Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Cliff House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 3
Type of inspection:	Short Notice Announced
Date of inspection:	13 August 2020
Centre ID:	OSV-0003257
Fieldwork ID:	MON-0026125

About the designated centre

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

The designated centre consists of two houses with the capacity to provide full-time residential care and support for four children with an intellectual disability and autistic spectrum disorder. Residents are supported with their positive behaviour support needs, augmentative communication needs, emotional support needs, and physical and intimate care support needs. The centre is situated in a suburban area of Co. Dublin with access to a variety of local amenities such as shops, train stations, bus routes, churches and the city centre. There are vehicles available to enable residents to access school and local amenities. There are two premises in the designated centre. The first house is a three-bedroom, split level, terraced home. The second house is a two bedroom, terraced split level house over three stories, situated within walking distance of the other house. Each resident has their own bedroom all of which are single ensuite rooms. Each resident is actively encouraged to personalise their own bedroom. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, person participating in the management of the centre, and healthcare workers. Staffing numbers are adjusted as the dependencies of the residents change.

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
Thursday 13 August 2020	10:00hrs to 15:30hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and briefly engage with three residents living in one of the houses during the inspection. On arrival to the centre, the inspector met one resident on their way out the front door to engage in activities in the local community. They greeted the inspector with a smile and appeared happy as they left the centre supported by two staff members. They remained out for the duration of the inspection.

In line with public health advice, the inspector's interactions with residents were limited to under 15 minutes, using personal protective equipment, whilst respecting social distancing. On entering the centre, the inspector observed one resident coming down the stairs and then go to the kitchen table to complete a jigsaw with the support of a staff member. As the inspector left the kitchen they could hear the resident singing. Later, the inspector observed this resident having lunch. They appeared to be enjoying their meal and they were laughing and smiling with staff. On leaving the centre, the inspector observed this resident spending time in the living room playing video games with a staff member.

The inspector also had the opportunity to meet one resident who was relaxing in their room watching their tablet computer. They greeted the inspector with a smile and then continued to watch their tablet computer.

Throughout the inspection residents appeared comfortable in the presence of staff and with the levels of support offered. The atmosphere in the house was quiet and relaxed and residents were observed being supported by staff to make decisions in relation to how they wanted to spend their time. The inspector viewed a number of compliments from residents' representatives in relation to care and support for residents in the centre. They were particularly complimentary towards the staff team.

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. However, improvements were required in relation to the systems in place relating to the oversight and administration of the centre.

There was a clearly defined management structure in place. 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. However, improvements were required in relation to the oversight and administration of the centre as a number of notifications had been submitted to the Chief Inspector for this centre, which related to two different designated centres. One of these related to another centre run by the registered provider and another which related to a centre operated by another company which was owned and run by the registered provider.

A new person in charge had commenced in the centre last year and 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 had worked in the centre for a number of years and were very familiar with residents' care and support needs. They were working full-time and had the qualifications and experience to fulfill the role. They were supported by a person participating in the management (PPIM) of the designated centre. They were meeting regularly since the person in charge had commenced in the role, and had been conversing over the phone or via teleconference more regularly during the pandemic.

During the last number of inspections in this centre, the inspectors found that there was a heavy reliance on the PPIM as they were required to be in the centre regularly to ensure oversight and the implementation of new systems. However, the local management team in the centre had been further strengthened since the last inspection which had led to a reduction in the reliance on the PPIM. There were two team leaders supporting the person in charge with the day-to-day management of the centre. A residential co-ordinator post had been created and filled. However, this person fulfilling this role was currently fulfilling another role at the time of the inspection. The residential co-ordinator was responsible for a number of centres owned by the registered provider.

There were systems in place to monitor the quality and support for residents including audits, an annual review and six monthly visits by the provider. The audits and reviews were were identifying areas for improvement in line with the finding of this and previous inspections. There was evidence that the actions following these reviews had been followed up on and completed and that these were leading to positive outcomes for residents. The action plan in the centre for 2020 identified areas for improvement in relation to restrictive practices, keyworker training, medication management, renovation plans, supervision, residents' health plans, safeguarding procedures, monitoring staff's competencies, car checks, contracts of care, developing residents' links with family and the community and non mandatory training and staff development. A number of the actions to bring about these improvements had already been made and a number were delayed as a result of the pandemic.

