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:	SVC - CN
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 7
Type of inspection:	Short Notice Announced
Date of inspection:	23 July 2020
Centre ID:	OSV-0003167
Fieldwork ID:	MON-0029681

About the designated centre

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

SVC-CN provides full-time residential care and support to 16 adults with a disability. SVC-CN is located within a campus setting in a residential area of Co. Dublin and is close to local shops and other amenities such as cafes, public houses and a swimming pool. The centre comprises of two bungalows with seven bedrooms in each, with six bedrooms being single occupancy and the seventh shared by two residents. The two bungalows within the centre are of a similar design, with residents having access to an open plan communal area which incorporates both a lounge, kitchen and dining room areas. The open plan area also has direct access to a well maintained garden with seating areas. Each bungalow provides laundry facilities which can be accessed by residents with staff support. The bungalows both have two toilets as well as a communal bathroom with an additional toilet facility as well as an accessible walk-in shower and adapted bath. A further smaller sitting room is also provided which is used for quiet activities and to enable residents to meet their friends and family in private. Residents are supported 24 hours a day, seven days a week, by a staff team which comprises of nursing, care and domestic staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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 23 July 2020	11:00hrs to 17:00hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and briefly engage with eight residents in one of the houses during the inspection. The inspector visited residents in the evening time while they were enjoying their evening tea. Throughout the visit, residents appeared comfortable and content and the inspector observed kind and respectful interactions between residents and staff.

A number of residents were observed being supported with their meals in a dignified manner by staff who were familiar with their likes and preferences. There were options available for residents in relation to food or drinks.

Other residents were observed relaxing either before or after their meal in the living room. The atmosphere in the living room was peaceful and residents appeared relaxed and content. One resident was observed spending some time in the garden and came to visit the inspector briefly on two occasions when they were spending time in the conservatory area of their home.

Capacity and capability

Overall, the registered provider and person in charge had systems in place for the oversight and monitoring of the quality of care and support for residents. There was evidence that the provider was identifying areas for improvement and developing plans to bring about the required improvements to bring about positive changes for residents in relation to their home and their care and support. However, a number of these actions remained outstanding at the time of the inspection. For example, the provider had identified the requirement for some works relating to fire safety, for the completion of an annual review and for implementing their plan to reduce the multi-occupancy bedrooms in the centre to ensure each resident had their own bedroom.

There was a clearly defined management structure in the centre. Staff had specific roles and responsibilities in relation to the day-to-day running of the centre, and the reporting structures within the organisation were clear in relation to authority and accountability. A new person in charge had commenced in the centre last year, they were in the process of developing systems, identifying areas for improvement and implementing the required actions to bring about positive outcomes for residents in relation to their environment and care and support. They were supported by a clinical nurse manager working in the centre, a number of persons participating in the management of the designated centre (PPIM) and a service manager. There was evidence that they were meeting regularly and discussing the day-to-day management of the centre. When the person in charge or clinical nurse manager

were not on duty, there was an on call support available.

The provider was completing six monthly visits and these visits were identifying some areas for improvement in line with the finding of this and previous inspections. There was evidence that a number of the actions following these reviews had been followed up on and completed and that these were leading to positive outcomes for residents such as; a review of residents' goals to ensure they were meaningful and measures for staff to continue to progress and find new ways of improving residents' links to and access to the community. Other areas for improvement relating to fire safety and ensuring each resident had their own bedroom were in progress, but not completed at the time of the inspection.

The provider had not fully completed an annual review for 2018 or 2019. The inspector viewed one annual review which covered the dates January 2017 to December 2019. Throughout this document it referred to progress of actions in 2017 and 2018 and reviewed incidents from 2017. In addition, there was a draft annual review for 2019 which had not been reviewed by the management team or fully completed. The provider was aware of the requirement to complete an annual review and was in the progress of ensuring one was in place for 2020. A member of the management team also explained that the views of residents or their representatives had not been captured in previous annual reviews and that plans were in place to ensure this occurred in the next annual review. A satisfaction survey had been sent out to residents' representatives in 2020.

