Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Bella Vista
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Short Notice Announced
Date of inspection:	12 March 2020
Centre ID:	OSV-0001701
Fieldwork ID:	MON-0026857

About the designated centre

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

Bella Vista is a large community house located in a housing estate with a total of nine bedrooms. The centre provides residential supports for up to eight adults, both male and female, with low to moderate supports needs. The centre is intended to support residents to live as independently as possible. The current staffing compliment is made up of social care workers and care assistants with the staff team supervised by a Client Service Manager. There is currently a whole time equivalent of 9.54 staff required to support residents in line with their needs. The support provided to residents varies depending on individual needs and requirements. All residents are involved in a community based day programme.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Thursday 12 March 2020	11:30hrs to 17:00hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

The inspector met and spoke with six of the eight residents who lived in the designated centre. Residents were returning from their day services and places of employment over the course of the inspection.

Residents who spoke with the inspector, said that they felt safe and comfortable living in the centre and that in general they liked who they lived with and were very happy with their bedroom and personal space. Some residents showed the inspector their bedroom, these were seen to be decorated in line with residents' wishes, with access to a television and DVD player. Residents' bedrooms had photographs and items of sentimental value to individuals, and their bedroom could be locked for privacy when they were not at home. Residents had adequate space for personal belongings and clothing.

The inspector observed residents using their environment with ease, making themselves meals and beverages and chatting to each other. The inspector found that interactions between staff and residents were friendly and respectful. Residents were encouraged to make their own decisions, and to do things for themselves if possible. The inspector saw staff supporting and encouraging residents to achieve personal goals that were important to them, such as making contact with their natural supports and using different communication methods to do so.

The inspector observed a homely atmosphere, with residents' art work and photographs on display throughout the house.

Capacity and capability

The inspector found that the provider and the person in charge had the capacity and capability to operate this designated centre in a way that was meeting residents' needs, was of good quality and ensured a person-centred approach to care and support. While some areas were in need of improvement, these had been identified either through the provider's auditing system, or identified by the person in charge since commencing their role in August 2019.

There were clear lines of reporting, accountability and management. There had been a change in the person in charge in August 2019, which had been notified to the Chief Inspector as required by the regulations. The designated centre was found to be managed by a suitably qualified and experienced full-time person in charge. There was a clear management structure in place in the designated centre, with the person in charge reporting to a senior services manager, who reported to the Chief Executive Officer (CEO). The senior services manager met with the person in charge

every two months to review the designated centre using a governance, management and performance template. This ensured effective follow up of any issues and demonstrated accountability for the quality and safety of the care being delivered in the designated centre.

There were monitoring systems in place which reviewed the standard of the care and support delivered to residents in the designated centre. 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 and staff team 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. The inspector reviewed the findings of the last two six-monthly review with the person in charge. The reviews on behalf on of the provider were comprehensive and assessed against the regulations and standards. The most recent audit identified some further areas for improvement such as extending the fire containment measures in the centre, addressing some repair work to the premises, and the requirement for a second living space for residents. While some of these actions remained in need of address, the person in charge had requested this from the relevant departments.

There was a transparent system in place to record accidents, incidents and other adverse events in the designated centre. There was evidence of effective oversight of adverse events, with the person in charge and the senior manager reviewing each individual incident. There was also a system in place to review adverse events on a quarterly basis, in order to identify any patterns or emerging trends. This information was used to continuously improve the quality and safety of the service being provided.

The person in charge held responsibility for two designated centres operated by the provider. It was noted there were adequate operational management and oversight systems in place for this arrangement.

Records of supervision, performance and management meetings between the person in charge and senior manager were maintained. The person in charge held regular staff meetings with the staff team that focused on 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. There was an adequate number of staff on duty each day and night to meet residents' assessed needs, in line with details of the written statement of purpose. However, some improvement was required to ensure that the actual staffing supports available were based on clear assessments of residents' needs. For example, some residents had one to one staff support during the week, but did not have this available at the weekends. The person in charge was ensuring that the staffing hours were managed in a way that

offered more choice to residents, and supported their daily and weekly activities and social roles. There was an actual and a planned roster in place, however some improvements were required to ensure these documents clearly reflected the staffing in place at all times.

