Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Cliff House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 3
Type of inspection:	Unannounced
Date of inspection:	14 February 2018
Centre ID:	OSV-0003257
Fieldwork ID:	MON-0021050

About the designated centre

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

The designated centre consists of two houses with the capacity to provide full-time residential care and support for four children with an intellectual disability and autistic spectrum disorder. Residents are supported with their positive behaviour support needs, augmentative communication needs, emotional support needs, and physical and intimate care support needs. The centre is situated in a suburban area of Co. Dublin with access to a variety of local amenities such as shops, train stations, bus routes, churches and the city centre. There are vehicles available to enable residents to access school and local amenities. There are two premises in the designated centre the first of which is a three-bedroomed, split level, terraced home. Each resident has their own bedroom all of which are single ensuite rooms. Each resident is actively encouraged to personalise their own bedroom. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, person participating in the management of the centre, and healthcare workers. Staffing numbers are adjusted as the dependencies of the residents change.

The following information outlines some additional data on this centre.

Current registration end date:	06/12/2018
Number of residents on the date of inspection:	4

How we inspect

To prepare for this inspection the inspector or 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
14 February 2018	09:20hrs to 17:30hrs	Marie Byrne	Lead

Views of people who use the service

The inspector met and spent some time with three of the four residents residing in the centre on the day of the inspection.

All residents who spoke with the inspector were happy and engaged in activities of their choosing. The inspector found that interactions between residents and staff were positive.

The inspector observed that residents in the centre were being supported to communicate their needs and wishes, and to receive the support they required to make decisions in relation to their day-to-day lives. This was facilitated through the use of pictures and easy read information for some residents.

The inspector observed residents taking part in programmes to increase their independence and life skills with staff support.

Capacity and capability

Overall, inspectors found that the registered provider was striving to ensure a good quality and safe service for residents in the centre. Improvements had been made to the care and support provided for residents since the last inspection and the provider had put measures in place to complete most of the actions required following the last inspection.

The inspector found that improvements had been made to the governance and management structures in the centre. A director of compliance and quality improvement had been employed and was putting systems in place to improve the quality of safety of care in the centre. This director was meeting with the person in charge on a weekly basis and supporting them in compliance planning, monitoring and review. They were also completing a weekly environmental walk around and regular check and challenge sessions with staff.

Seven new staff had been employed in the centre over the last three months. Formal induction training and an in-house induction were provided for these new staff. The inspector found that improvements were required in relation to the skill mix in the centre and that some improvement was required in the in-house induction.

Formal staff supervision was in place in the centre; however the inspector found that improvement was required in relation to the quality of supervision and the

follow up and completion of actions following the supervision.

There was a marked decrease in the use of relief and agency staff since the last inspection. The inspectors spoke with a number of staff, some of whom were new to the centre. Overall, they were aware of residents' care and support needs; however, it was clear that the new staff members were at their infancy of getting to know the residents and their support needs.

Members of the original staff team had received further training and education in line with residents' needs. This included safeguarding training and positive behaviour support training.

There was an annual review of the quality and safety in the centre, and six monthly visits by the provider or their representative. The director of compliance and quality improvement was closely monitoring the progress of actions from these reviews. A number of new internal audits were now being completed regularly in the centre.

Each resident had a key worker who supported them to make their views, suggestions and complaints known regarding the care and support in the centre. There was accessible information on display on how to make a complaint. Residents' representatives and those in their circle of support were made aware of the complaints policy.

There was a written statement of purpose which was reflective of the service being delivered and contained the information required by schedule 1 of the regulations

There were policies and procedures in place to guide staff practices in supporting residents with their care and support needs.

Regulation 15: Staffing

Improvement was required in relation to the skill mix and staffs' knowledge of residents' care and support needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The arrangements in place for staff supervision and induction were not adequate.

