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:	Parknasilla
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	01 August 2019
Centre ID:	OSV-0001691
Fieldwork ID:	MON-0025046

About the designated centre

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

This is a centre that can provide residential services for up to ten adults with disabilities (both male and female). It is located in Co. Wicklow within walking distance of a large town which provides access to a range of community based amenities to include hotels, restaurants, pubs, parks, shops and shopping centres. The centre comprises of two large houses on the same street. Each resident has their own individual bedroom, decorated to their individual style and preference. Communal facilities are provided including kitchen/dining room, sitting rooms, visitors' room and a TV room. The centre is staffed with an experienced and qualified person in charge. The person in charge is supported in their role by a team of qualified social care workers. Residents are also supported to experience best possible health and have access to a range allied health care professionals, as required to include General Practitioners and clinical services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
01 August 2019	12:30hrs to 19:30hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

The inspector met and spoke with a number of residents during the inspection. Residents told the inspector that they liked where they lived and felt that they had a comfortable home with good support from the person in charge and the staff team. Residents also said they where very happy with the location of the centre, with local shops, pubs and travel routes which were within easy walking distance. Some residents told the inspector how the staff team were supporting them to gain more independence, for example, helping residents to understand the value of money. Other residents showed the inspector photographs of their achievements and goals. Residents who spoke with the inspector said that they knew how to raise a complaint or concern, and felt they could easily speak to any member of the staff team if necessary.

The inspector observed residents preparing and cooking their own meals for dinner. Residents appeared comfortable and relaxed in their own home, engaging with other residents and staff and making decisions about their day, for example, choosing when to spend time alone, or choosing to go out independently.

Capacity and capability

The provider and person in charge demonstrated capacity and capability to operate a safe and good quality person-centred service for residents living in this designated centre.

There was a clearly defined management structure and monitoring systems in place which reviewed the standard of the care and support delivered to residents. The person in charge demonstrated effective oversight of the individual needs of residents, the care and support they received and the day-to-day operation of the designated centre. The person in charge carried out monthly audits in areas such as housekeeping, documentation, care planning, health and safety and staff knowledge. The provider had made arrangements for an annual review of the centre in addition to six-monthly unannounced visits that assessed the standard of the care and support being delivered.

While the local management and monitoring systems were effective, improvements were required to ensure the provider carried out identified actions that were raised through Health Information and Quality (HIQA) inspections or unannounced provider-led audits in order to bring about positive changes. Actions that could be addressed by the staff team, person in charge or senior manager were seen to be done in a timely manner. However, actions that required input or resources from the

provider had not all been addressed, or took significant time to carry out.

In September 2018 the provider had a restricting condition applied to their certificate of registration. This additional condition required the provider to address non-compliance in relation to fire containment and risk management by an agreed time-line. The provider had failed to take the agreed action by the time line of February 2019 and had applied to the Chief Inspector to extend the deadline of the additional condition until the end of July 2019. On the day of inspection, the inspector observed fire doors had been installed, confirming suitable fire containment measures were now in place in the designated centre. The installation of these doors had occurred the week prior to the inspection. Further documentary evidence was submitted following the inspection to verify that the containment measures were fit for purpose and had been installed by an appropriate professional.The provider had adhered to the matters of their additional condition of registration.

However, further improvements by the provider were required. The provider had committed, in the previous HIQA inspection action plan, to address the garden pathway in the front of one of the homes which was on a slope and had previously been identified as posing a risk for some residents who were at risk of falls. While the provider had taken the action as described in their compliance plan response from August 2018, and had begun to make arrangements to deal with this, on the day of the inspection the pathway had not been addressed. There was no set time frame or end date for this work to occur. This had been raised in the most recent provider- led audit in March 2019 with iimprovements to the pathway had also been recommended by an allied health professional.

In the designated centre, there were clear lines of reporting, accountability and management. The management structure of the centre and the wider organisation was known to residents and staff members. The person in charge was supported in his role by a deputy manager who worked in this role for eight hours a week. The person in charge reported to, and was supervised by a senior services manager. At the time of the inspection, the organisation was recruiting for the role of Chief Executive Officer which was vacant. The provider had submitted a plan to the Chief Inspector outlining how this role would be filled, and improvements that would be made overall to improve the governance and management of the organisation at a provider level. This plan included improvements to the pathway of information about each designated centre to the provider, and tools that would be used to monitor and scrutinise information about designated centres and the care and support that they deliver.

