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:	Esmonde Gardens
Name of provider:	St Aidan's Day Care Centre Limited by Guarantee
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	12 and 13 April 2018
Centre ID:	OSV-0001855
Fieldwork ID:	MON-0020869

About the designated centre

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

The following information has been submitted by the registered provider and describes the service they provide. The centre was registered in 2015 to provide long-term care to 11 adults, both male and female, with diagnosis of mild to moderate intellectual disability, mental health, dual diagnosis behaviours that challenge and nursing care needs in one of the units. The centre comprises of two residential units and one standalone self-contained apartment. The residential units accommodate up to 3 and 7 residents respectively, while the apartment can accommodate one resident. The self-contained apartment was not occupied at the time of this inspection. All the units are suitable for purpose and located in a large town within close proximity to all services and facilities. There were a number of day services/ workshops allied to the centre.

The following information outlines some additional data on this centre.

Current registration end date:	02/06/2021
Number of residents on the date of inspection:	10

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
12 April 2018	09:00hrs to 19:00hrs	Noelene Dowling	Lead
13 April 2018	09:00hrs to 19:00hrs	Noelene Dowling	Lead
12 April 2018	09:00hrs to 19:00hrs	Liam Strahan	Support
13 April 2018	09:00hrs to 19:00hrs	Liam Strahan	Support

Views of people who use the service

There were 10 residents living in the centre at the time of the inspection. The inspector met with five of the residents and spoke with four. The residents who communicated with inspectors said that they were satisfied with their lives in the centre and enjoyed their various activities and workshops though it was noisy at times if others were upset.

One resident commented very favourably on the move to the newly opened smaller unit saying it was much quieter and there was more freedom there . Some residents also completed questionnaires supported by staff which were also positive. No questionnaires had been received from representatives.

Capacity and capability

While there was a management structures in place for the centre, it was inadequate to provide effective oversight and direction of the quality and safety of care.

This is demonstrated by a number of findings which showed a disconnect between the management of the centre and the happenings within the centre and also a lack of knowledge of the responsibilities inherent for the provider in managing a designated centre. These matters had been raised in the report following the December 2017 inspection by HIQA and following previous regulatory activity by HIQA within the organisation.The inspection in December was undertaken in response to need for an emergency variation to one unit in the centre.

The provider did not demonstrate the capacity to to implement the action plan given to HIQA following the previous inspection. While the dates for completion of the actions in that report had not been reached in some instances the findings of this inspection did not provide the assurances that they have or will be satisfactorily resolved.

The arrangements for the role of person in charge were not satisfactory. While the person in charge had the required qualifications and experience they remained responsible for three other centres .The provider had not ensured that they were effectively engaged in the management of the centre. Following the previous inspection report the provider had appointed a team leader in the unit to support the person in charge. However, the team leader was given no protected time or decision making capacity which despite the best efforts was not satisfactory.The provider was requested to address this as a matter of urgency.

Training had been undertaken by the provider in relation to the regulations and legal responsibilities involved in managing a designated centre following the findings of the last inspection. However, there was continued evidence of lack of oversight,

direction and knowledge on behalf of the provider despite the obvious commitment evident. This affected residents in the following areas:

· safeguarding practices, responses and recognition of abusive incidents

· risk management procedures and fire safety.

· the impact on some residents of the very different needs accommodated in one unit with no systems to mitigate this in the interim.

· unnecessary infringement of privacy

The previous inspection had raised concerns about the numbers, changing needs and compatibility of the residents (who had initially and historically been admitted without such issues being considered). The response of the provider to this was not detailed sufficiently to demonstrate that this and its impact on the residents was considered in any substantive manner. However, inspectors were concerned to be informed that in order to alleviate this problem a resident with high nursing needs might be discharged. Given that the unit concerned is staffed full time by nurses this does not demonstrate clarity of purpose regarding role of the centre.