Judgment: Substantially compliant

Regulation 23: Governance and management

Systems to ensure the effective delivery of care and support in the centre were in the development stages and required improvement.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained all the information required in schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that although there had been improvements made since the last inspection, areas for improvement remained in relation to ensuring residents were fully supported and in receipt of a safe and quality service. The provider had put measures in place to complete most of the actions required following the last inspection.

Each resident in the centre had a personal plan in place and a review of these had commenced; however, these reviews were in their infancy and required further review to ensure they were effective and supported residents to live a life that was varied and in line with their goals and aspirations.

To further support residents with an enriched life a social activity assessment had commenced to inform goal setting and meaningful activity planning. Key workers were also being facilitated to spend protected time every week to carry out assessments and documentation in relation to activities and goal development.

Family forum meetings had been held to guide implementation and review of personal plans with residents' representatives, Health Service Executive (HSE) case workers, and other relevant members of the team in attendance.

A behaviour specialist had been recently been employed in the centre to enhance the support provided to the residents. Each resident had a behaviour support plan in

place with proactive, reactive and where applicable restrictive strategies.

In addition, restrictive practices in the centre had been reviewed and staff had received training in behaviour that challenges including the use of de-escalation and intervention techniques, and on site positive behaviour support training. The behaviour specialist was regularly completing a check and challenge document to garner staff knowledge in relation to behaviour support plans, recording incidents, using picture exchange communication systems and token systems.

Incident forms were being reviewed on a regular basis and adjustments were being made to behaviour support plans as necessary following this. On reviewing records in the centre there was a reduction in behaviour related incidents since the last inspection.

The provider now had systems in place that supported residents with their healthcare needs. A gap analysis had recently been completed in relation to residents' healthcare needs and appropriate assessments and care plans were found to be in place. Residents were supported and had access to relevant allied health professionals in line with their assessed needs.

The provider had put some measures in place to protect residents being harmed or suffering abuse in the centre. Weekly safeguarding assessments were being completed and a staff reference folder was put in place to guide staff in relation to safeguarding procedures.

The majority of staff had been provided with training and refreshers in relation to the prevention, detection and response to abuse, including reporting any concerns or allegations of abuse to statutory agencies. The inspector found that improvement was still required in relation to staff training and knowledge on the types of abuse and the procedures to follow in the event of a safeguarding concern. Residents' intimate care plans had been recently reviewed and updated.

The health and safety of residents, visitors and staff was promoted in the centre. There were policies and procedures in place for risk management and emergency planning. There was a risk register in place, and a log maintained of any changes to the risk register. Corporate, environmental, and residents' individual risk assessments had been reviewed and updated since the last inspection. There were arrangements in place for identifying, recording, investigating, and learning from incidents.

Suitable fire equipment was available throughout the centre. Works had been completed to install magnetic closing system on two fire doors in the centre. However, a number of fire doors were wedged open on the day of inspection negating their use in the event of a fire.

Staff in the centre had completed suitable training in fire prevention and emergency procedures. There were evacuation procedures in place and fire drills were completed. The fire alarm system was serviced on a quarterly basis and fire-

fighting equipment serviced on an annual basis.

Works had been completed in the centre to ensure satisfactory infection control procedures were in place.

Medicines management practices and procedures had been reviewed in the centre and changes made to improve residents' safety. However, the inspector found areas for improvement remained in relation to labelling of medicines, documentation of incidents, and completion of competency assessments for staff administering medicines to residents in the centre.

Works had been completed in the centre to ensure the privacy and dignity of each resident was respected. Personal information was stored securely. Accessible information was on display in the centre in relation to the complaints process and advocacy services.

Should residents require the assistance of an advocate they had access to an independent advocacy service.

Regulation 26: Risk management procedures

The safety of residents, staff and visitors was promoted in the centre through appropriate risk management and emergency planning.