There was an audit schedule in place and evidence that these were being completed and the actions followed up on. Team meetings were occurring regularly and were found to be resident focused. They included topical agenda items and provided opportunities for staff to add agenda items for discussion. The provider had developed a business continuity plan for use during the pandemic and a number of policies, procedures and guidelines had been developed or reviewed to guide staff practice.

Residents were supported by a staff team who were familiar to them. There were no staffing vacancies at the time of the inspection. However, the provider had completed a risk assessment in relation to staffing levels in the centre over a 24 hour period, as staffing levels were lower at times, particularly in the evenings. The risk assessment detailed additional control measures in place and outlined that there was flexibility in the rosters at a local level to support residents with evening activities or social events. The provider was keeping this risk assessment under review and monitoring and trending incidents in the centre and monitoring for any changes in relation to residents' care and support needs, to determine if there was any change in the level of risk.

During the inspection, the inspector observed staff engaging with residents in a supportive and respectful manner. Resident appeared comfortable in the presence of staff and with the levels of support offered to them. In line with the current pandemic, the provider had systems in place to reduce the movement of staff between the two houses. A sample of rosters reviewed, showed that all the required shifts were covered in each of the houses. New staff to the centre were in receipt of

an area specific induction to ensure they were aware of residents' care and support needs and knew who to contact if they required support.

Staff supervision had been formalised in the centre since the last inspection. However, it was not being completed in line with the organisation's guidelines and some staff had not had supervision or an annual performance review for an extended period of time. For example, the inspector reviewed one staff's supervision records and they had one supervision meeting in 2019 and had not had an annual performance review since 2015. A supervision plan had been developed for 2020. Staff had access to training and refresher training in the organisation. However, a number of staff required training and refresher training in relation to fire safety, safeguarding, manual handling and the use of personal protective equipment (PPE). For example, one staff required refresher in fire safety, two in safeguarding and seven in manual handling. Eight staff were due to complete PPE training.

A record was kept of all incidents occurring in the centre and notifications were sent to the Chief Inspector in line with the requirements of the regulations.

Regulation 15: Staffing

Residents were supported by a staff team who were familiar with their care and support needs. The provider was closely monitoring the staffing numbers and skill mix in the centre to ensure there were sufficient to meet residents' needs at all times. They had a risk assessment in place and were monitoring and trending incidents to monitor for any changes in the level of risk.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training and refresher training in line with residents' assessed needs. However, a number of staff required refresher training in fire safety, safeguarding, manual handling and some required training in the use of PPE. Formal staff supervision had commenced in the centre. However, it was not being completed in line with the organisation's guidance and some staff had not received supervision or an annual performance review for an extended period of time.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were systems in place to ensure residents were in receipt of good quality and safe care and support. The management team were meeting regularly and completing audits and reviews which were found to be resulting in positive outcomes for residents. There were six monthly visits completed. However, the annual review was not completed annually. The provider was aware of this and had plans in place to ensure it was completed in 2020.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider had systems in place to record incidents in the centre and to notify them to the Chief inspector in line with the requirements of the regulations.

Judgment: Compliant

Quality and safety

The provider had systems in place to monitor the quality of care and support for residents. These included a clearly defined complaints process, regular residents' meetings and residents and their representative's satisfaction surveys.
Through discussions with the local management team and a review of documentation, it was evident that staff and the local management team were motivated to ensure residents were safe living in a caring environment where they were supported to make choices in relation to their day-to-day lives. The provider was identifying areas to further improve residents' lived experience in the centre. For example, plans were in place to review accommodation to ensure each resident had their own bedrooms and to review residents goals to ensure they were taking part in meaningful activities both at home and in their local community.

