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:	Sunny Gardens
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	18 September 2018
Centre ID:	OSV-0005299
Fieldwork ID:	MON-0024591

About the designated centre

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

Sunny Gardens is a designated centre operated by Sunbeam House Services and is situated close to a town in County Wicklow. Sunny Gardens can provide full-time residential support for up to three residents with intellectual disabilities. The designated centre is a two storey house decorated and maintained to a good standard. Some areas of the premises, for example bathing facilities, have been modified for residents requiring mobility supports. The centre is also resourced with a transport vehicle. The centre is managed by a person in charge who also has responsibility for another designated centre.

The following information outlines some additional data on this centre.

Current registration end date:	26/01/2019
Number of residents on the date of inspection:	3

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
18 September 2018	10:00hrs to 17:40hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

The inspector met with all three residents living in the centre. Residents told the inspector that they were very happy in their home and felt safe. Residents discussed what it was like to live in the centre previously when there hadn't been as much staff resources. They explained that previously when their peers had an appointment for example, they all had to go because there wasn't enough staff in the centre to let them stay at home.They told the inspector that they didn't think that it was fair and this had made them annoyed. Now they were much happier. Residents told the inspector they had lodged a complaint as they were concerned the current additional staffing resources might stop. Complaints records maintained in the centre documented evidence of this.

Residents were complimentary of staff and the person in charge and told the inspector that staff were supportive and kind. Residents also discussed jobs and hobbies they enjoyed and upcoming holidays they were looking forward to. It was observed throughout the course of the inspection that staff and residents had a good rapport with each other and respectful, pleasant interactions occurred between staff and residents throughout the inspection.

Capacity and capability

The registered provider, the person in charge and persons participating in management of the centre were effectively ensuring each resident received a good quality service. Good levels of compliance with the regulations and standards were found on this inspection. The person in charge demonstrated high levels of management competence and knowledge of their regulatory responsibilities ensuring good levels of compliance found in this centre.

An increase in staffing resources had brought about significant improvements in the quality of life for residents and residents told the inspector that they were happier and more content since the increased staffing resources had been instated. It was not demonstrated that this additional staffing resource would be maintained for the next registration cycle to ensure sustained compliance with the regulations and standards and continued quality outcomes for residents.

Sunbeam House Services had made a number of governance and management improvement initiatives in the months prior to inspection. These changes were found to be effective and impacted in a positive way on the centre. This meant that systems were in place to identify and respond to residents' needs and ensure that they received a good service.

Appropriate oversight arrangements were in place. The person in charge provided the day-to-day operational management and oversight of the centre to a good

standard.

The provider had ensured that staff were accountable in their roles. Meetings between the senior services manager and person in charge had occurred in Sunny Gardens on two occasions in 2018. Specific key quality indicators were reviewed at this meeting. Senior services managers were required to review a sample of information in the designated centre to check the work of the person in charge, resulting in improved accountability and performance management initiatives taking place at an operational level within Sunbeam House Services designated centres. This inspection found evidence that this had occurred.

The provider and person in charge were using an audit system to self identify areas for improvements. Ongoing operational management audits were in place and there was evidence that staff were encouraged to take responsibility and be accountable through improved governance arrangements in the centre.

The person in charge presented as a competent manager who understood their regulatory role and responsibilities to a good standard. This included knowledge of notifications to the Health Information and Quality Authority (HIQA) as required by the regulations. Required notifications had been submitted to HIQA within the time-lines stipulated in the Regulations. The person in charge demonstrated a good understanding of the support requirements for each resident, residents in turn were complimentary of the person in charge and found her to be approachable and supportive.

Six-Monthly provider led audits had been carried out by the provider as required by the regulations. These were found to be comprehensive documents with associated action plans devised following each audit. There was evidence that the person in charge had completed the actions for each audit as they took place. An annual report for the centre had also been carried out by a representative for the provider. Feedback from residents and families was incorporated into this report as required by the regulations.

The provider had ensured there were an adequate number of consistent staff with appropriate qualifications, experience and skill mix to meet the assessed needs of residents at the time of inspection by increasing staffing resources changing the centre from lone working to two staff during periods of the day. Residents and staff told the inspector that this increase in staffing resources had made a significant improvement to the quality of support and care for residents.