Judgment: Compliant

Regulation 27: Protection against infection

There were appropriate infection prevention and control procedures and practices in place in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate arrangements were not in place in relation to fire containment.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were required in relation to medicines management procedures.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Improvement was required in relation to reviewing the effectiveness of residents' personal plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' behaviour support needs were being supported in the centre.

Judgment: Compliant

Regulation 8: Protection

Improvement was required in staff training and staff knowledge on safeguarding.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' privacy and dignity was being respected in the centre.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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 3: Statement of purpose	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cliff House OSV-0003257

Inspection ID: MON-0021050

Date of inspection: 14/02/2018

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 registered provider in conjunction with the person in charge and director of compliance and quality improvement has updated the risk assessment in place to ensure the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of residents. This risk assessment will now be reviewed and amended if required at the monthly incident review forum in the designated centre. The registered provider has recruited 2 new social care workers since February 2018. The 2 new social care workers have received a comprehensive induction to the centre and have all required mandatory training in place. March 30th 2018	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A monthly review of the training analysis is conducted by the person in charge and HR officer to ensure all staff members are scheduled in a timely manner for any mandatory or refresher training. The registered provider in conjunction with the person in charge has devised a schedule of training for May 2018 in the areas of positive behaviour support and LAMH as part of staff members continuous personal development programme. This programme is separate to mandatory training requirements.	

A member of the management team as nominated by the registered provider has conducted an audit of staff members' supervision records in March 2018.

The registered provider has put in place a revised supervision file for each staff member following this audit in conjunction with the person in charge to enhance records of formal and informal supervision processes.

A revised supervision schedule is now in place for the designated centre coordinated by the person in charge and overseen by the registered provider. Formal supervision sessions are now scheduled weekly and reflected on the roster to facilitate adequate preparation and goal setting by the person in charge and staff member.

The person in charge attended training in supervision goal setting in April 2018.

The person in charge has revised the induction checklist for staff members. This ensures that adequate, comprehensive and appropriate detail regarding care and support needs of residents is included in all inductions.

The registered provider updated the centre's supervision policy in line with the revised formal and informal supervision approaches now in use in the centre.

A further audit is scheduled to review supervision records in quarter 2 of 2018

Timeline: 15th May 2018.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The registered provider, person in charge, director of compliance and quality improvement and behaviour specialist continue to review management systems in the centre to ensure services are safe and appropriate to residents' needs. These systems include:
Incident Review Forums (monthly)
Family Forum Meetings (monthly)
Restrictive Practice Committee (quarterly)
Risk Logs (Daily by person in charge)
Behaviour Incident Reviews (weekly by behaviour specialist in conjunction with person in charge)

The person in charge, director of compliance and quality improvement in conjunction with the registered provider conduct a monthly review of data in the areas of adverse incidents, behaviours of concern, safeguarding, complaints, notifications and near misses. Shared learning notices are compiled and made available to staff teams and representatives to recognize positive risk taking and focus on additional controls to reduce or eliminate risk reoccurrence.

The person in charge, registered provider and director of compliance and quality improvement review and update risk assessments as applicable once the data sets are analyzed. All risk assessments were reviewed and updated for quarter 1 at the end of March 2018.
An overarching Quality Improvement Plan is now in place for the centre. HIQA Compliance Plan Actions, Internal audit recommendations from quarter 1 of 2018 and actions from internal unannounced visits inform this plan.

The Quality Improvement Plan is reviewed at the end of each month by the person in charge and director of compliance and quality improvement. The plan is then forwarded to the registered provider for further review and feedback.

A further internal audit schedule is in place for quarter 2 of 2018. Audits include medication management, aspects of personal planning, staff supervision and daily documentation used in the centre. These audits are completed by the person in charge and director of compliance and quality improvement.

30th June 2018.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider has installed an additional magnetic closing system on downstairs doors in the designated centre to facilitate preferred access of residents and to ensure adequate arrangements in relation to fire containment.

The individual fire evacuation procedures of each resident have been revised and updated by the person in charge.

