Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	HSE Cork - Youghal Community Hostels
Name of provider:	Health Service Executive
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	21 February 2018
Centre ID:	OSV-0004646
Fieldwork ID:	MON-0021184

About the designated centre

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

Youghal Community Hostels comprises two houses; one house is based on the grounds of another designated centre and can accommodate six residents. The second house is located in the community and can accommodate 10 residents. The centre provides a long-stay, full time, residential service for 16 residents (male and female) with an intellectual disability, with or without autism. Day activities and programmes for each resident may be coordinated from the centre and take place in the centre and gardens. It is also envisaged that many activities will take place in the local community. There is a registered nurse on duty during the day and at night to address residents' medical needs. The service aims to provide a range of person centred services and supports, recognising each individual's preferences, needs and aspirations.

The following information outlines some additional data on this centre.

Current registration end date:	20/09/2021
Number of residents on the date of inspection:	16

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
21 February 2018	09:00hrs to 16:15hrs	Caitriona Twomey	Lead
21 February 2018	09:00hrs to 16:15hrs	Geraldine Ryan	Support

Views of people who use the service

Inspectors met with 10 residents. Residents welcomed and invited inspectors into their home. Residents were observed as relaxed and engaged with staff in a positive manner.

Residents the inspectors spoke with in one house stated that they were happy, enjoyed going out, praised the staff and stated that they felt safe. All residents were very familiar with the person in charge and said that staff were good to them.

However, residents accommodated in the second house, while very complementary of the staff, stated that they did not like living there as it was noisy at times and some residents did not get on with others. This matter is discussed in further detail in the report.

Capacity and capability

On 6 November 2015 the Health Information and Quality Authority (HIQA) applied to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities run by the Health Service Executive (HSE). This report concerns one of those centres and was the sixth inspection of the centre. Particular lines of enquiry were identified pertinent to compliance with specific regulations as this inspection was undertaken to follow up on actions generated from the previous inspection.

Improvements previously noted regarding residents' increased community participation and the monitoring and oversight of the service provided in the centre had been sustained. While inspectors found that there was a clear governance structure and a dedicated staff team working in the centre, there were areas that required improvement by the provider to ensure that a quality and safe service was being delivered to residents. The provider's response to the action plan generated from the inspection undertaken in March 2017 stated that this centre would be closed by 31 December 2017. This had not yet materialised as the acquisition and adaptation of alternate accommodation had not been finalised. In addition, the planned transition of some residents had not occurred. As noted under Quality and Safety, this had a negative impact on the quality of life and safety of residents in one of the houses that comprised the centre. Other identified areas for improvement included the staffing provision in one house, the notification of specific events to HIQA, and the complaints process.

Staff who met with inspectors were clear on the reporting relationships and lines of

accountability in the centre. The person in charge worked full-time and fulfilled this role for this centre only. He was an experienced manager and had an understanding of his role, regulatory requirements and of the residents' assessed needs. He was supported in this role by three clinical nurse managers. Staff stated that the person in charge was supportive and visited the houses daily.

The provider had systems in place for reviewing the quality and safety of the care and the services provided to the residents. The annual review for 2017 was near completion and was available for review. This made reference to consultation with some residents and their representatives. Records reflected that unannounced visits at the required six monthly intervals had been undertaken. It was unclear from the annual review and six-monthly visit reports what progress if any had been made in addressing the identified areas for improvement. Inspectors were shown a more detailed and up-to-date digital version of these documents available to management in the centre.

Residents had access to the provider's complaints policy. Inspectors reviewed the provider's management of complaints. The complaints logs in both houses that comprised the centre had been reviewed and signed off by senior management. It was not always possible to identify what actions had been completed to address complaints, if the complaints were fully resolved, or the satisfaction of the complainant. For example, one person had expressed a wish to live elsewhere. The log indicated that this complaint had been resolved, despite the person continuing to live in the centre. These findings were discussed with the person in charge. As with the six-monthly visit report action plans, a separate, more detailed record of each complaint and how these were addressed was stored digitally. The person in charge advised that the organisation’s complaints policy was due to be reviewed and this may entail a revision of the complaints log template.