Overall, the inspector found residents were happy with their home, felt supported and had active lives of their own choosing. This inspection found a high level of compliance with the regulations and standards, with any areas identified for improvement already captured through effective monitoring systems. The provider and person in charge had drawn up plans to address some of these issues at the time of the report.

Regulation 15: Staffing

In general, there was a stable and consistent staff team in place, with some temporary agency staff required to cover some sick leave or staff absences. The person charge was reviewing the staffing resources on a consistent basis to ensure residents' needs were being met.

Some residents were provided with one to one staff support for 12 hours each day midweek. However, this increased staffing was not been provided for at the weekends. There was an absence of a formal assessment to determine the actual staffing requirements for all residents each day in this regard.

The person in charge had made improvements in recent months to plan the resources in the designated centre in a manner that was better meeting residents' individual and collective needs. There was flexibility in the staffing resources to cover the choices and wishes of residents. However, some improvements were required to ensure the roster displaying the actual hours worked was demonstrating which staff were working in which location and the times of shifts.

Judgment: Substantially compliant

Regulation 23: Governance and management

This inspection found strong governance and leadership in the designated centre, with an increased focus on rights-based approach to care.

There was a clearly defined management structure in the centre and the organisation overall.

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.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a new person in charge of the designated centre in August 2019.

The person in charge worked full-time and was suitably skilled, experienced and qualified.

The person appointed was in charge of two designated centres and demonstrated effective governance, operational management and administration of the designated centre.

Judgment: Compliant

Quality and safety

The person in charge and provider demonstrated capacity and capability to operate the centre in a way that was meeting residents' health, personal and social needs, and provided a service that was of good quality. Some improvements were required to the fire safety systems and the premises.

Residents were supported to promote relationships with their natural supports, through visiting family or friends and spending time with them during the week or through phone calls, video calls and letters. Residents told the inspector about their lives, how they spent their days and the different social roles they had. Some residents attended formal day services where they could access employment support, skills teaching and a variety of activities.

There was a system in place to assess and plan for residents' health, social and personal needs. From a review of a sample of residents' records, the inspector noted health issues, that were identified through the assessment process, had a relevant personal plan in place to outline the individual supports required to address them. Residents' personal and social needs and wishes were identified through the use of an additional validated tool, and residents' had identified goals that they

wished to work on.

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 Services CLG, for example, physiotherapy, social work and counselling. Residents had access to psychiatry services as required. Where applicable, residents had access to National screening programmes relevant to their age and gender.

Staff had received training in safeguarding vulnerable adults and there was a clear pathway to be followed if residents, staff or families had any concerns or suspicions regarding residents' safety. The person in charge was aware of the reporting responsibilities for safeguarding concerns, in line with National policy, and the provider's own safeguarding procedures.

In general the person in charge and staff team were promoting a restraint free environment. There was no physical, chemical or mechanical restraints in place, residents had access to all parts of the designated centre. Some improvement was required to ensure the control measures for identified risks that were restricting for some residents were reviewed regularly, and validated in their use through clear assessments of residents' needs and a clear understanding of the underlying cause of unwanted behaviour. The person in charge and staff team were discussing this issue through team meetings, and seeking further information to ensure any restrictive control measures were regularly reviewed and that alternative measures that were least restrictive were considered first.

The provider had recently employed a behaviour therapist, to which residents could be referred if required for support with planning positive behaviour support. Staff were suitably skilled to support residents who may display behaviours of concern, and had received training in de-escalation and intervention techniques.

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 to ensure that identified risks, which were at a particular risk rating, were discussed with the senior manager and monitored and reviewed more frequently. There was a system in place to record, review and respond to any incidents or adverse events that occurred in the designated centre.

