the mix of residents in the centre contributed to a lack of personalised daily activities. Staff were observed supporting residents with meal times and personal care for the majority of the day. A new daily planner had been devised as day services had been temporarily suspended due to COVID19. However some activities identified on this planner were not happening on the day of inspection like going to the shop and gardening. It was not clear what residents were doing with their time instead of these activities. The person in charge communicated residents did not go to the shop due to risks associated with COVID19.

Capacity and capability

This was a short term announced inspection. The centre had also recently submitted an application to renew registration. This application outlined the centres plans to reduce overall capacity in the centre from ten residents to eight. The centres most previous inspection prior to this one identified a number of areas of concern. Some areas identified had been addressed and some areas continued to require improvements including, food and nutrition, assessment of need, residents rights, staffing and training.

The staff team consisted of nurses and care assistants. There was a clear staff rota in place which identified all staff on duty. Staffing levels had increased since the centres previous inspection with two nurses and five care assistants on duty on the day of inspection. The person in charge was completing regular one to one supervisions and performance management with staff. The inspector reviewed a number of staff files on the day of inspection. In general, the staff files contained all items set out in Schedule 2. However, the inspector noted that two staff members had not been Garda vetted since 2014 and there there was no clear policy

or procedure in place for the re-vetting of staff. Management communicated that this had been previously self identified and a new policy was being drafted and implemented in relation to the re-Garda-vetting of staff.

There was a training program in place for staff that was regularly reviewed. Training was provided in areas including fire safety, infection control, behaviour management, safeguarding, manual handling, food hygiene, childrens first and health and safety. On the day of inspection, one staff member was due refresher behaviour management training and three staff were due refresher manual handling training.

There was a clear management structure in place and clear lines of accountability. There was an on call management system in place for staff to contact outside of regular working hours. Regular reviews and audits of the care provided was being completed. Six monthly audits of the service were being completed. The format of these had slightly changed due to COVID-19, persons in charge were completing them in the centre rather than an external person in charge. An annual review was also completed in July by the Director of Nursing. Management were holding weekly online meetings in light of COVID-19. Persons in Charge in the service also had regular meetings to facilitate shared learning. However, issues highlighted on the centres previous inspection had not been appropriately addressed.

There was a clear complaints procedure in place that was prominently displayed in the designated centre. Any complaints appeared to be addressed in a serious and timely manner. All residents met with on the inspection day used non verbal methods to communicate. The inspector did not ascertain that any residents had an issue or complaint with the service provision.

Regulation 15: Staffing

The staff team consisted of nurses and care assistants. There was a clear staff rota in place which identified all staff on duty. The person in charge was completing regular one to one supervisions and performance reviews.

Two staff members had not been Garda vetted since 2014. There was no clear policy or procedure in place for the re-vetting of staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a training program in place for staff that was regularly reviewed. On the day of inspection, one staff member was due refresher behaviour management

training and three staff were due refresher manual handling training.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had ensured insurance was up-to-date in the designated centre. This was submitted to the Chief Inspector as part of the prescribed information for renewal of registration.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and clear lines of accountability. Regular reviews and audits of the care provided was being completed. However, issues highlighted on the centres previous inspection had not been appropriately addressed. Some areas of concern were identified on inspection which continued to impact on the provision of a safe and effective service.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place that was prominently displayed in the designated centre. Any complaints appeared to be addressed in a serious and timely manner.

Judgment: Compliant

Quality and safety

While some improvements had been noted since the centres previous inspection, some areas of non compliance continued to be identified which impacted the quality of care being provided.

Effective fire safety management systems were in place in the designated centre.

Following a walk around the centre, the inspector observed appropriate emergency lighting, fire fighting equipment, detection systems, containment measures and emergency exit procedures around the designated centre. One issue was noted with the centre fire door on the morning of the inspection, and this was addressed in the afternoon on the inspection day by maintenance staff. All residents had individualised personal emergency evacuation plans in place for in the event of a fire. Fire drills were being completed on a monthly basis in a timely manner and these simulated both day and night time conditions. Weekly checks were being completed by staff on escape routes, alarm systems, potential hazards and fire fighting equipment.