Based on the evidence available to the inspectors, staffing numbers were appropriate to the residents' assessed needs in one house. However, inspectors were not assured that the provider had the required arrangements in place to meet the residents' assessed needs, particularly at times of busy activity. A planned and actual staff rota indicated that consistent staff worked in the centre. Relief staff were sourced from the provider's relief staff. There were no volunteers working in the centre.

Staff confirmed and records reviewed evidenced that regular team meetings were convened. The person in charge explained that the teams in each house operated these meetings separately, meeting at different frequencies. He further explained that while all staff were invited to attend these meetings, attendance was not rostered. The person in charge informed inspectors that if any staff member does not attend a staff meeting, he meets with them on an individual basis to ensure all information discussed is shared and to facilitate staff feedback. In addition, inspectors saw evidence that a suite of meetings were convened at regular intervals for example, quality and safety, a safeguarding meeting every weekday, and regular governance meetings.

Staff training records reviewed and the person in charge confirmed that staff had

attended all required and mandatory training including, for example, fire safety, safeguarding, de-escalation and intervention techniques, and medicines management. It was identified in the annual review completed by the provider that staff required training in communication, dementia, dysphagia and understanding restrictive interventions. During feedback, the plans in place to address these identified needs were outlined.

At the opening of the inspection the person in charge advised that a review of the organisation's safeguarding policy was underway. This was due to the previous implementation of an 'Adult Protection Thresholds Guide' document which was not consistent with the national safeguarding policy or regulations. During the inspection records of incidents were reviewed. These included instances of alleged, suspected or confirmed peer-to-peer abuse. The majority of these incidents had not been notified to HIQA, as is required by the regulations. Following the inspection, a number of retrospective and contemporaneous safeguarding notifications were submitted.

The person in charge is obliged to notify HIQA on a quarterly basis of any occasion on which a restrictive procedure including physical, environmental or chemical restraint was used. During a review of one resident's file it was identified that a restriction was in place, for a number of years, limiting one resident's access to alcohol. This had not been notified to HIQA. Inspectors also questioned whether the use of a door alarm system in one of the houses should be notified to HIQA. During feedback, the provider advised that a person from another organisation was scheduled to attend various centres to identify restrictions in place.

Regulation 15: Staffing

Staffing levels in one house required review particularly in the afternoons when all residents returned to the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

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

Staff spoken with demonstrated an in-depth knowledge of residents and, in particular in matters relating to safeguarding of residents. Training for staff in communication was scheduled and the person in charge, cognisant of the cohort of residents in the centre, had identified and scheduled training for staff in dementia.

Judgment: Compliant

Regulation 23: Governance and management

As a result of the ongoing, identified incompatibility of the residents in one house and the failure to implement transition plans proposed to address this, the provider did not ensure that the service provided to residents in one of the houses was safe and appropriate to their assessed needs.

Judgment: Not compliant

Regulation 31: Notification of incidents

The use of restrictive practices and a number of incidents of peer-to-peer abuse had not been notified to HIQA, as is required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

It was not clear if complaints were addressed to the satisfaction of the complainant.

Judgment: Substantially compliant

Quality and safety

Particular lines of enquiry were identified pertinent to compliance with specific regulations as this inspection was undertaken to follow up on actions generated from the previous inspection in March 2017.

While there were demonstrated, sustained efforts to provide a more individualised, high quality and safe service in the centre, there remained a number of areas that required improvement, specifically in one of the houses. There was a marked contrast in the experiences of the residents living in each of the houses. While the staff teams in each house were equally committed to improving the quality of life and service provided to residents, systemic issues negatively impacted on their ability to achieve these aims. These included the ongoing unsuitability of the

premises, lack of appropriate professional input to support residents who at times engaged in behaviours that challenge, and the incompatibility of residents living together.

