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:	Limelawn Green - Community Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	04 March 2020
Centre ID:	OSV-0003065
Fieldwork ID:	MON-0025335

About the designated centre

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

This centre is a community based residential home with the capacity to provide full-time residential care and support to four residents with an intellectual disability. The centre is home to four residents with low support needs. The centre is located in an urban setting in County Dublin with access to a variety of local amenities such as shops, a local shopping centre, bus routes, and local churches. The premises is a semi-detached, five bedroomed house which provides adequate private and communal space for residents. The centre shares a vehicle with another designated centre in the locality to enable residents to access day services and local amenities. Residents in the centre are supported by a staff team comprising of a person in charge and social care workers. All four residents attend day services four days a week and enjoy a prearranged day off. Residents are supported by a sleepover staff and have some additional staffing support during the day.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 4 March 2020	09:00hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspector met and spoke with all four residents in the centre on the day of inspection. Residents spoke about their daily routine, upcoming events that day, family, friendships, previous holidays and other activities and events that were important in their lives. During this time some residents showed photographs of different places they had visited on their own individual i-pads. The inspector had the opportunity to explain their role for the day and when asked if residents felt safe and happy all residents stated they were happy in their home.

In addition to speaking with the residents, the inspector had time to observe the morning routine with residents and also observed staff interactions at this time. The inspector sat with some residents when they were eating their breakfast. Residents were observed to be independent in this routine and staff assistance was only offered when necessary. At this time residents appeared happy in each other's company, with the support of the staff member. The staff member continually offered support during interactions to ensure they were positive between the residents.

Kind, connective, patient and respectful interactions between staff and residents was observed across the day of inspection. A resident was observed to be very excited to be supported by their keyworker on this day after the staff member had returned from leave and stated this on a number of occasions across they day. Interactions observed on the day, indicated that staff and residents were very familiar with each other. Staff were always available to give their full attention to residents and they communicated effectively with them at all time by using language and explanations that were suitable to different situations.

Residents had different plans for the day, some residents were heading out independently and other residents were collected to attend their day service, while some residents were enjoying a day off at home and relaxing and choosing to complete different leisure activities or to catch up on daily chores. The residents clearly led their day and were very involved in the planning and decision making. For example, a resident who required a new shower was browsing through relevant catalogues and choosing which one they liked and marking it on the book to show staff. Residents proudly spoke of their social care goals and upcoming meetings in relation to this.

Capacity and capability

Overall, the inspector found a very person-centred service was in place for the residents. The person in charge and provider were striving to achieve a quality driven and safe service. Positive outcomes were noted for residents. However, improvements were required in a number of regulations to ensure the quality of the service could continue and be maintained.

The provider had put measures in place to address most of the actions from the previous inspection in April 2018, however some time lines stated in the providers action plan had not been adhered to, resulting in some actions remaining outstanding. The monitoring of the effectiveness of the time lines put in place by the provider required improvement to ensure outstanding actions were being completed as stated and any barriers to completion were addressed accordingly. This is discussed in further details under the relevant sections in the report.

There was a clearly defined management structure which defined the lines of authority and accountability in the centre. There was evidence of regular staff meetings in the centre and a sample of notes reviewed indicated that these meetings were resident focused. Meetings also occurred between the person in charge, their relevant line manager, and the registered provider representative. Shared learning was discussed in these meeting were findings from other inspections, staff training and supervision topics were discussed.

There was an annual review of the quality of care in the designated centre and six monthly visits by the provider completed in line with regulations. The annual review used observations, discussions with service users and documentation review to gain the feedback of residents. Actions were developed following these reviews and there was evidence of follow up and completion of a number of the actions. The annual review in the centre had similar findings to this inspection, it must be noted that some of these findings remained outstanding from the previous inspection findings. This indicated that some improvements were not occurring in a timely manner and improvements were required to ensure the systems in place were continuing to drive improvements within the centre.

Additional staffing hours of 39 hours a week had been put in place to respond to the residents presenting needs and preferences. The additional staffing hours had a very positive impact in the home, resulting in the number of safeguarding incidents being significantly reduced. This is discussed in further detail in the report. The inspector found that the number and skill mix of staff was appropriate to the needs of the residents. There was an actual and planned roster in place. However continuity of staffing required improvements. There was a core staff team in place that were familiar with the residents. However the additional 39 hours a week, holidays, sick leave and additional cover was provided by relief or agency staffing. In a four week period 12 different staff were utilised to cover the additional 39 hours a week. The provider discussed that they were in the process to recruiting a staff member to complete this shift but to date no one had been recruited.