Overall, the premises were found to be clean and comfortable. Areas of the centre were designed an decorated to meet residents' needs. For example, the decoration of one house was minimalist to meet the needs of residents living there. There were systems in place to ensure maintenance of the property and servicing of equipment as required. However, as previously mentioned, there there were two shared bedrooms in the centre, one in each of the houses. It was reported to the inspector by members of the local management team that there were no complaints on record from the residents or their representatives and that every effort was being made to ensure residents' privacy and dignity were maintained. For example, privacy screens were used at times to ensure residents' privacy. The provider had previously submitted a plan to the Chief Inspector in relation to reducing multi-occupancy

bedrooms in the organisation within a specified timeframe in the future. Each of the houses had a well maintained garden which was secure and provided a pleasant outdoor space and seating for residents.

Residents were protected by the risk management polices, procedures and practices in the centre. There was a risk register and general and individual risk assessments were developed as required. There were systems in place for recording, investigating and learning from serious incidents and adverse events and there was an emergency plan in place.

During the inspection, the premises were found to be clean. There were cleaning schedules in place, which had been adapted in line with COVID-19. Social stories in relation to COVID-19 and infection prevention and control were available for residents and discussed during residents' meetings. They also had access to accessible information in relation to public health measures during the pandemic. This included leaflets relating to handwashing, COVID-19 and testing. The provider had developed policies, procedures and guidelines for use during the pandemic. They had also updated existing polices, procedures and guidelines. The provider had good stocks of personal protective equipment available and systems in place for stock control and ordering. Most of the staff team had completed additional training in relation to infection prevention and control including hand hygiene training and training relating to the use of PPE. There was a COVID-19 information folder available in the centre, which was updated with relevant policies, procedures, guidance or correspondence.

There were systems in place to ensure that fire fighting equipment and fire alarm systems were serviced and maintained and there were systems in place for the prevention and detection of fire. The provider had identified that improvements were required in relation to emergency lighting and the installation of closing mechanisms on doors. The inspectors viewed evidence that these works were planned and in the interim the provider had a risk assessment in place. Fire drills were taking place at suitable intervals. Each resident had a personal evacuation procedures which considered their mobility and cognitive understanding in relation to the evacuation procedures in the centre. Overall, staff had received suitable training in fire prevention and emergency procedures, building layout and escape routes. One staff member required refresher training in relation to fire safety. Fire evacuation procedures were on display in the centre.

Residents' healthcare needs were assessed and healthcare plans were developed as required. In addition, short term care plans were developed when residents were unwell. The business continuity plan for the organisation outlined how residents could be supported to access a GP, psychiatrist, speech and language therapist, social worker, occupational therapist, psychologist or physiotherapist during the pandemic. In addition, there were local guidelines for GP visits and other allied health professionals consultations in the centre. From the sample of residents' healthcare plans reviewed, there was evidence that they were being supported to attend national screening services, if they so wish. Residents were in receipt of support at time of illness and at the end of their lives. End of life care plans were developed as required and included information in relation to residents' wishes and

preferences.

There were a number of restrictive practices in place in the centre. These were detailed in the restrictive practice register and regular meetings were being held to review restrictions. There reviews included a review of the rationale for the restrictions and that considerations were given to the use of the least restrictive practices, for the shortest duration. There was evidence that a number of restrictions had been removed, reduced or trialled off since the last inspection and plans were in place to further reduce and eliminate some restrictions. Residents had access to allied health professionals and had support plans developed as required. These plans were guiding staff to support residents in line with their assessed needs.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. safeguarding was discussed during residents' meeting, at handover and staff meetings. Safeguarding plans were implemented as required. Residents had intimate care plans which clearly outlined their wishes and preferences.

Residents were being supported to make decisions in relation to their care and support. Residents' meetings were occurring regularly and agenda items were varied and included discussions relating to the day-to-day running of the centre. There was evidence of communication with residents to keep them informed during the pandemic and a number of leaflets and social stories had been made available. There was also evidence that residents and their representatives were kept informed in relation to any updates or changes in the visitors policy in the centre during the pandemic. There were systems in place to ensure residents could access independent advocacy service, should they so wish.