Appropriate systems were in place for infection prevention and control. The centre was visibly clean on the day of inspection. The centre had a contingency plan in place for COVID-19 that was subject to review. The inspector observed staff donning face masks in line with national guidance and adhering to cleaning schedules throughout the day. Regular precautionary symptom checks were being completed with staff and residents twice daily. All staff had completed training in infection control and Up-to-date guidance regarding the best practice and the management of COVID-19 was available to staff.

The inspector observed some residents at meal times throughout the inspection day. Some improvements were noted since the centres previous inspection with residents having more free access to the centres kitchen. However, this was still restricted at times if appropriate staff support was not available due to identified risks. The centre also continued to use a communal kitchen for some meals which was located in a separate premises. This meant residents were not always facilitated to buy, prepare and cook all of their own meals in the designated centre. Furthermore, evidence that non verbal communication methods to offer choice for snacks to residents in between meal times was not observed.

A system was in place for the assessment, management and ongoing review of risk in the centre. Residents had individualised risk assessments in place for various individual risks associated with their needs. for example risk of pressure sores, risk of de-hydration, risks associated with coeliac disease, and risk of malnutrition. Emergency plans were also in place for in the event of adverse incidents like loss of heating, loss of electricity and and loss of water.

Residents were supported to manage their health and had appropriate access to a range of multi-disciplinary services with staff making appropriate referrals on behalf of residents when required. Residents presented with high healthcare needs and had appropriate access to nurse support when required. Residents had clear individualised care plans in place these were reviewed at a minimum annually. Residents also had personalised social goals in place that were subject to three monthly reviews. Some of the residents goals had been impacted by the COVID-19 pandemic. However, following a review of residents personal plans and discussion with the person in charge, it was found that the service did not have a clear assessment of need in place that assessed and highlighted the levels of care and support required. This meant that personal plans and levels of staff support were being implemented at times without any clear rationale for them. This had been an

area of concern highlighted during the centres most previous inspection.

Residents had full access to, and regular input from, a behavioural support specialist. Comprehensive behavioural support plans were observed with clear traffic light systems in place for target behaviours that residents may present with. Plans also included clear crisis prevention techniques. Restrictive practices were reviewed and approved by a restrictive practice committee. Documentation in place did not sufficiently evidence the reasons for one restrictive practice observed on the day of inspection. This had not been notified to the Chief inspector of social services as required.

Residents living in the centre had high care needs, it appeared that the mix of residents in the centre contributed to a lack of personalised daily activities and person centred care at times. Staff were observed spending the majority of the day supporting residents with personal care and meal times. Daily activity schedules were in place, however these detailed some activities that residents were not doing on the day of inspection like going to the shops and gardening. There were high levels of restrictive practices in place in the designated centre. These were in place secondary to identified risks posed to some of the residents. However, there were no risks posed to other residents and these individuals were living in this restrictive environment secondary to living with their peers. This posed queries regarding the compatibility of these residents living together on a long term basis.

Residents in the centre were being safeguarded. Staff had received up to date training in the safeguarding and protection of vulnerable adults. All residents had intimate care plans in place. There was a designated safeguarding officer in place and any safeguarding concerns were treated seriously and in line with national policy. Residents had full access to and regular input from a behavioural support specialist. Restrictive practices were reviewed and approved by a restrictive practice committee. However, documentation in place did not sufficiently evidence the reasons for one restrictive practice observed on the day of inspection. This had not been notified to the Chief inspector of social services as required.

Regulation 18: Food and nutrition

Some improvements were noted since the centres previous inspection with residents having more free access to the centres kitchen. However, the centre continued to use a communal kitchen for some meals meaning residents were not always facilitated to buy, prepare and cook their own meals in the designated centre.

Evidence that non verbal communication methods to offer choice for snacks to residents was not observed. Staff when spoken with, communicated that residents usually get a yoghurt for a snack.