Overall, and as identified on previous inspections, the design and layout of the centre was not suitable for its stated purpose. It was also brought to inspectors' attention that due to unforeseen leave, one of the houses required additional resources to ensure cleanliness of the premises.

All residents had a multidisciplinary assessment of their needs and the resulting plans were informative to guide staff on residents' needs. Staff ably demonstrated their knowledge of residents' health care needs and requirements. The person in charge outlined, that despite funding approval, the organisation had been unable to recruit some allied health professionals to work in the service. Public and private services were referred to or sourced in the interim. All residents had access to a general practitioner (GP), nursing, psychiatry, speech and language therapy, dentistry and chiropody. Resident access to dietetics was being organised by the person in charge. However, as noted on the previous inspection, residents did not have access to a psychologist if required.

The absence of psychology input into the Behaviour Support Plans of residents who engage in behaviours that challenge was highlighted in the March 2017 inspection. The requirement for psychology support was included in the centre's risk register. The person in charge advised that the service had employed a psychologist to work on a sessional basis and was due to start the following month. He further advised that one resident was identified to access these supports as a priority. Inspectors reviewed the Behaviour Support Plan currently in place for this resident. This document was unsigned and undated. When asked, a staff member advised that this had been completed by a regional support service. However, the person in charge later advised that he had compiled this plan. There was no evidence of an assessment to identify the cause of the resident's behaviour.

Inspectors identified that there were ongoing, significant issues regarding the incompatibility of residents in one of the houses that comprised the centre. This ongoing issue was reported to inspectors by staff and residents and was documented in records of incidents that occurred in the centre and the 'feeling safe' plans in place for the majority of residents living in that house.

The incompatibility of residents and the negative impact it was having on all residents was identified during previous inspections completed by HIQA in May 2016 and March 2017. In the action plan that resulted from the March 2017 inspection, the provider stated that specific individuals would transition from the centre by 31 October 2017. One resident had moved since the most recent inspection; however, the rationale for this transition was not related to the identified compatibility issues. The planned transitions had not occurred and the provider was unable to provide inspectors with a clear, time bound plan as to when these would occur. The provider reported that this placement issue had been escalated to the Health Service Executive. Despite the acknowledged incompatibility of residents in this house, the practice of sharing bedrooms continued for the majority of residents. The person in

charge told inspectors that changing the combination of residents who shared bedrooms was trialled in the past, however this had proven ineffective in improving residents' quality of life. While the provider had made efforts to address this matter, the impact on residents' continued safety and welfare is of concern.

While inspectors acknowledge the positive approach demonstrated by staff to support residents with behaviours that may challenge, the provider, person in charge and staff agreed and evidence indicated that the incompatible age mix and placement of residents in one house continued to have a negative impact on the residents. Again on this inspection, residents stated to inspectors that they did not want to live in this house because of peer-to-peer incidents.

Regulation 7: Positive behavioural support

There was no evidence of an assessment undertaken to identify the cause of a resident's challenging behaviour. Some residents' plans had no date of review or were not signed.

Judgment: Not compliant

Regulation 8: Protection

The provider agreed and evidence indicated that the residents in one house were inappropriately placed resulting in peer-to-peer incidents occurring on a regular basis between residents in this house.

Judgment: Not compliant

Regulation 6: Health care

The provider met the requirements of the regulations ensuring appropriate health care was provided to the residents living in the centre.