The provider was not seen to be effectively listening to residents and taking actions to address their concerns. While there was reporting structures in place the fact that the managers were not aware of a number of significant events occurring in the centre was of concern. Matters seen in records, which constituted complaints, were not addressed via the complaints process and effectively not addressed at all. Similarly daily notes reviewed by inspectors had recorded a number of abusive incidents that should have been notified to HIQA, but had not been. Management indicated that in some instances they had no knowledge of these incidents and in a number of cases did not respond in accordance with legislation or practice guidelines.

Following the inspection the provider forwarded a brief plan to address the above issues as they were outlined by HIQA at the feedback meeting. While this plan identified a change to the person in charge it did not address the substantive issues of the provider's responsibility for directing practices in the centre or provide assurance that while awaiting for the five year accommodation plan interim arrangements would be made to address the difficulties experienced by residents in one unit. The five year plan provided no details and was not specific.

The policies required by Schedule 5 were available in the centre. They were however out-of-date and required review. This included the risk management policy, which had been required following the last inspection and risks were identified on this inspection.

Inspectors observed interactions between residents and staff and spoke with staff. Staff were knowledgeable of residents and their individual needs and all interactions witnessed were respectful. Actions in relation to staff training and staff files resulting from the previous HIQA inspection had been completed. However, at a previous

inspection of another of the provider centres, the provider had failed to procure satisfactory references and clearances for an external consultant who had significant access to residents in residents in the interim. This had not been addressed despite the risk it could present.

The provider had identified that some additional staff were required in the morning and evening time to provide personal care. The provider was in the process of allocating resources to this at the time of this inspection but this had not been achieved.Nursing care was provided as required by the residents needs.

The provider's representative had undertaken two unannounced inspections during 2017. These were conducted via reviewing documentation, observing staff, interviewing staff, reviewing health and safety, reviewing rosters and reviewing minutes of meetings. An annual review was also conducted. This incorporated a range of aspects including the findings of the unannounced provider inspections, resident feedback, and relative feedback from a 2016 survey and audits amongst other aspects of the service.

The annual report contained an action plan. However, the actions were primarily related to issues identified by HIQA as opposed to a robust review by the provider and planning for a long term strategy. This also applied to the quality management systems such as audits as accurate information on incidents to provide meaningful data and review was not available. The provider therefore did not demonstrate to inspectors that they had capacity to identify areas of the service that required improvement, and to then devise and implement actions to achieve those identified improvements.

Registration Regulation 5: Application for registration or renewal of registration

A complete application to renew the registration of this centre was submitted to the office of the chief inspector.

Judgment: Compliant

Regulation 21: Records

Records were kept in the centre in accordance with Schedules 2, 3 and 4 of the regulations.

Judgment: Compliant

Regulation 22: Insurance

Evidence of insurance was submitted to the office of the chief inspector as part of the application to renew the registration of this designated centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies as required by Schedule 5 required review and updating.

Judgment: Not compliant

Quality and safety

At the last inspection a number of actions had been identified in relation to safeguarding, compatibility needs of the residents group, risk management and privacy and dignity of residents. These were not completed and based on the progress made and conversations with the managers inspectors were not assured that that were being satisfactorily addressed or understood.The findings indicate that the living environment , resident compatibility and lack of aaction by the provider to address residents concerns impact on the quality and safety of life.

Residents had good access to multidisciplinary services including health and psychological supports. Residents' healthcare was well supported with fulltime nursing support as dictated by their needs in one of the units. Detailed support plans and interventions were implemented by staff for clinical care needs. They had good access to pertinent clinicians including physiotherapy, speech and language and neurology. Personal plans also identified their preferences for social access and supports.

However, it was apparent that in one of the units the quality of life and safety of residents was impacted on by the different and complex needs of the resident group. It was also impacted on by the ability of those managing the service to recognise abusive interactions and put systems in place to manage these.