Records of supervision, performance and management meetings between the person in charge and senior manager were maintained, and the inspector found there to be a clear agenda and follow up on any issues discussed. The person in charge held staff meetings with the team every two weeks, and these meetings were well attended, well recorded and had a clear plan of action to ensure continuous improvement in key areas regarding residents' care and support. Staff were appropriately supervised, both in a day to day capacity and through formal

one-to-one meetings by the person in charge.

There was a stable and consistent staff team in place, with an additional position currently being recruited for a set amount of hours each month. The person in charge had identified this increase as beneficial to enhance to supports currently in place. All staff working in this centre were suitably qualified, skilled and experienced in social care. The inspector reviewed training records and spoke with some staff, and found that there was a system in place to ensure all staff received training in mandatory fields, as determined by the provider. Refresher training was available for staff, as guided by the provider's policy. The person in charge had good oversight of the training needs of the staff team, and took measures to ensure staff had training that was relevant to their role, and kept up to date. Planned and actual rosters were maintained by the person in charge. Staff working in this centre, also supported four people who lived independently in apartments located close by. This had been reflected clearly in the working rosters to demonstrate duties and responsibilities during the course of a working week.

Overall, the person in charge and provider demonstrated that they had the capacity and capability to operate a safe, and good quality service. With some improvement required at provider level to ensure timely action and response was taken to address identified issues.

Regulation 15: Staffing

The provider has ensured that the number and qualifications of the staff team were appropriate to the number and assessed needs of residents, the statement of purpose and the layout of the centre.

Residents received continuity of care from a stable and consistent staff team employed by the provider.

The person in charge maintained a planned and actual staff roster, which clearly reflected the hours worked in the designated centre, along with any additional responsibilities of the staff team.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had good oversight of the training requirements and achievements of the staff team. There was a system in place to provide for mandatory training on a routine basis, as guided by the provider's policy. Staff had access to refresher training when this was required.

The person in charge had ensured effective supervision was in place, both informal supervision of the day to day practice along with formal one to one meetings with each staff on a three monthly basis. Staff meetings were held on a two weekly basis and were well attended.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre and the organisation overall. Any vacant posts were currently being recruited by the provider.

The inspector found that there was good local oversight in the designated centre and effective systems of reviews and audits to monitor the quality and standard of the care and support being delivered to residents.

The provider had completed an annual review along with six-monthly provider-led visits, which were unannounced, to monitor the safety and quality of the care and support provided. These reviews and visits generated an action plan to address any concerns. While the audits and reviews in general, identified that the centre was providing a good quality and person-centred service, there were outstanding actions that the provider had not yet addressed. These actions had also been raised at previous HIQA inspections also.

Judgment: Substantially compliant

Quality and safety

The provider and person in charge demonstrated that they had the capacity and capability to operate and manage the designated centre in such a way that was resulting in a good quality and person-centred service for the residents living in the designated centre.

Residents told the inspector about how they spend their time and the various different activities they took part in and roles that they had. All residents living in the centre had access to a day service if they wished to avail of one. Some residents were in paid employment and others were working on increasing their skills in order to secure a job in the future. Residents living in the centre were active members of their local community, and spent time outside of the organisation and without the need for staff support.

Residents decided on the menu for their meals each week, and all residents

contributed to shopping, preparing and cooking meals in the designated centre, if they so wished. Residents were supported to understand how to make healthy choices when preparing their meals, and also enjoyed eating out in pubs, restaurants and coffee shops.

Residents living in the centre were comfortable raising any issue with the staff team and voicing their opinion on the centre and the supports provided. Residents held monthly house meetings to discuss any issues and make certain decisions about the centre. Residents appeared aware of their rights. An independent advocate was also available to residents in the centre for any time they felt they needed extra support, and could offer advice or guidance to the staff team if required. Some personal plans reviewed were focused on promoting residents' rights and ensuring a balance between keeping people safe, and ensuring residents could make their own choices.