Judgment: Compliant

Regulation 17: Premises

While the centre was warm and personalised by the residents themselves, the

design and layout of the centre was not suitable for its stated purpose. Additional resources were required to ensure the cleanliness of one of the houses.
Judgment: Not 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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 6: Health care	Compliant
Regulation 17: Premises	Not compliant

Compliance Plan for HSE Cork - Youghal Community Hostels OSV-0004646

Inspection ID: MON-0021184

Date of inspection: 21/02/2018

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: A comprehensive staffing assessment was completed 20 months previous to inspection. In addition, a review of the quality and safety of the service offered is completed annually. The number of residents who reside in the two hostels has reduced from 16 to 15 from date of the inspection and is to reduce further to 13 before the 20th June 2018. Staffing levels remain unchanged.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The purchase of the 3 bedroom house has been delayed due to a range of external issues which include the purchasing of a house through CAS funding through a third party purchaser (who required arrangement of interim funding which required approval by its board), the requirement of a legal process to ensure payment for additional works this process has been completed. The completion of additional works which include an extension has commenced. The 3 bedroom house will be ready and residents who have commenced the transition process with the support of an assigned community transition co ordinator will have moved into the house by the end of September 2018.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: A rights application was completed by the PIC in Feb 2017 (to seek guidance on whether a resident who has identified that excessive consumption of alcohol has a negative impact on his/her emotions- which is further impacted by his/her low tolerance to alcohol due to his prescribed medication which is part of his/her mental health support)- as a part of development of his/her individual person centre plan he/she expressed his/her	

wish that staff support him/her when he/she was consuming alcohol to encourage him/her (after he/she has consumed 2 alcohol drinks) to change to non alcoholic drinks (which he/she requested be Coca cola or Heineken zero / Becks). This was reviewed by the rights review committee in March 2017 and the findings were that this was not a restrictive practice. This decision has been reviewed by an independent external professional from the organization with extensive experience in the area of rights review prior to submission of this action plan, and there finding are consistent with the findings of the rights review committee.
The door opening bell fitted to the main door of Bayview was last used 15 months ago while the door opening bell in Seaview was last used 10 months ago. Notification of use of door opening bell if and when used will be included in ¼ notifications.
An audit of restrictive practices will be completed before July 2018 by an external professional who is competent to fulfill this role. All staff will receive training in rights before November 2018. Following review of local safeguarding policy and removal of threshold reporting guidelines in January 2018, there has been full compliance with the regulations in regards to notifications to HIQA.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Audit of complaints has been completed in March 2018 and repeated in May 2018. The log of complaints stored locally had a lack of clarity of the outcome of each complaint and this has been addressed. Complaints policy has been updated and circulated. Complaints report continues to be completed annually. The accurate and more detailed complaints log which was maintained electronically has been circulated to each hostel and has replaced the locally maintained log.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Each resident who presents with behavior of concern have an assessment of the causes of their identified behavior of concern.
The one behavior support plan which was unsigned and undated was signed and dated on the day of the inspection.
All remaining support plans are dated and signed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A 3 bedroom house will be ready for the end of September 2018. The residents who are proposed to move into this house have commenced their transition process with the support of an assigned community transition co Ordinator. Part of this transition plan was an assessment of the compatibility of these 3 men.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The purchase of the 3 bedroom house has been delayed due to a range of external issues which include the purchasing of a house through CAS funding through a third party purchaser (who required arrangement of interim funding which required approval by its board), the requirement of a legal process to ensure payment for additional works, and the completion of these works which include an extension. The 3 bedroom house will be ready and residents who have commenced the transition process with the support of an assigned community transition co Ordinator will have moved into the house by the end of September 2018. The number of residents who reside in the two hostels has reduced from 16 to 15 from date of the inspection and is to reduce further to 13 before the 20th June 2018. From the end of September 2018 the number of residents will reduce further to 11.
Resources have and continue to be provided to each house to ensure the cleanliness of the houses.

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	12.11.18
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	September 30th 2018
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	July 31st 2018

	designated centre are clean and suitably decorated.			
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	September 30th 2018
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	12.11.18
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure	Not Compliant	Orange	12.11.18

	including physical, chemical or environmental restraint was used.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	12.11.18
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	12.11.18
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	September 30th 2018