Fire drills required in quarter 2 of 2018 have been scheduled for the designated centre by the person in charge.

A shared learning notice has been circulated to all staff by the registered provider regarding their critical roles and responsibilities regarding daily fire safety checks and evacuation.

Adherence to fire safety arrangements as per the daily fire checks are now also monitored via an additional environmental walkround checklist conducted by the person in charge or person nominated by the registered provider.

4th of May 2018

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The person in charge has checked that all current medication in the centre is clearly labeled.

The person in charge has amended the weekly stock control sheet to ensure medication received from the pharmacy is checked to ensure all medications are labeled.

A review of all staff members' medication competency assessments was conducted. Where gaps were identified a schedule was devised to monitor the completion of outstanding competency assessments.

Findings from an internal medication audit in Quarter 1 of 2018 are being monitored through the Quality Improvement Plan. The status of these actions is reviewed monthly by the person in charge and director of compliance and quality improvement.

Medication variances are included as adverse incidents and analyzed at the monthly incident review forum. Risk assessments regarding medication management are adjusted as required based on variance trends. Where warranted shared learning notices are circulated to staff members recognizing improvements but also focusing on aspects of medication management that require further improvement. A shared learning notice was circulated at the end of quarter 1 2018.

A further audit of all residents' medication is scheduled during May 2018 by the director of compliance and quality improvement on behalf of the registered provider.

May 30th 2018

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:

The person in charge in conjunction with the keyworkers has completed a quarterly review of each resident's personal plan. Social goals and health care goals set for quarter 1 of 2018 were reviewed and are up to date. New goals have also been set with residents through family forum meetings for April and May 2018. This process of planning and review will continue.

The person in charge continues to coordinate in conjunction with keyworkers, residents' representatives and HSE representatives the monthly family forum meetings which commenced in January 2018.

30th March 2018

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The registered provider in conjunction with the person in charge continues to review and update (monthly) the overarching safeguarding risk assessment in place for the centre.

The registered provider coordinated refresher training for all staff members on April 24th and 25th 2018.

All staff members have now completed the TUSLA on line child protection training in conjunction with the refresher training.

A new designated liaison person has been assigned to the designated centre by the registered provider.

A shared learning notice has been issued to all staff members by the registered provider post the refresher training to ensure clarity in their roles and responsibilities regarding safeguarding residents.

Residents' representatives have received the revised safeguarding statement at family forum meetings in March & April 2018.

The person in charge, director of compliance and quality improvement in conjunction with the registered provider conduct a monthly review of data in the areas of adverse incidents, behaviours of concern, safeguarding, complaints, notifications and near misses. Shared learning notices are compiled and made available to staff and representatives to recognize positive risk taking and focus on additional controls to reduce or eliminate risk reoccurrence.

The person in charge, registered provider and director of compliance and quality improvement review and update risk assessments as applicable once the data sets are analyzed. All risk assessments were reviewed and updated for quarter 1 at the end of March 2018.

The person in charge, behaviour specialist and PPIM continue to conduct weekly informal check and challenge sessions with staff members regarding critical care and support needs of residents. These informal supervision sessions are recorded in staff members supervision file and include roles and responsibilities of staff members in safeguarding residents.

The behaviour specialist has commenced as part of enhanced supervision practices with staff members a schedule of competency assessment regarding their knowledge and application of positive behaviour supports as reflected in current behaviour support plans.

The behaviour specialist continues to review behaviour incidents weekly in conjunction with the person in charge and attends meeting forums in the designated centre such as incident review meetings, restrictive practice committee meetings and family forum meetings.

Timeline: 30th April 2018

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	30th March 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	15th May 2018

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	30th June 2016
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	4th May 2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30th May 2018

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.	Substantially Compliant	Yellow	30th March 2018
Regulation 08(8)	The person in charge shall ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.	Not Compliant	Orange	30th April 2018