Residents told the inspector that they had more choices and were happier with this arrangement. As a result the frequency and number of behaviours that challenge had decreased significantly and the requirement for behaviour support planning had ceased. By way of example, 18 behaviours that challenge incidents had occurred in 2016, in 2018 one incident had occurred. While this arrangement was meeting the assessed needs of residents, it was not demonstrated that the provider had resourced the centre to maintain this additional staffing resource to meet the assessed needs of residents for the coming registration cycle. This required improvement.

The provider had however, ensured that staff had the right skills and training. All staff had completed necessary mandatory training in management of behaviours that challenge, fire safety and safeguarding vulnerable adults. Staff had also completed training in other areas such as safe administration of medication, risk and incident management, management of complaints and training in supporting residents with diabetes. A training needs analysis for the centre was in place and refresher training was also available and scheduled for staff.

Staff supervision meetings were ongoing, the inspector reviewed a sample of staff supervision meetings that had occurred since January 2018. The person in charge had completed a supervision meeting with all the staff working in the centre. Supervision meetings were of a good standard and demonstrated they were opportunities for staff to raise ideas and suggestions with the person in charge.

The inspector reviewed the statement of purpose during the course of the inspection. Inspection findings and observations made during the course of the inspection indicated the service was being operated in line with the matters set out in the statement of purpose. The statement of purpose required updating to reflect the incumbent person participating in management (PPIM).

A change to a key management position had not been notified to HIQA. It was not demonstrated, therefore, that the provider had an effective system for notifying key prescribed information for the purpose of registration.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a complete application to renew registration of this centre.

Judgment: Compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The provider had failed to notify HIQA of an incumbent change to a key person participating in management position. It was not demonstrated that the provider had appropriate arrangements in place to notify the office of the Chief Inspector of key required information for registration purposes.

Judgment: Not compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre. She was appointed in a full-time capacity for this and one other designated centre.

The person in charge presented as competent person to carry on the role of person in charge of the centre. They met the requirements of regulation 14 and its sub-regulations. A good level of compliance was found on this inspection.

Judgment: Compliant

Regulation 15: Staffing

At the time of inspection the staffing numbers and skill mix were found to meet the assessed needs of residents. Additional staffing resources were in place to meet the assessed needs of residents and this was found to have brought about significant improvements in the quality of life for residents.

A planned and actual roster was maintained in the centre. Schedule 2 files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had received good quality supervision meetings with the person in charge since January 2018.

Staff had access to a programme of training and development. Refresher training was available and staff were booked for refresher training in advance. All staff had up-to-date mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

The provider had met their regulatory responsibilities by carrying out an annual report for the centre and six monthly provider led audits. Operational management auditing was also carried out by the person in charge to ensure consistent oversight of the quality of care provided.

While the numbers and skill mix of staff were found to meet the assessed needs of staff at the time of inspection, this additional resource was not a long term

arrangement. The provider did not have resources in place to ensure residents assessed needs could continue to be met to the good standard found on inspection for the next registration cycle.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had received a contract of care which described the services and supports provided to them in the centre. Fees payable by the resident were outlined clearly in the contract of care and each contract had been signed by the resident and a representative for the resident.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained all matters as required in Schedule 1 of the regulations.

The provider was required to update the statement of purpose to reflect the new governance arrangements for persons participating in management of the centre and submit the revised statement of purpose to HIQA.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents that required notification had been submitted to HIQA.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The person in charge had been absent for more than 28 days in the months previous. The provider had notified HIQA of this absence and arrangements in place to manage the centre in their absence.

Judgment: Compliant

Regulation 34: Complaints procedure

Most staff working in this centre had received training in complaints management. It was demonstrated that residents were supported to make complaints when they wished. It was also demonstrated that residents complaints had been documented and the complaints procedure and policy adhered to.

Judgment: Compliant

Quality and safety

Overall the provider had ensured the service provided to residents was safe and residents had opportunities to live full and interesting lives.