The designated centre had a fire detection and alarm system, emergency lighting, identified fire exits and fire fighting equipment. Fire safety management systems and equipment were seen to be serviced and checked regularly by a relevant professional, and records of these checks were maintained. Emergency evacuation drills were completed routinely which also included deep sleep evacuation drills to ensure all residents and staff knew what to do in the event of an emergency. Staff had completed training in fire safety. Residents told the inspector that they felt safe in the centre, and they knew what to do in an emergency situation. Fire containment measures were in place in some parts of the designated centre.

However, the provider was required to extend fire containment measures to other parts of the designated centre, and to ensure documentation was maintained to

verify the effectiveness of these measures. This was raised through a health and safety audit in October 2019. There was also a requirement for certain doors in the centre to be fitted with devices that would allow them to close in the event of a fire, as some doors were required to remain open to promote accessibility for residents.

The designated centre was a large house, with an apartment attached. It had a large living room, a kitchen/ dining room and residents had their own private bedrooms, which could be locked if they wished. There was a large back garden for residents to use in nice weather. Residents were seen to move around the environment with ease, and there was adequate facilities available for meal preparation, storage and laundry.

There were three rooms identified for staff use in the designated centre, two as sleep over rooms and one as a staff office. However, there remained a need for a staff computer desk and chair to be placed in the communal hallway of the designated centre, which limited space and did not promote a homely environment. The person in charge and staff team were considering the requirement for this going forward. The use of space in the designated centre required review to ensure adequate space was available for residents to meet visitors in private, and separate space for staff to complete tasks.

Overall, residents expressed satisfaction with their home and the support that they were given by the person in charge and staff team. While some areas were in need of address, residents were in receipt of safe and person-centred supports.

Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with evidence-based practice and with regard to the assessed needs and wishes.

Residents had access to meaningful occupation through their formal day services, employment support and continuous learning.

Residents were engaged in suitable and chosen activities of interest, in the designated centre and locally.

Links with family and natural support networks were supported and encouraged. For example, through visits, video calling and writing letters.

Residents had lives of their choosing and were active members of their community.

Judgment: Compliant

Regulation 17: Premises

Overall, the provider had ensured residents had a homely environment that was designed and laid out to meet residents' needs.

In general, the premises were of sound construction and kept in a good state of repair externally and internally. However, some internal repair and decorative works were required in the bathroom areas.

The designated centre was promoting accessibility with ramped entrance and downstairs bedrooms for residents who required them. There was guides along corridors to support residents with visual impairments.

While the majority of the matters in Schedule 6 of the regulations were met, some improvements were required in relation to the following:

- Adequate communal space. While there was a large living room with adequate seating for all residents, there were eight people living in this designated centre, and no identified second living space for residents to spend time apart or to see visitors in private. This was raised at the provider's last audit of the centre.

- There were three rooms for staff use in the designated centre, and a staff desk area in residents' hallway. This required review to ensure the available space in the centre was best used to meet residents' needs and wishes.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had put in place a risk management policy which offered clear guidance on the identification, assessment, management and response to risk in the designated centre.

In the designated centre, there was a positive approach to risk taking which did not impose on residents' independence. Residents were aware of any controls to manage risk that may restrict their independence.

There was a system in place to record adverse events or incidents and good oversight arrangements in place to ensure patterns or trends were identified, along with actions taken to reduce the likelihood of incidents reoccurring. There was a pathway in place to escalate risk to senior management and the provider, if necessary.

The person in charge and staff team were in the process of reviewing all risk control measures in place to ensure no control measures were overly restrictive.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had put in place fire safety management systems in the designated centre. There was a fire detection and alarm system in the designated centre, fire fighting equipment, emergency lighting, emergency exit lighting and some fire containment measures. Improvement was required to put extend fire containment measures to other parts of the designated centre, and to ensure documentation was maintained to verify the effectiveness of these measures. This was raised through a health and safety audit in October 2019. There was a requirement for certain doors in the centre to be fitted with devices that would allow them to close in the event of a fire, as some doors were required to remain open to promote accessibility for residents.