Inspectors saw evidence in daily records where some residents had been the subject of ongoing and persistent verbal and in some instances physical interaction, which required an adequate safeguarding response.While these were not consistently at the critical level in some instances, no safeguarding plans had been implemented. This was especially pertinent to the more vulnerable residents in the unit.Inspectors did not find that their experience had been considered.The lack of identification of such issues occurring also prevented the implementation of systems which would

improve the day-to-day quality of life of the residents in the unit.

Where safeguarding plans in relation to external persons were required, the substantive actions necessary to ensure residents safety were not outlined and the directions given were ambiguous pending the review the statutory agency involved. This could place residents at risk of harm and ongoing traumatic experiences. In addition, adequate records of the matter disclosed had not been made.

From conversations with managers, it was apparent to inspectors that there was a lack of knowledge of what constitutes or reaches the threshold for abusive behaviours. This was despite the training in safeguarding which had been provided. It was also of concern that managers were not aware of a number of these issues despite staff reporting them.

By contrast the residents in the newly opened unit which supports three residents told inspectors they were really enjoying the new environment; it was much quieter and more relaxed than the previous unit.

Behaviour supports plans were being reviewed by a specialist and key staff had received training from this specialist. They advised inspectors that this was very beneficial to them and provided a greater understanding of the residents needs . Inspectors were informed that it was hoped this would support better interventions. However, the environment itself and the combined needs of the residents together had not been reviewed to consider its impact both the behaviours presented, the staff's ability to manage them and provide the appropriate care for all of the residents. Inspectors saw that some residents were telling management of these difficulties. While this had been an action in the previous report on this centre the providers' response lacked a clear strategy based on assessed needs to resolve this or mitigate the current situation.

Improvements were also required in the oversight of fire safety management systems.

The units had suitable fire safety systems, which were serviced and maintained as required. Each resident also had a personal evacuation plan in place. However, inspectors were very concerned at the lack of oversight of the plans for evacuating and a lack of direction to staff for specific circumstances. For example, in one case when the alarm was activated because of steam staff closed the bedroom door of three residents who declined to evacuate. This was detailed in the record of the event as the action required in these circumstances.

Management informed inspectors they were not aware of this direction. While this action may be necessary as a last resort there were no guidelines or alternative strategies considered prior to this action being taken in that or future incidents. This posed a significant risk to these residents. It was not known if the alarm in one unit could be activated or tested if a drill was required.

A revised risk register had devised by an external consultancy firm.This was detailed but the findings in fire safety and protection indicate that the provider had

not reviewed this to ensure risk identified were acted on.

Staff were however engaging in a very supportive manner with residents and inspectors found that they were very aware of the difficulties faced by residents in the unit. Staff also had the required mandatory training.The social care needs of the residents were very identified and supported by staff. They had access to a variety of day-care arrangements, which were suited to their wishes, needs, and interests. Training included life skills gardening, weaving and cookery. They had good access to the local community, went shopping, to religious services and concerts, coffee shops and the pub.

Guidance on intimate care demonstrated a commitment to protecting residents' dignity and integrity. However, the viewing panel in bedroom windows could impact on residents reasonable expectation of privacy. While in this instance, blinds were placed on in the inside there was no direction for staff as to the appropriate use of the panels if they were required following a transparent assessment. Inspectors were not assured that managers clearly understood the impact on residents of this action.

Regulation 29: Medicines and pharmaceutical services

Systems were safe and monitored and all residents had regular medicines review.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 29: Medicines and pharmaceutical services	Compliant

Compliance Plan for Esmonde Gardens OSV-0001855

Inspection ID: MON-0020869

Date of inspection: 12 and 13/04/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

In relation to the Policies & Procedures to be maintained in respect of the designated centre as outlined in schedule 5 (Regulation 4).

The Cared 4 Systems which comprises of all Policies, Procedures & Forms have been reviewed. Bettal Consultancy are currently updating the online Cared4 system for the organization and have confirmed by email on 23rd May that they will be uploaded to the online system by end of June 2018.

The Risk management policy has been reviewed and revised in line with regulation and are to be uploaded to the Cared4 system.

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 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/06/2018