Judgment: Not compliant

Regulation 26: Risk management procedures

A system was in place for the assessment, management and ongoing review of risk in the centre. Emergency plans were in place for in the event of adverse incidents.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate systems were in place for infection prevention and control. The centre was visibly clean on the day of inspection. Control measures were in place for the management of COVID19.

Judgment: Compliant

Regulation 28: Fire precautions

Effective fire safety management systems were in place in the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The service did not have a clear assessment of need in place that assessed and highlighted the levels of care and support required.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported to manage their health. Clear plans of care were in place for residents specific health care concerns. Residents had appropriate access to nurse support when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had full access to and regular input from a behavioural support specialist. Restrictive practices were reviewed and approved by a restrictive practice committee. Documentation in place did not sufficiently evidence the reasons for one restrictive practice observed on the day of inspection. This had not been notified to the Chief inspector of social services as required.

Judgment: Substantially compliant

Regulation 8: Protection

All residents in the centre were safeguarded. Staff had received up to date training in the safeguarding and protection of vulnerable adults. All residents had intimate care plans in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents living in the centre had high care needs and at times, it appeared that the mix of residents in the centre contributed to a lack of personalised daily activities and person centred care. Residents choice and control in their daily lives were limited at times due to daily schedules.

Judgment: Not 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 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Not 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	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Florence House OSV-0002632

Inspection ID: MON-0023546

Date of inspection: 01/10/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A new policy has been developed regarding garda vetting and the process of re vetting staff members has commenced. One staff member who's garda re vetting had been highlighted as overdue has now been re vetted and the second staff members is currently in the process of being re vetted.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Mandatory training has re commenced following restrictions due to COVID 19 and dates have been set to ensure all staff members are fully compliant regarding mandatory training. One of the staff members highlighted has had re fresher manual handling and the dates have been set for the other two staff members manual handling and MAPA refresher.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An Assessment of needs has been completed for all residents in Florence House and discussions are ongoing with residents and families regarding a possible move for 2 residents to a smaller community house. OT assessments have been organized to ensure the new house is suitable for the needs of the residents who are due to re locate. Discussions are ongoing with the residents and families.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A PECS system has been introduced for the residents around snack times to ensure choice for each person is adhered to.
The residents currently have a take away of choice one night a week and there are 4 cooking and baking sessions scheduled on the activity time table in Florence House to ensure the residents are involved in preparation of some meals/ snacks. Breakfast is cooked fresh each morning ensuring residents choice and some evening meals are cooked on site. A weekly shopping list is complied so as there is a variety of food items and alternative choices available to the residents at all times.
Prior to COVID 19 the residents were supported to complete the weekly shop locally but at present due to the risk of contracting COVID 19 due to underlying medical conditions and the inability of the residents to wear face coverings this is on hold at present.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The PIC has developed and completed an assessment of needs for each resident to highlight the level of support and care each person requires. This has been discussed with senior management and a new community house has been identified which may be suitable for two residents from Florence House to re locate to pending discussions with the residents, families and MDT members.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A locked press had not previously been identified by the service as a restrictive practice has now been risk assessed and discussed with the restrictive intervention review committee and guidelines put in place regarding the locking of this press. The PIC has notified this restrictive practice to the Chief inspector of social services through the quarterly returns.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
An assessment of needs has been completed for each resident to highlight the supports each person requires to ensure person centered care in all aspects of their lives. A new community house has been identified for possible re location of two residents from Florence House which in turn will ensure each person receives the support they require in all aspects of care.

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(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/01/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/01/2021
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Not Compliant	Orange	22/12/2020
Regulation	The person in	Substantially	Yellow	31/01/2021

18(2)(c)	charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Compliant		
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.	Not Compliant	Orange	31/12/2021
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	01/12/2020
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Not Compliant	Orange	01/12/2020

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Yellow	01/12/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	01/12/2020
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his	Not Compliant	Orange	31/12/2021

	or her daily life.			