Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	The Anne Sullivan Centre
Name of provider:	The Anne Sullivan Centre CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	11 June 2019
Centre ID:	OSV-0001388
Fieldwork ID:	MON-0022427

About the designated centre

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

The centre was established specifically to meet the needs of people who are deafblind. The centre provides a residential service to a maximum of 12 residents at any one time who are deafblind with multi-sensory disabilities. The centre comprised of four houses and two apartments, all within a cul-de-sac in a residential area in a suburb of Dublin. The centre was in located a short distance from a range of shops, restaurants and public transport. Each of the residents had their own bedrooms which had been personalised to their own tastes. A number of the residents had their own kitchen and living room area whilst other residents shared these areas. Each of the houses and apartments had a kitchen and living room area. There was a communal garden and then each of the houses had their own garden to the rear of the house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 June 2019	09:30hrs to 17:30hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with five of the twelve residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. None of the residents were able to tell the inspector their views of the service. However, warm interactions between the residents and staff caring for them were observed. From these observations, it was evident that staff and residents were effectively able to communicate with each other. Each of the staff wore a personalised bracelet or watch which residents were observed to seek out in order to identify who was interacting with them. Residents had their own bedrooms and individual living spaces which had been personalised to their own tastes.

Each of the residents had an individualised and personalised programme with one-to-one staffing in place for each of the residents. Activities which individual residents were reported to enjoy included; cooking, horse riding, swimming, movement and well being classes, music therapy, dancing and arts and crafts. Three of the residents, with the support of staff, had departed on the morning of the inspection for a holiday in Scotland and another resident was scheduled to depart on a short break the day after this inspection. In addition, at the time of inspection another resident was abroad on holiday with relatives.

There was evidence that residents and their family representatives were consulted and communicated with, on decisions regarding their care and the running of their house. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits. The inspectors did not have an opportunity to meet with the relatives of any of the residents but it was reported that they were happy with the care and support their loved ones were receiving. The provider had completed a service user satisfaction survey in 2018 which indicated that residents and their family representatives were happy with the quality of care provided in the centre.

On the day of inspection, preparations were underway for an open day the following Saturday, with entertainment and a barbecue, for residents with their friends and family.

Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs.

The purpose of this inspection was to inform an application by the provider to renew the registration of the centre and a separate application to vary the conditions of the centres registration so as to increase the numbers living in the centre from 12 to 13.

The centre was managed by a suitably qualified, skilled and experienced person who had an in-depth knowledge of the needs of each of the residents. The person in charge who also held the title of chief executive officer had taken up the position in December 2015. Prior to taking up this position, she had worked for more than 13 years in management positions in other organisations. She held an advanced diploma in child protection and welfare, a higher diploma in education and a degree in psychology. She was in a full-time position and was not responsible for any other centre. She was found to have a sound knowledge of the requirements of the regulations and standards. Staff members spoken with, told the inspector that the person in charge supported them in their role and promoted a person centred approach to the delivery of care.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by a social care leader, a quality improvement manager, policy and advocacy lead, and a human resource manager. There were five team leaders in place who reported to the social care leader. Residential support workers in turn report to an identified team leader. The person in charge reported directly to the board of the organisation and was required to submit a monthly report to the board on operational and strategic matters. The person in charge formally met with the chair of the board at regular intervals.

An annual review of the quality and safety of care and six-monthly unannounced visits as required by the regulations had been undertaken. The provider had recently commissioned an external company to complete an audit of medication management practices and healthcare plans. There was evidence that actions were taken to address issues identified in these audits. There was evidence that other audits were undertaken in the centre and acted upon. Examples of audits completed included, medication practices, health and safety, fire safety, incidents, hygiene and personal folders.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were not in place, with one whole-time-equivalent staff vacancy at the time of inspection. A number of new staff members had joined the staff team since the last inspection following a suitable induction. The inspector reviewed a sample of staff files and found that they contained all of the information as required by the regulations. There were 15 volunteer bus drivers working in the centre. Appropriate recruitment and vetting arrangements were found to be in place for these volunteer. A volunteer coordinator was in place to provide supervision and support.