Equipment that was in place was checked and serviced by a relevant fire professional on a routine basis, and records of this were well maintained.

Staff had received training in fire safety, and this training was refreshed routinely. Evacuation drills were carried out at different times of the day and night to ensure all staff and residents could be safely evacuated in the event of an emergency. Residents knew what to do in the event of an emergency situation.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a system in place to assess and plan for residents' needs and these documents were reviewed regularly. Where a need had been identified, there was a written personal plan in place outlining how each resident would be supported in relation to it.

Assessments and plans in place were seen to be supporting residents to live a life of their choosing, with a focus on promoting independence and ability.

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.

Residents had access to national screening programmes in line with their age and gender.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had up to date knowledge and skills to respond to behaviour of concern, if required along with training in de-escalaton and intervention techniques.

In general, the person in charge and staff team were promoting a restraint free environment. Some improvements were required to ensure all restrictive interventions were reviewed regularly as part of the personal plan and all alternative measures were considered.

Improvements were required to identify and alleviate the underlying cause of certain behaviours, that were managed through restrictive means.

Judgment: Substantially compliant

Regulation 8: Protection

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

The person in charge was aware of their responsibilities to investigate any safeguarding concerns, and how to report any suspicions, allegations or concerns in line with national policy.

Residents felt safe living in the designated centre, and knew how to raise any concerns.

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	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bella Vista OSV-0001701

Inspection ID: MON-0026857

Date of inspection: 12/03/2020

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: 15(1) A formal assessment will be done to determine the actual staffing requirements for all residents each day. This will ensure the qualifications and skill mix of the staff is accurate to the assessed needs of residents in their home /community, and also any additional supports in the home for safety reasons. 15(4) The roster will be planned and will show staff on duty during the day and at night and this will be maintained by the CSM. A workforce planner has been completed. The organisation has ceased the use of Agency staff and will continue to do so until the Covid-19 pandemic is declared at an end by the government. The care of residents is being supplemented by day service staff and will continue during the pandemic.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 17(1)(b) The bathroom areas need repair: Maintenance request completed. 17(7) Adequate communal space: It is intended to move some resident's bedrooms around in the coming year due to changing support needs. This will incorporate the creation of a separate communal space for residents to spend time apart or to see visitors in private. Staff desk /computer in hallway: The staff desk and computer currently in the hallway will be moved to a more suitable place to ensure the available space in the center is best	

used to meet the needs of the residents.

Only emergency maintenance works are being carried out during the pandemic. The physical health of one resident with mobility difficulties has improved, however we are mindful the bathroom still requires repairs. A shower chair has been provided. This will be addressed when it is safe to do so.
A plan is in place to change residents' bedrooms to meet their assessed needs. A second sitting room will be created when it is safe to do so.

The computer will be moved when IT staff can enter the designated to run cables in another room.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire doors are required in some areas of the center. Also the glass area in the hallway needs to be considered and adjusted to ensure fire containing:

When the improvements are in place documentation will be maintained to verify the effectiveness of these measures.

Door guards to be installed in the doors where required so they can remain open to promote accessibility for residents.

Contractors are not permitted to conduct any works in the designated centre during the pandemic. However, there are several safety measures in place to mitigate the risk.
There is waking staff on duty at night.
There are no wedges holding fire doors open.
There is a serviced fire alarm in the designated centre.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
7(5)(a) All restrictive interventions have been reviewed and will continue to be on a regular basis.

A referral has been made to the new Psychologist in SHS for one resident. This will help

identify any underlying causes of certain behaviors and assist staff to alleviate and manage behavior through restrictive means if necessary.

7(5)(b) Before any restrictive practices are used all alternative measures will be considered

Bella Vista staff have been in consultation with the Human Rights Committee. Keyworker is scheduled to attend another HRC meeting on 3rd June 2020.
A referral has been made for resident with SHS Behavioural Therapist.

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	30/08/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/08/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and	Substantially Compliant	Yellow	30/12/2020

	kept in a good state of repair externally and internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/12/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/12/2020
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/10/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	30/10/2020