Regulation 17: Premises

Overall, the premises was clean and designed to meet the needs of residents. However, there was not sufficient private space for residents as there were two multi-occupancy bedrooms in the centre, resulting in two residents sharing their bedroom in each of the houses. The provider had a plan in place to reduce multi-occupancy bedrooms in progress, and the timeline had not yet passed for completion of this plan.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Residents were protected by the risk management policies, procedures and practices

in the centre. There was a risk register and general and individual risk assessments were developed and reviewed as required.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had policies, procedures and guidelines in place in relation to infection prevention and control. These were detailed in nature and clearly guiding staff to prevent or minimise the occurrence of healthcare-associated infections. A number of staff had completed training in hand hygiene and the use of PPE. Cleaning schedules had been adapted in line with COVID-19 and social stories had been developed and made available for residents in relation to COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The premises was equipped to detect, contain, and alert people to fire or smoke in the designated centre. Practice evacuation drills were occurring and records maintained. Residents had personal evacuation plans in place. The provider had identified that improvements were required in relation to emergency lighting and that door closer were required in the centre. The inspectors viewed evidence that these works had been planned for February 2020 and due to restrictions relating to the pandemic, had not been completed. In the interim the provider had a risk assessment in place.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had their healthcare needs assessed and care plans developed as required. They were supported to access allied health professionals in line with their assessed needs and to access national screening programmes in line with their wishes.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices in the centre were reviewed regularly to ensure that the least restrictive measures were used for the shortest duration. A number of restrictive practices had been reduced or removed since the last inspection and plans were in place to reduce or remove others. Plans and guidelines were developed as required to support residents and they were detailed and clearly guiding staff to them.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Allegations or suspicions of abuse were reported and followed up on in line with the organisation's and national policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to make decisions in their daily lives and consulted with in relation to the day-to-day management of the centre. There were regular residents' meetings and arrangements in place to support them to access advocacy services if they wish to.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for SVC - CN OSV-0003167

Inspection ID: MON-0029681

Date of inspection: 23/07/2020

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Regulation 16 (1)(a) - PIC has completed Audit of Training Needs in designated Centre and has a training plan scheduled to year end. Training requirements have been forwarded to CNM 3 office for discussion with Training coordinator. PIC will ensure that all staff who are due refresher training will complete online HSELAND Safeguarding and Manual Handling Training. All staff will be reminded of the importance of keeping up to date with Fire Regulations and also keeping up to date with – Personal Evacuation Plans, use of fire extinguishers, completing Fire Drills. As soon as it is safe to resume and in line with Public Health and Infection Prevention and Control requirements all required training will be completed Regulation 16(1)(b) – The PIC will ensure all staff have Annual Personal Development Reviews completed before year end. The PIC has a System in place for staff Supervision.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 23 (1)(c) – All identified actions from Provider visits will be progressed to completion by PIC. Regulation 23 (1) (d) – Annual Review for the Designated Centre for 2019 will be completed by October 30th 2020. Service Manager will contact Quality and Risk Officer to confirm a date for completion of Annual Review.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Regulation 17 (1) (a) - A Plan was submitted to HIQA on 30th November 2018 which outlined that shared occupancy will be addressed as vacancies occur. Regulation 17 (6) – Service Manager and PIC will review shared occupancy each time a vacancy occurs within the Centre.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28 (2) (c)) - A Risk Assessment has been completed for external contractors to enable them to carry out their work safely as agreed and approved with the Serious Incident Management Team (SIMT). Regulation 28 (3) (a) – External Contractors have commenced work to ensure all emergency lighting and self – closing mechanisms on all internal doors are installed.	

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 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	31/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/12/2026
Regulation 17(6)	The registered provider shall ensure that the	Substantially Compliant	Yellow	31/12/2026

	designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/10/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/10/2020
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape,	Substantially Compliant	Yellow	30/09/2020

	including emergency lighting.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/10/2020