The inspector found that staff had access to some training and refreshers to meet residents' needs. However, residents had specific assessed needs in relation to managing behaviours that challenge and self-injurious behaviour and not all staff

had completed autism training, positive behaviour support training on the management of behaviour that is challenging including de-escalation and intervention techniques. The provider had committed to complete this training by the 31 December 2018 in their previous action plan submitted to the Office of the Chief Inspector, however they had failed to adhere to this timeline and training remained outstanding. In addition, the agency and relief staff that were utilised on a frequent basis may not have completed this training. In addition to this, supervision was not occurring on a regular basis for staff. Again, this was identified in the previous inspection report and there was a commitment from the provider to have the person in charge commence relevant training in this area and commence supervision with all staff. In formal supervision of staff was occurring, however, the effectiveness of this supervision in relation to supporting staff to perform their duties to the best of their abilities could not be determined.

Regulation 15: Staffing

There was an actual and planned staff rota. The number and skill mix of staff was appropriate to the number of residents. However, continuity of staffing required improvements. Agency and or relief staff were being utilised to cover an additional 39 hour shift a week.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff in the centre had access to a number of training courses that enabled them to provide up-to-date evidence based practice. However, not all staff had completed autism specific training or training in positive behaviour support training and training on the management of behaviour that is challenging including de-escalation and intervention techniques. In addition, to this staff were not receiving formal supervision. Both these actions had previously been identified in the inspection report dated April 2018.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were systems in place to monitor the quality of care and support provided in the centre which included the annual review and six monthly unannounced provider visits. The annual review had identified similar findings to the current inspection.

However, some of these findings were also identified in the previous inspection in April 2018. The provider had failed to adhere to the agreed time lines submitted to the Office of the Chief Inspector as stated in their action plan. Improvements were required in staff training and supervision. Also, although the number of incidents relating to safeguarding had significantly reduced, the situation relating to the incompatibility of residents remained with no plan in place to address this.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Schedule 5 written policies and procedures were in place and reviewed in line with time lines stated in the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the provider and the person in charge were striving to provide a safe, quality service for residents in the centre. Residents enjoyed a good quality of life, where their views, needs and wishes were respected. Residents spoke proudly of their different goals in place and it was evident that they were involved in the planning of activities and events that were meaningful to them. In order to ensure the quality of care was maintained, improvements were required in relation to risk management, medication management and meeting the assessed needs of residents.

The inspector completed a walk around of the premises and found the home, warm, clean and nicely decorated. The inspector was invited to view two of the residents' bedrooms. They had pictures of families and friends on display as well as many other personal items. The rooms were decorated according to residents' wishes. There was a nicely kept back garden that the residents had access to and residents were also involved in the development of this in line with their individuals' goals and wishes.

One resident kindly spent some time reviewing their personal plan with the inspector. With support they spoke about their goals and were familiar with the different parts of their plans. Additionally, the inspector also reviewed a sample of the other residents' personal plans. A person-centred assessment of need was in place that reflected residents current assessed needs in relation to health, personal and social needs. This informed a subsequent plan of care which was updated on a regular basis to reflect changes in needs or recommendations from relevant

professionals. There was evidence of multi-disciplinary (MDT) reviews of the plans as required. Residents spoke to the inspector about partaking in MDT reviews and also person centred planning meetings where elements of their care were discussed and reviewed.

Although the registered provider had put arrangements in place to meet the needs of residents, the ability of the registered provider to do so effectively was at times impacted by the ongoing incompatibility of some of the individuals living together. There had been a significant reduction in the number of peer-to-peer safeguarding incidents in the centre from the second quarter of 2019. This reduction in number of incidents corresponds with additional staff being in place in the centre. The staff team have worked to the best of their ability to keep residents safe. In addition to this the provider had put in place a number of measures to keep residents safe such as reviewing incidents, putting safeguarding plans in place and making referrals to relevant professionals when they required additional support. However, the underlying cause of these incidents was a direct result of the incompatibility of some of the residents living in the same home.
The incompatibility of residents was a direct result of their specific assessed needs and at times the presentation of behaviours that challenge associated with their specific diagnosis. This at times was impacting on the quality of life experienced by residents. For example, some residents were choosing to spend more times in their rooms. The annual review had recognised this issue and to date there was no plan to address this in the near future.

Residents' health needs were being appropriately met. There was an assessment in place and the residents had access to allied professionals in line with their assessed needs. Residents had attended appointments in relation to National Screening Program.