Residents told the inspector that they felt safe living in the designated centre. There was a security alarm in place, staff were available on sleep over duty each night and residents knew what to do in the event of an emergency. Residents also used their mobile phones to keep in touch with the staff team when they were out, in case they needed support or help. Residents were aware of who to talk to if they had a concern and information on the designated officer was on display in the centre. Staff had received training in safeguarding vulnerable adults, and residents could avail of training in understanding relationships.

There was a system in place to assess and plan for residents' health, social and personal needs. Residents had yearly health and well-being assessments along with a yearly assessment of their personal and social needs and preferences using a recognised tool. From a review of a sample of residents' records, the inspector noted health issues or personal development preferences, that were identified through the assessment process, had a relevant personal plan to outline the individual supports required to address them. Information in the personal plans was up-dated following a review, or a change in information. Some residents showed the inspector photographs of their achievements from their previous personal plan and told the inspector of the different things that they were working on as part of their personal development.

Residents had access to their own General Practitioner (GP), and were supported to avail of additional allied health professionals through referral to the primary care team or to allied health professionals provided by Sunbeam House, for example, physiotherapy, social work and counselling. Residents had access to psychiatry and psychology services as required. Where residents presented with behaviour support needs, clear behaviour support planning was in place to support staff to positively manage residents' presenting behaviour. These plans were reviewed by members of the allied health team.

The designated centre comprises two houses. Each house offered residents their own private bedroom, suitable communal spaces, such as living rooms, dining room, sun rooms or TV rooms and adequate bathroom facilities. The two houses were nicely decorated, homely and located within walking distance of a large town and

amenities. Residents were encouraged to be as independent as possible, and a number of residents spent time outside of the centre without requiring staff support.

Residents told the inspector that they liked their bedrooms and the house in general, and enjoyed how close it was to shops, pubs and travel links. One home was a period type property, which offered residents bright rooms, high ceilings and was a unique and pleasant environment. However, this building required additional attention in order to keep it in a good state of repair. Staff were involved in carrying out regular household cleaning duties on a daily and weekly basis with the predominant focus of their time spent engaging and supporting residents as was required.

It was noted there was limited time available for staff to address larger household chores. The provider was required to review what additional supports were required to ensure these larger household chores could be responded to in order to maintain the overall upkeep of the premises without impacting on staff time supporting residents assessed needs. Due to the lay out of the premises, the provider would also be required to continuously assess the suitability of the centre in meeting residents' needs as they got older, or should their needs change. For example, there were three flights of stairs, and steps down into the kitchen area. That being said, at the time of inspection residents appear comfortable in their home and could access all parts of the centre with ease.

There was a risk management policy in place and the person in charge maintained a risk register for the designated centre. There was an escalation pathway so that risk rated above a particular rating was discussed with the senior manager and monitored and reviewed more frequently. Similarly, there was a system in place to record, review and respond to any incidents or adverse events that occurred in the designated centre, for example, falls or medicine errors.

The inspector found that there were fire safety systems in place in the two homes of the designated centre. There was a fire detection and alarm system in place, emergency lighting, identified fire exits and fire fighting equipment in place. All systems and equipment were seen to be serviced and checked regularly by a relevant professional, and records were maintained. Emergency evacuation drills were completed routinely and included deep sleep evacuation drills to ensure all residents and staff knew what to do in the event of an emergency. Staff had also completed training in fire safety.

The provider had recently arranged for fire doors to be installed in the centre in order to improve the fire containment measures. These doors were in place on the day of inspection. Some of the rooms that were frequently used by residents had the doors held open by furniture or door stoppers to assist with residents access and preferences. While it was recognised staff were implementing arrangements to support residents to move about their home as independently as possible, these arrangements impacted on effectiveness of the newly installed fire doors to contain smoke and fire. The provider was required to review these arrangements and put measures in place to ensure residents could continue to freely move about their home but in a way that did not impact on the containment measures offered by the

fire doors that had been recently installed.

Overall, the inspector found that residents were in receipt of a safe, good quality service that was meeting their individual and collective needs.