Staff meetings had not been occurring regularly during the pandemic but discussions were held in relation to the day-to-day running of the centre at handover and in the centre's communication book. In addition, shared learning notices had been created and made available to staff in relation to areas such as; COVID-19, the use of PPE, hand washing, cough and sneeze etiquette, food safety, choking hazards and

visiting. Staff who spoke with the inspector stated they were well supported and could raise any concerns relating to the centre to the team leaders, person in charge, residential co-ordinator or PPIM. Staff meetings were planned in the centre over three dates in August.

Residents were supported by a staff team who were familiar to them. There were no staffing vacancies at the time of the inspection. Through discussions with staff, a review of rosters, audits and staff records, it was evident that improvements had been made since the last inspection in relation to the recruitment and retention of staff, and continuity of care for residents. 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. During the inspection, the inspector observed staff engaging with residents in a supportive and respectful manner. Residents appeared comfortable in the presence of staff and with the levels of support offered to them. New staff to the centre were in receipt of an area specific induction programme to ensure they were aware of residents' care and support needs and knew who to contact if they required support.

There was a system in place to ensure staff had access to and were completing the required training and refresher training, in line with residents' needs. Plans were in place for one staff member to complete manual handling training following the inspection and for all staff to complete area specific positive behaviour support training over three dates in August 2020. Staff had recently completed infection prevention and control training including hand hygiene and the use of PPE.

Staff supervision and support had been further strengthened since the last inspection. Following induction staff were in receipt of a review of competencies including regular assessments of their competency in relation to critical care and support areas. Formal supervision was being completed approximately every six to eight weeks.

Residents' admissions were found to be in line with the centre's policy and statement of purpose. The centre's policy considered the needs of residents already residing in the centre. Residents and their representatives were provided with the opportunity to visit the centre prior to admission. There was a written contract of care in place for residents which contained details in relation to support, care and welfare, the services to be provided and fees. However, one residents' contract of care had not been signed by them or their representative.

Regulation 14: Persons in charge

There was a full time person in charge who had the qualifications, skills and experience to manage the centre. They were familiar with residents' care and support needs and had systems in place to ensure they were monitoring the quality and safety of care for residents.

Judgment: Compliant

Regulation 15: Staffing

Residents were supported by a stable staff team and there was evidence of continuity of care though the use of regular relief staff and agency staff.

There were planned and actual rosters in place. However, improvements were required to ensure staff's second names were consistently recorded on them.

The inspector reviewed a sample of staff files and found that they mostly contained the information required by the Regulations. However, there were gaps in the employment history in one file reviewed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' assessed needs. There was a system in place to monitor when staff required training and refreshers.

Staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities.

Judgment: Compliant

Regulation 23: Governance and management

The centre was resourced to ensure effective delivery of care and support for residents.

The provider had systems in place to monitor the quality of care and support for residents including regular audits, an annual review and six monthly visits by the provider or their representative. These reviews were identifying areas for improvement and these were followed up on and leading to improvements for residents, both in their home and in their care and support.

Improvements were required to ensure that effective systems were in place to effectively govern the operational management and administration of the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There were admissions policies and procedures which take into account the need to protect residents residing in the centre.

Residents and their representatives had the opportunity to visit the centre prior to admission.

Residents had a contract of care which included a summary of the services and facilities and terms and conditions of residency. However, one residents' contract of care had not been signed by them or their representative.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose available in the centre which had been regularly reviewed and contained the required information.

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector was given notice in writing of incidents occurring in the centre 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. Through discussions with staff and a review of documentation, it was evident that staff and the local management team were motivated to ensure residents were safe and 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, the action plan in the centre for 2020 identified areas for improvement in relation to restrictive practices, the maintenance and upkeep of the centre, residents' health plans, safeguarding procedures and the need to further develop residents' links with family and the community. A number of these had been completed but a number were delayed as a result of the pandemic.

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. A monthly meeting was held to review incidents with members of the management team and there was evidence of learning and follow up from these reviews.

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. The provider had developed policies, procedures, guidelines and contingency plans for use during the pandemic. They had also updated existing polices, procedures and guidelines. There were good stocks of personal protective equipment available and systems in place for stock control and ordering. Staff 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 for the prevention, detection and containment of fire. 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. There were systems in place to ensure that fire fighting equipment and fire alarm systems were serviced and maintained. Staff had received fire safety and training. Fire evacuation procedures were on display in the centre.

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 considerations given to the use of the least restrictive practices, for the shortest duration. There was evidence that a number of restrictions had been removed or reduced since the last inspection and plans were in place to further reduce and eliminate other restrictions.