Residents were supported to achieve their personal goals. Personal plans for residents had been reviewed regularly and an up-to-date annual review had been carried out. Person centred planning was managed in this centre to a good standard and residents were fully involved in the identification and planning process for their identified goals. An up-to-date comprehensive assessment of needs had been completed for each resident. Where needs were identified an associated support plan was in place. Personal plans incorporated allied health professional recommendations and daily notes of the implementation of residents plans were maintained electronically. Overall personal planning arrangements were met to a high standard in this centre.

Residents' physical were assessed and responded to. There was evidence that residents had received health care assessments since the previous inspection and associated recommendations and care planning was in place to ensure each resident's specific health-care need was supported. Residents were supported to attend healthcare appointments and avail of preventative health checks. Residents were also supported to manage their own health. Supportive arrangements and support planning was in place for residents in relation to smoking and encouraging them to smoke less each day. Residents were also supported to make appropriate dietary choices in the management of diabetes.

Residents were also supported to experience best possible mental health. Ongoing review and consistent liaison with psychiatry services were a feature for some residents and provisions were in place to ensure residents were supported where they had an identified need in this regard.

As referred to earlier in this report, residents no longer required positive behaviour

support planning as their assessed needs were being better met. Where and if required residents had access to allied health professional support with regards to behaviour support management. All staff had received training in the management and response to behaviours that challenge.

A restraint register was in place which identified restrictive practices. Overall, the inspector noted there were limited restrictions in place and of those that were in place a rationale demonstrated and review dates documented.

Residents were supported to be independent. In some instances residents had received training in how to travel independently which had been a successful process for them and had lessened the necessity for staff to accompany them at all times while in the community. Residents were supported to maintain employment and attend day services. Residents had greater choices available to them now in planning how they spent their day due to the increased staffing resources available.

An up-to-date policy on safeguarding vulnerable adults was in place and it was evidenced that the policy and associated procedures were in effect in the centre. Designated contact persons were displayed in the centre. All staff had received up-to-date training in safeguarding vulnerable adults. Staff spoken with demonstrated knowledge of safeguarding procedures and reporting structures. Residents spoken with told the inspector they felt safe and would tell a member of staff or the person in charge if they had a concern.

The systems in place to ensure safe medication management practices were found to be adequate and all staff that administered medication had been trained to do so. Medication audits had taken place at an operational level by the person in charge on a monthly basis. Audits by external persons had also occurred and where actions were identified they had been addressed by the person in charge.

There was evidence that the provider's risk management policy and associated procedures were implemented in the centre. A number of staff had received training in incident and risk management. also. An up-to-date risk register was in place for the centre which included specific control measures for each risk identified. Personal risks for residents had also been identified with associated control measures in place for each risk identified. Each risk had been analysed and a risk rating assigned to each risk. Risk of absconding was a personal risk feature in this centre. At the time of inspection appropriate management and response systems were in place to mitigate, respond to and manage the potential risk. The provider was required to review risk management procedures should a change in staffing arrangements occurred.

Falls were also a personal risk feature in this centre. It was demonstrated that appropriate manual handling arrangements were now in place to support residents during transfers. During the course of the inspection some residents were assessed for mobility aids and appliances with a plan in place to source mobility equipment to better meet their needs and to promote their independence, residents told the inspector they were excited about this.

Infection control procedures for the management of sharps were appropriate and in

line with best practice guidelines. The person in charge had ensured standard operating procedures were in place for their management and disposal of sharps boxes as required.

The provider had ensured appropriate fire safety precautions were in place. The centre's fire alarm was serviced on a quarterly basis, emergency lighting had also been serviced and fire extinguishers had received an annual service and check. Fire drills were carried out monthly and a night time evacuation drill had been carried out in the centre to assess if arrangements in place were appropriate. Overall, it was demonstrated that residents could be evacuated in the event of an emergency in a timely way.

Regulation 13: General welfare and development

The increased staffing resources had ensured residents were provided with appropriate care and support having regard to their assessed needs. For example, it was demonstrated that residents no longer required behaviour support plans in place to manage behaviours that challenge because their assessed needs could be better met. Residents told the inspector they had greater choice in their daily lives which they said was important to them and made them happier.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured residents were provided with a pleasant, homely environment which met the assessed needs of residents. Residents had decorated their home and bedrooms in line with their personal style and interests. Accessibility arrangements had also been instated to ensure all residents' mobility needs were provided for.