Regulation 13: General welfare and development

Residents were in receipt of appropriate care and support that was in line with evidence-based practice and individual needs.

Residents had access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and preferences.

Residents were encouraged and supported to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Residents were supported to learn skills that would enhance their independence and abilities.

Judgment: Compliant

Regulation 17: Premises

While the two homes that make up the designated centre were comfortable, homely and well located the provider had not ensured that all parts of the premises were kept in a good state of repair and were kept clean:

- The centre had some dust and debris following the installation of fire doors

- general maintenance was required of plaster work and paint work

- Deep cleaning was required for cloth furniture and couches

- The small garden court yard area in one home was not well maintained, not easily accessible and was used as storage space for items

- The garden pathway at the front of one of the homes had not yet been addressed by the provider to ensure an even surface that was safely accessible for all residents.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were supported to buy, prepare and cook meals of their own choosing.

Residents were encouraged to make healthy choices, and understand food and nutrition.

There were adequate provisions for the storage of food and drinks.

Residents had choice at mealtimes, and received assistance (if required) with eating and drinking.

Residents had access to meals, snacks and refreshments at any time.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured there was a risk management policy in place in the designated centre and a policy on incident management. There was a written emergency plan in the designated centre.

Risks were clearly identified, assessed, reviewed and responded to and there was good oversight of risk through the use of a risk register. The person in charge demonstrated that control measures to alleviate risks were reasonable and proportionate and respectful of residents' wishes and rights.

There was a system in place to review and escalate risk in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured that effective fire safety management systems were in place in the designated centre, and had taken action to improve the fire containment arrangements.

While it was recognised staff were implementing arrangements to support residents to move about their home as independently as possible, these arrangements impacted on effectiveness of the newly installed fire doors to contain smoke and fire. The provider was required to review these arrangements and put measures in place to ensure residents could continue to freely move about their home but in a

way that did not impact on the containment measures offered by the fire doors that had been recently installed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a system in place to ensure residents' health, social and personal needs were comprehensively assessed and planned for in the designated centre.

Personal plans were reviewed regularly and developed through a person centred approach with the participation of residents.

Advise from allied health professionals or other multi-disciplinary team members was incorporated into personal plans, and reviewed regularly by the relevant professional.

Judgment: Compliant

Regulation 6: Health care

Residents were provided with appropriate health care as outlined in their personal plans.

Residents had access to their own General Practitioner along with access to allied health professionals through referral to the primary care team, or to allied health professionals made available by the provider.

Judgment: Compliant

Regulation 8: Protection

Residents felt safe living in the centre and were aware of who to talk to if they had a concern. Information on the designated officer along with contact details were on display in the designated centre.

Staff had received training in safeguarding residents and the prevention, detection and response to abuse. Some residents had completed training in understanding relationships.

The person in charge was aware of their responsibilities to investigate any

safeguarding concerns, and how to report any concerns in line with national policy.

Judgment: Compliant

Regulation 9: Residents' rights

Decisions about residents care and supports were done through a person-centred approach.

Residents had freedom to exercise choice and control in their daily lives.

Residents had access to advocacy services, when required.

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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Parknasilla OSV-0001691

Inspection ID: MON-0025046

Date of inspection: 01/08/2019

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Resurfacing of front of Parknasilla house will be completed by end of Quarter1 2020.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The internal doors will be snagged and completed by November 1st 2019. Painting of fire doors will be completed by end of Quarter 1 2020. Painting of Communal areas of Parknasilla house. Sitting room, hall and communal areas will be completed by the end of Quarter 1 2020. An external cleaner will be engaged to provide a service on a fortnightly basis. This will commence in November 2019. Cleaning of Soft furnishings will be completed by October 15th 2019. Resurfacing of front of Parknasilla house will be completed by end of Quarter 1 2020.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Closers will be fitted to fire doors and connected to fire alarm to provide ease of access to public areas of 3a Vevay while providing appropriate fire containment and will be installed by 31st of December 2019.	

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 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.	Substantially Compliant	Yellow	31/03/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2020
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of	Substantially Compliant	Yellow	31/03/2020

	purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2019