Monthly incident reviews were completed and used to inform changes to residents' support plans. Residents had access to allied health professionals and had support plans developed as required. A new behaviour specialist had just commenced in the centre and was in the process of updating a number of residents' support plans in line with their changing needs, to ensure they were clearly guiding staff to support them. Staff who spoke with the inspector were knowledgeable in relation to

residents' support plans and changing needs. Staff had access to training to support residents and further specific training was planned in the centre at the end of August.

Residents' healthcare needs were assessed and healthcare plans were developed and reviewed as required. These plans were detailed in nature and guiding staff to support residents. Staff who spoke with the inspector were aware of residents' healthcare needs and could explain the signs and symptoms to look out for, the steps to take in an emergency and when to administer medications in line with medication protocols. Systems were in place to ensure residents could be supported to access a general practitioner and other allied health professionals during the pandemic.

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 plans were developed and implemented as required. Residents had detailed intimate care plans in place.

Residents were being supported to make decisions in relation to their care and support and in relation to the day-to-day running of the centre. Choice and menu boards were available to support residents to make these choices. Residents were meeting with their keyworkers regularly. A number of documents were available for residents in format accessible to them, such as; the centre's statement of purpose, the complaints procedures, information relating to advocacy services and choice and rights, the residents' guide, residents' personal plans, residents' contracts of care and fire safety procedures. 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. Posters were available in relation to hand washing, cough and sneezing etiquette and testing for COVID-19. 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.

Regulation 26: Risk management procedures

Residents were protected by the risk management policies and procedures in the centre.

There were systems in place for the assessment, management and ongoing review of risk and systems in place to respond to emergencies.

Judgment: Compliant

Regulation 27: Protection against infection

Residents were protected by the policies, procedures and practices relating to the risk of healthcare associated infections.

Judgment: Compliant

Regulation 28: Fire precautions

Arrangements were in place to detect, contain and extinguish fires.

Staff had completed fire safety training and fire drills were occurring regularly in the centre. There were systems in place to maintain and service equipment.

Residents had personal evacuation procedures which clearly detailed the supports they required in the event of an emergency.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. Their healthcare needs were assessed and support plans were developed and reviewed as required.

Residents had access to allied health professionals in line with their assessed needs. Staff who spoke with the inspector were familiar with residents' healthcare needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had support plans developed and reviewed as necessary. At the time of this inspection, a number of residents' support plans were in the process of being reviewed and updated.

Staff had completed training to support residents and staff who spoke with the inspector were knowledgeable in relation to residents support needs.

Restrictive practices were reviewed regularly to ensure the least restrictive measures were used for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding residents.

Staff had completed training and those who spoke with the inspector were familiar with their roles and responsibilities in relation to reporting and escalating allegations or suspicions of abuse in line with the organisation's and national policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were communicated with during the pandemic in a format accessible to them.

There was evidence that residents were supported to make choice in relation to their day-to-day lives.

Information was available in relation to advocacy services should residents wish to access them.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cliff House OSV-0003257

Inspection ID: MON-0026125

Date of inspection: 13/08/2020

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 staff member's file was reviewed by the Registered Provider Representative, PPIM and PIC. The required amendments was made by the HR manager. It is now in line with Schedule 2. 20th August 2020. The current rostering systems was reviewed by the Registered Provider Representative, PPIM and PIC and amended. The PIC will now ensure to capture the full name of all staff named on the roster going forward. 17th August 2020	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Future Notifications for the center will now be submitted to the Chief Inspector on site where access to the portal is limited to that center. Submission of notifications will be overseen by the Residential Coordinator a new post within our governance and management structure 7th Sep 2020 The registered provider is in the process of incorporating all centers owned and operated by them under one entity. The organizational structures and lines of accountability are clearly defined within this entity. The appointment of 2 x residential co coordinators have	

been made to ensure management systems are in place in the designated centers to ensure that the service provided is safe, appropriate to the resident's needs, consistent and effectively monitored.

An external quality and compliance officer will monitor and oversee the residential coordinators role

The required paper work has been submitted to the regulator.

30th Sep 2020

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Registered provider representative, PPIM and PIC reviewed the current contract in care in place.

PIC spoke with resident's representatives and the contract of care will be signed at the next statutory review meeting.

30th September 2020

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	17/08/2020
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	20/08/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details	Not Compliant	Orange	07/09/2020

	responsibilities for all areas of service provision.			
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	07/09/2020
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	30/09/2020