Training had been provided to staff to support them in their role of caring for deafblind people and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the quality improvement manager. Training records showed that staff were up to date with mandatory training requirements.

Suitable staff supervision arrangements were in place. The inspector reviewed a sample of staff supervision files and found that supervision in the preceding period had been undertaken in line with the frequency proposed in the providers policy. Supervision undertaken was found to be of a good quality. This was considered to support staff to perform their duties to the best of their abilities.

Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

The staff team were considered to have the required skills and competencies to meet the needs of the residents living in the centre. However, there was one staff vacancy at the time of inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents and to support staff in their role of caring for deaf blind people. Suitable staff supervision arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 30: Volunteers

Volunteers working in the centre had been appropriately recruited and were supported and supervised.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality, person centred and promoted their rights. However, improvements were required to the maintenance and upkeep of the centre.

Each of the four houses and two apartments were found to be clean, homely and comfortable. However, significant improvements were required in relation to the maintenance and upkeep of a number of areas. These areas for improvement included: flooring in a number of areas was worn and in need of replacement, chipped paint on woodwork and walls in some areas, stained grouting in a number of bathrooms and damage to the kitchen and counter tops in one of the houses. An outside ground trampoline was obsolete and required removal. Each of the houses had an individual back garden and there were communal garden areas with seating and sensory planting for residents to enjoy.

Residents' personal plans were found to be person-centred. Each resident had a comprehensive assessment of need in place which was reviewed and updated in line with their changing needs. Support plans were in place which were informed by assessments of need and personalised to each resident. There was an annual person centred planning meeting with the involvement of family representatives and the resident where the effectiveness of plans in place were reviewed with progress in reaching goals set the previous year being established, and and goals for year ahead agreed. There was a separate multidisciplinary team annual review for each resident.

There were appropriate practices in relation to keeping residents safe and protecting them from abuse. Staff had access to training to support them to carry out their roles and responsibilities in relation to safeguarding residents. Staff who spoke with the inspector were knowledgeable about their responsibilities regarding safeguarding and how to escalate concerns. Residents had intimate care plans in place with a good level to guide staff in meeting the intimate care needs of the individual residents. Staff were observed to treat residents with dignity and respect and to advocate on their behalf. The provider had a safeguarding committee in place with internal and external expertise as part of its membership. In addition there was a rights committee who met at regular intervals.

Residents were provided with appropriate emotional and behavioural support. There were a small number of residents who presented with some challenging behaviour which had the potential to be difficult for staff to manage in a group living environment. However, at the time of this inspection it was found that the assessed needs of residents were being appropriately responded to. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual residents. There was evidence that plans in place were regularly reviewed by the provider's psychologist and behaviour support specialist. Regular positive behaviour support disciplinary meetings were held to discuss individual residents and support plans in place. There were high staffing levels in the centre with one to one staffing to support residents during the day. A restrictive practice register was maintained and there were quarterly reviews of all restrictive practices by the providers restrictive practice committee.

The health and safety of residents, visitors and staff were promoted and protected. There was a risk management policy. The inspector reviewed individual risk assessments for the residents which contained a good level of detail, were specific to the resident and had appropriate measures in place to control and manage the risks identified. There was a safety statement, with written risk assessments pertaining to the environment and work practices. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There was a computerised incident reporting system in place. Incident reviews were completed on a monthly basis in each of the houses at team meetings chaired by the team leader assigned to each house. An incident review meeting occurred on a quarterly basis to review incidents across the centre. The quality improvement manager reviewed trends of incidents across the service.This promoted opportunities for learning to improve services and prevent incidences.

Precautions were in place against the risk of fire. There was a fire safety policy. A fire risk assessment had been completed. There was documentary evidence that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures and had received appropriate training. Fire drills involving residents had been undertaken at regular intervals. There were high levels of staffing in the centre to support residents to evacuate in the event of fire.

Resident's healthcare needs were met in line with their personal plans and assessments. Residents health needs were appropriately assessed and met by the care provided in the centre. A general practitioner (GP) visited the centre on a two weekly basis. A composite health assessment and plan was in place for each of the residents which had been signed by their GP. Each of the residents had their own general practitioner (GP). An out of hours GP service was also available. In addition a registered nurse visited the centre on a two weekly basis. The provider had a wound management committee in place who reviewed the care and management of wounds. This promoted opportunities for learning to improve wound management practices.