Judgment: Compliant

Regulation 26: Risk management procedures

An up-to-date health and safety statement was in place. An up-to-date risk register was also maintained in the centre. Overall, risks and hazards were managed to an appropriate standard in this centre. The person in charge ensured an up-to-date risk register was in place which captured all environmental and personal risks in the centre.

Risk of absconding was a personal risk feature in this centre. An emergency plan

and mental health support planning was also in place to manage and mitigate this risk. The provider was required to continue to review control measures in place if a change of staffing resources occurred.

Judgment: Compliant

Regulation 27: Protection against infection

It was demonstrated that sharps were appropriately managed in this centre. Residents were supported to manage this arrangement in line with best practice infection control procedures. Standard operating procedures were also in place to guide staff in appropriate infection control management.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety and containment systems in this centre were found to be compliant. A fire alarm was in place and had received a quarterly service as required. Fire safety equipment was also present in the centre and had also received necessary servicing with service reports maintained in a fire safety register in the centre. Fire drills occurred each month and demonstrated residents understood what to do in the event of the fire alarm sounding. Fire safety risks associated with cigarette smoking was risk assessed and managed appropriately in the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medications were securely stored in the centre. Each resident had their own pharmacist and regular medications were supplied to the centre in pre-dose blister packs with PRN (as required) medications supplied separately. Medication administration and recording charts were clearly documented and up-to-date. Maximum doses for PRN medications were clearly documented and each medication was individually signed by the prescribing physician on residents' medication administration charts. Staff administering medications had received training in in safe medication administration procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had received an up-to-date annual assessment of need. There was evidence of allied health professional recommendations incorporated into residents' personal plans where required to guide care planning development and evidence based supports for residents.

Person centred planning was of a very good quality and residents had achieved a number of personal goals this year. Each personal goal plan had an associated action plan in place, a time-line for achievement and a person responsible to support the resident identified.

Personal planning in this centre was managed to a high standard.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve their best possible physical and mental health. Each resident had received an annual health check with their General Practitioner (GP). Where a health need was identified an associated support plan was in place to guide staff in how to support the resident. Residents were supported to avail of preventative health checks and attend hospital appointments as required. Staff had received training in management of diabetes.

Judgment: Compliant

Regulation 7: Positive behavioural support

Due to changes in resource arrangements residents no longer required behaviour support management plans. This evidenced residents assessed needs were being met to a better standard. The provider had ensured where required appropriately qualified and experienced allied health professionals were available to provide evidence based supports in relation to positive behaviour support if required. Residents were also linked to mental health and psychiatry services if and when required and were supported to attend appointments and reviews as required.

Staff had received training in the response and management of behaviours that challenge.

A restraint register was in place. Overall, a restraint free environment was

promoted.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured there were appropriate safeguarding reporting mechanisms in place for the reporting and responding to allegations of abuse. Contact details of designated persons assigned to the centre were on display in the centre.

At the time of inspection there were no safeguarding allegations under review. Residents spoken with told the inspector they felt safe and could tell any member of staff if they were unhappy. Staff spoken with demonstrated an understanding of safeguarding reporting procedures.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sunny Gardens OSV-0005299

Inspection ID: MON-0024591

Date of inspection: 18/09/2018

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: The Service Provider submitted a NF31 on 24th September as notification of the change in PPIM of this Centre which was to occur on 1st October. The service Provider will ensure any further Notifications are submitted in the required timeframe.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider has liaised with the local Disability Officer in the HSE and has submitted a business case to fund the extra resources required to ensure supports remain in place to meet the assessed needs of all residents. The Senior Manger has monthly meetings with the Disability Officer which the business case will be reviewed.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Service Provider submitted an up to date Statement of Purpose on 11th October which reflects the changes in Management of this Centre. The statement of Purpose will be reviewed yearly or before should there be any changes.	

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
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.	Not Compliant	Orange	24/09/2018
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	11.10.2018