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:	Prosper Fingal Residential Respite Service 1
Name of provider:	Prosper Fingal Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	29 November 2018
Centre ID:	OSV-0001860
Fieldwork ID:	MON-0021622

About the designated centre

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

Prosper Fingal Residential Respite 1 provides respite services to approximately 80 residents and can accommodate up to seven residents at any one time. The house is located in a suburban town close to a range of local amenities. Public transport as well as a centre bus are available. The aim of the service is to provide residential respite which is short term, in a safe and comfortable home, in response to individual's and carers' needs.

The following information outlines some additional data on this centre.

Current registration end date:	28/02/2022
Number of residents on the date of inspection:	5

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
29 November 2018	10:05hrs to 17:30hrs	Amy McGrath	Lead

Views of people who use the service

The inspector met with each of the five residents who were availing of the service at the time of inspection. Residents were observed to be comfortable in eachothers company, and were chatting with staff while waiting for dinner. Residents spoke with the inspector and expressed that they enjoyed their time in respite and liked the food and the activities.

Residents' views were also elicited from seven resident questionnaires received. Residents complimented the premises, and commented that they liked the bedrooms and facilities. Residents also reported that they felt they were supported well and that the staff were welcoming and caring.

Capacity and capability

The governance and management arrangements in the centre had ensured, for the most part, that the service was effectively governed, with good oversight systems. Improvements to a number of reporting and recording systems were required to further enhance this oversight, and are outlined later in the report. There was a clearly defined management structure in place, and the provider had ensured that the service was adequately resourced to deliver the care and support as set out in the statement of purpose. There were significant improvements required in the area of policies and procedures.

The provider had prepared a statement of purpose, which accurately reflected the service provided. For the most part, the statement of purpose contained the information required as per Schedule 1 of the regulations, although the floor plans were inaccurate and required review. There was a directory of residents maintained that included the information specified in Schedule 3.

There were sufficient staff, who were suitably qualified and experienced, to meet the assessed needs of residents. A review of staff files found that the information required under Schedule 2 of the regulations, for example, a Garda vetting disclosure and a full employment history, had been obtained for all staff. The person in charge maintained an accurate planned and actual roster, and effective workforce planning had ensured continuity of care for residents.

Residents were supported by a team of staff nurses and care assistants, who reported to a senior staff nurse. The senior staff nurse fulfilled both a nursing and a local leadership role, and reported directly to the person in charge, who in turn reported to an operations manager. The person in charge had responsibility for an

additional designated centre, and the arrangements in place facilitated sufficient protected time to carry out the responsibilities of the role.

Staff had received training in all mandatory areas, for example, fire safety and safeguarding, as well as additional training specific to residents' support needs, such as communication through Lámh and dementia training. At the time of inspection the provider was implementing a more formalised supervision process for staff, however, the arrangements in place had ensured that staff were being effectively supervised. A review of minutes of team meetings and one to one meetings found that the presence of a team lead facilitated local supervision on a consistent basis, and it was observed that staff could highlight issues or concerns through these mechanisms.

There were a number of policies that had not been reviewed or updated within a three year period (the minimum requirement of the regulations); this was an outstanding action from the previous inspection. Multiple policies had not been reviewed for a significant period of time, and did not accurately reflect best practice. For example, the policy on retention and destruction of records had not been updated since 2012, and the policy on the provision of intimate care had not been updated since 2008. The provider had a plan in place to review and update all outdated policies. The provider had not prepared and implemented a policy on the prevention, detection and response to abuse, and relied on the national policy in lieu of an organisation specific policy. This did not effectively guide staff practice in relation to protecting residents from the risk of potential abuse.

The provider had carried out an annual review of the quality and safety of the service, which consulted with residents and their representatives. The annual review generated a quality improvement plan which was monitored to ensure implementation. The person in charge oversaw a suite of internal audits, such as health and safety audits and review of medication errors. While there were audits carried out regularly by competent persons, the provider had not carried out a six monthly unannounced visit, and prepared a written report on the quality and safety of the care and support provided to residents.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced in their role. While the person in charge had responsibility for more than one designated centre, they demonstrated effective governance and operational management of this service.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff, who were suitably qualified and experienced, to meet the assessed needs of residents. The provider had ensured good continuity of care for residents, and the planned and actual rosters were well maintained.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received mandatory training, as well as supplemental training appropriate to residents' specific support needs. Formal supervision arrangements were being developed at the time of inspection, however the arrangements in place were effective in ensuring that staff were suitably supervised.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had prepared a directory of residents, and had ensured that all required information in relation to residents was held in the centre, as outlined in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the governance and management arrangements were effective in delivering a good quality service to residents. Improvements were required to ensure that the providers six monthly unannounced visits, and associated reports on the safety and quality of care and support, were comprehensively and consistently conducted.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