Residents were provided with a nutritious, appetising and varied diet. There was a chef working in the centre number of days each week. Dietician assessments had been completed for residents identified to require same. There was regular monitoring of residents weights. Each of the houses and apartments had a suitable dining area.

There were systems in place to ensure the safe management and administration of medications. However, assessments to assess the ability of individual residents to self manage and administer medications had not been undertaken for all residents. An assessment had been completed for one resident and based on that assessment they were responsible for the administration of their own medications. Individual medication management plans were in place. A medication management policy was in place. There was a secure cupboard for the storage of all medicines. All staff had received appropriate training in the safe administration of medications. There were systems in place to review and monitor safe medication management practices. Counts of all medications were undertaken on a regular basis. Audits of medication practices were undertaken in each of the houses by the assigned team leader on a two monthly basis. There were procedures for the handling and disposal of unused and out of date drugs. A record was maintained of all unused and out of date medications returned to pharmacy. An external company had recently completed a review of medication management practices and there was evidence that actions were taken to address issues identified in this review.

Residents' communication needs were met. There was a strong focus on communication which was considered a fundamental requirement for the residents. Each of the 12 residents living in the centre were non-verbal, deaf and blind or significantly visually impaired. There was a policy on communication. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. Each of the residents had a communication profile in place to guide staff. Residents' sensory abilities and strengths had been assessed with sensory support needs identified. An active use and promotion of different means of communication pertinent to each resident was promoted. Communication methods and tools observed in use, included hand over hand sign language, communication schedule boards, 'swell' symbols. picture exchange and object of interest. These were used to assist resident to choose diet, activities, daily routines and journey destinations. One of the residents used Brail and there were some supports in place specifically for this resident. Each of the staff wore a personalised bracelet or watch which residents were observed to seek out in order to identify who was communicating with them.

Regulation 10: Communication
Residents' communication needs were met.
Judgment: Compliant

Regulation 17: Premises
Each of the four houses and two apartments were homely, clean and comfortable. However, significant improvements were required in relation to the maintenance and upkeep of a number of areas.
Judgment: Not compliant

Regulation 18: Food and nutrition
Residents were provided with a nutritious, appetising and varied diet.
Judgment: Compliant

Regulation 26: Risk management procedures
The health and safety of residents, visitors and staff were promoted and protected.
Judgment: Compliant

Regulation 28: Fire precautions
Precautions were in place against the risk of fire.
Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications. However, assessments to assess the ability of individual residents to self manage and administer medications had not been undertaken for all residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' personal plans were found to be person-centred and to be effectively reviewed in line with the requirements of the regulations.

Judgment: Compliant

Regulation 6: Health care

Residents healthcare needs were being met by the care provided in the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Regulation 8: Protection

There were appropriate practices in relation to keeping residents safe and protecting them from abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially 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 The Anne Sullivan Centre OSV-0001388

Inspection ID: MON-0022427

Date of inspection: 11/06/2019

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 Centre has initiated a comprehensive recruitment campaign and is actively recruiting for quality staff to join the service. We have engaged the services of a HR company to support us in this campaign. As a service provider we are very cognisant of the need for service users to have consistent and familiar staff and thus do not employ agency staff. The service operates an in house relief panel from which we draw off when permanent staff are on leave. We are also currently seeking to recruit additional staff for our relief panel. Date to be fully compliant 30th September 2019	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The Centre has a refurbishment plan in place and is actively working through this plan. The areas highlighted in the Inspection Report have been added to the plan and all items will be addressed as a matter of priority. A refurbishment plan has already been forwarded to HIQA for their consideration. Date to achieve full compliance 30th September 2019	

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 Centre avails of the services of a consultant GP and pharmacist to ensure that the service user’s medicines and pharmaceutical support needs are met. Since the inspection an assessment of each resident’s ability to self-manage and administer their medications has been undertaken for all residents and are now on file.

We are now compliant with Regulation 29.

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	30/09/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and	Substantially Compliant	Yellow	09/07/2019

	assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			