Positive behaviour support plans were in place in line with residents' assessed needs. The inspector reviewed a sample of these plans. These plans had originally been informed by a function based approach in line with evidence-based practice. Improvements were required in relation to the documentation approach. For example a traffic light based approach was used to topographically define a resident's presentation. Underneath these definitions was a section that defined staff management strategies however this was not cross referenced with the system above. This was discussed with the person in charge on the day of inspection. The majority of the core staff had completed positive behaviour support training including de-escalation techniques with one staff member outstanding, however, this staff member was booked on this training in the coming weeks. There were no systems in place to ensure that agency or relief staff had completed this training. This has been addressed under Regulation 16, staff training and development.

In relation to risk, there was a system in place to identify risks, assess risk and manage and review risks on a regular basis. The inspector reviewed a sample of individual risk assessments and the local risk register. Overall, risk was well managed and the level of risk was proportional to the control measures in place. However, this system was not always identifying all risks in the centre and

therefore some risks were not being managed in line with the relevant procedures.

Generally the practice relating to the ordering, receipt, prescribing, storing including medical refrigeration, disposal and administration of medicines was appropriate. All medication was stored in a locked press in the office or resident rooms. However, on the day of inspection, medication storage was not in line with the organisations policy. Also, there was insufficient guidance for staff to safely administer PRN medicine (a medicine only taken as required) , as the daily maximum doses were not stated on the medicine management system for all medications. This lack of guidance could potentially result in a risk of the daily maximum dosage of the medication being exceeded.

Suitable fire equipment was provided in the home. There was adequate means of escape, with exits suitable for evacuating all residents. Suitable fire containment measures were in place in the home. There was a procedure for the safe evacuation of residents and staff in the event of a fire which was prominently displayed. Fire drills occurred at regular intervals and reflected scenarios with the least amount of staff and the maximum number of residents.

Regulation 17: Premises

The centre was warm, homely and nicely decorated. The design and layout of the centre was in line with the statement of purpose.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall arrangements were in place to ensure risk control measures were relative to the risk identified. However, the systems in place to identify all risks required improvements to ensure that all risks in the centre were being managed appropriately.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was adequate means of escape, including emergency lighting. Residents were involved in fire drills. Suitable fire containment measures were in place.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Practice relating to the ordering; receipt; prescribing; storing, including medicinal refrigeration; disposal; and administration of medicines was not always appropriate. At times medication was not being stored and administered in line with the organisations policy. Also, there was insufficient guidance for staff to safely administer PRN medicine, as the daily maximum doses were not stated on the medicine management system for all medications.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which outlined their likes, dislikes, goals, and care and support needs. Care plans were in place in line with residents' assessed needs and there was evidence of regular review to ensure plans were effective. Although the registered provider had put arrangements in place to meet the needs of residents, the ability of the registered provider to do so effectively at all times was impacted by the ongoing incompatibility of some of the individuals living together.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were assessed and supported through appropriate health care planning. There was evidence to indicate that residents were supported to attend the National Screening Program.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' behaviour support needs were assessed in the centre. There were corresponding positive behaviour support plans in place that were based on a function based approach in line with evidence based practice.

Judgment: Compliant

Regulation 8: Protection

There had been a significant reduction in the number of peer-to-peer safeguarding incidents in the centre from the second quarter of 2019. This reduction in number of incidents corresponds with additional staff being in place in the centre. The staff team have worked to the best of their ability to keep residents safe and this is being reflected in the reduction of incidents. In addition to this the provider had put in place a number of measures to keep residents safe. However, the ongoing incompatibility between residents remains which is addressed in Regulation 5.

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 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Limelawn Green - Community Residential Service OSV-0003065

Inspection ID: MON-0025335

Date of inspection: 04/03/2020

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: The Provider will ensure that regular staff are available in the designated centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Provider will ensure that all staff have completed the required training for the designated centre. The provider will ensure that the PIC attends supervision training.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that actions not completed from the April 18 visit are completed. The provider will review the risk assessments in the centre.	

The provider will review the assessed needs of each resident and their compatibility to live in the designated centre.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk assessments have been reviewed and an additional risk assessment put in place.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The PIC has reviewed the Medication Policy with all staff. The PIC has introduced a new system of administering morning medications to take in to account safeguarding issues and safe administration of medication. The GP has reviewed the MPARS to ensure that maximum PRN dosage clearly indicated.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The Provider will review the assessed needs of each resident in the centre and their compatibility to live together with staff support.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/09/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/11/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/11/2020
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	30/11/2020

	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.			
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.	Substantially Compliant	Yellow	10/03/2020
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	10/03/2020
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable	Substantially Compliant	Yellow	10/03/2020

	practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	10/03/2020