For the most part, the statement of purpose contained the information set out in Schedule 1 of the regulations, although there were some corrections required to the floor plans.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

There were a number of policies and procedures that had not been reviewed and updated within a three year period, although the provider had a plan in place to address this. The provider had not prepared in writing and adopted a policy on the prevention, detection and response to abuse.

Judgment: Not compliant

Quality and safety

Overall, residents were receiving a good quality service; the provider had ensured that residents' views were central to service delivery, and residents received individualised care during their stay. There were some improvements required in relation to risk management and positive behaviour support, as well as the arrangements for keeping residents safe from potential abuse.

A comprehensive assessment of need had been undertaken for each resident by their referring day service, with input from staff in the centre, the resident and their family. Support plans had been developed for identified needs, and these were reviewed regularly by a multidisciplinary team. Improvements had been made since the previous inspection to the system of identifying changing needs, and this was reflected in updated support plans for residents.

Residents were supported to avail of opportunities for recreation in the local community, and although residents attended the service for short periods, their longer term goals and interests were facilitated throughout their stay, such as attending a training course or going to church. Residents enjoyed an active social life where this was their preference, and there was adequate space and resources for residents to choose alternative activities.

There was adequate food and drink available, and inspectors viewed a meal plan developed by residents for the duration of their stay that reflected various choices and preference. Residents' specific dietary requirements were catered for, and where additional support was required for eating or drinking, staff were knowledgeable of any specialist recommendations, and these needs were

supported appropriately.

Staff had received training in positive behaviour support, and where required, there were positive behaviour support plans in place. There were some restrictive procedures in place, each of which had been discussed with residents and their families prior to implementation. However, restrictive practices had not been implemented with a clear evidence base. For example, an environmental restraint was in place to mitigate a choking risk for one resident, however this risk had not been assessed, and therefore there wasn't a clear rationale for its use, or capacity for review of effectiveness.

There were risk management policies and procedures in place, and whilst operational risks were well identified and assessed, improvements were required to ensure that risks to residents were assessed, control measures identified, and included on the centres risk register. Risks to residents had been informally identified in some cases, with control measures in place, however these were not implemented in line with the providers own risk management policy and did not provide sufficient oversight of the current risks.

The inspector reviewed the records of accidents and incidents in the centre, and found that some risks had not been identified or risk assessed, for example, a choking incident that required first aid to be administered, and resulted in updated speech and language recommendations. While the inspector acknowledges that there were some measures in place to protect residents from risk, there were improvements required to ensure that risk management procedures were implemented appropriately, to facilitate an effective ongoing review of risk and learning from adverse incidents.

The provider had ensured that staff had received mandatory training in safeguarding adults. Staff spoken with had a good understanding of their responsibilities, and residents reported that they felt safe. However, it was found that not all potential safeguarding incidents had been investigated or escalated as per national policy; for example an incident in which a resident received an injury as a result of another resident's behaviour had not been screened appropriately, and there were no formal safeguarding plans in place. Improvements were required to ensure that all incidents, allegations, or suspicions of abuse were responded to appropriately.

There were detailed intimate care support plans in place for residents which guided care that was dignified and respectful of residents needs and preference.

There were fire safety management systems in place, and staff had been appropriately trained in fire safety. There were adequate arrangements in place for the detection, containment and extinguishing of fires, and equipment was regularly serviced. Residents took part in fire drills at scheduled intervals and there were personal evacuation plans in place for each resident.

Records of fire drills were found not to include sufficient detail to inform an effective review of evacuation plans, for example, an evacuation drill that included the evacuation of five residents took twice as long as an evacuation of seven residents, with no record of any difficulties or issues. A staff member recalled that the longer

evacuation time was due to the changing needs of a resident, however this was not included in records or subsequent evacuation plans.

Regulation 13: General welfare and development

Residents were receiving appropriate care and support, in accordance with their needs and wishes. Residents were supported to avail of opportunities for recreation in the community, and were given support with personal development goals during their stay.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were supported to prepare and cook their own meals, in accordance with their abilities and preferences. Residents had access to ample quantities of food and drinks, and individual dietary needs were catered for.

Judgment: Compliant

Regulation 26: Risk management procedures

Risks were not identified, assessed, and managed as outlined in the providers risk management policy. Learning from adverse incidents had not been reflected in risk management arrangements, and the centres risk register did not outline risks pertaining to individual residents.

Judgment: Not compliant

Regulation 28: Fire precautions

There were fire safety management systems in place, and the provider had ensured there were appropriate arrangements for detecting, containing and extinguishing fires. Residents regularly took part in fire drills, however records of such did not contain sufficient detail to ensure that residents' support needs were appropriately planned for.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need had been carried in collaboration with each residents day service, and appropriate support plans were developed for their time in respite. There were adequate arrangements in place to ensure that residents needs were effectively reviewed by a multidisciplinary team.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were appropriately trained to provide positive behaviour support. There were support plans in place for residents who required support in this area. There were some restrictive practices in place that did not have a clear rationale or evidence base for use.

Judgment: Not compliant

Regulation 8: Protection

Staff had received training in safeguarding adults. Not all potential safeguarding incidents were investigated or escalated appropriately, and there were no safeguarding plans in place for residents, despite risks to safety being identified for some residents through incident recording.

Judgment: Not 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Prosper Fingal Residential Respite Service 1 OSV-0001860

Inspection ID: MON-0021622

Date of inspection: 29/11/2018

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 23(2) (a) A schedule of six monthly unannounced provider visits will be prepared and visits undertaken as per the schedule. These will be monitored and logged by the Quality Department. The first unannounced visit is scheduled for February 2019. 23(2) (b) The associated written reports will be completed and disseminated in a timely manner.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The required corrections will be made to the floor plans and the Statement of Purpose will be updated accordingly. The Statement of Purpose will be re-issued to the centre and HIQA.	

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
4(1) A local Safeguarding Policy has been developed and implemented.

4(3) A policy action plan was put in place, prioritising the review and updating of the required policies in accordance with Schedule 5. The action plan outlines the key steps of the review process, specific responsibilities and target dates. Reviews have been completed on almost all the required policies, with each at various stages of approval by Senior Management or sign off by the Board of Management. A schedule of implementation has commenced on a phased basis with staff over the coming weeks.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A new Standard Operating Procedure will be developed for identifying, assessing, managing and reviewing resident risks. This procedure will include devising, and subsequently putting in place an Individual Risk Management Plan for every resident who requires one. An implementation plan will be developed by which to action this, including piloting the Individual Risk Management Plan.

The organisation's Risk Management Policy will be updated accordingly.

The Centre's Risk Register will be updated to include resident risks.

Staff will be trained on the new procedure and associated paperwork.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The organisation's HSC Form 9: Record of Emergency Evacuation Drill has been enhanced in order to prompt staff, more clearly, to provide sufficient detail to inform the effective review of evacuation plans. This has been implemented and all staff informed.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Risk assessments have been completed and implemented on all restrictive procedures currently in place in the organisation in order to provide a clear rationale and evidence base for the use of that restrictive practice.

The organisation's Restrictive Procedures Policy will be updated accordingly to ensure risk assessments are completed where restrictive procedures are required in the future.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All suspected or confirmed safeguarding incidents, which fall within the definition of abuse in S.I 367 of 2013, and described further in the HIQA Monitoring Notifications Handbook (2018), will be notified to HIQA in the required manner and within the required timeframe.

These incidents will be escalated to the Company Safeguarding Officer in accordance with the Company Safeguarding Policy. The Safeguarding Officer will determine an appropriate course of action in accordance with local policy. This may include investigation and/or putting in place formal safeguarding plans as deemed appropriate.

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 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	15/02/2019
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an	Not Compliant	Orange	25/02/2019

	unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	29/03/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	22/01/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing	Substantially Compliant	Yellow	28/02/2019

	the information set out in Schedule 1.			
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	04/01/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	15/03/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	22/02/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of	Not Compliant	Orange	10/01/2019

	abuse and take appropriate action where a resident is harmed or suffers abuse.			