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:	Hawthorns
Name of provider:	Health Service Executive
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	17 October 2019
Centre ID:	OSV-0003359
Fieldwork ID:	MON-0027925

About the designated centre

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

Hawthorns provides residential care for up to 23 adults both male and female with a mild to severe intellectual disability. The centre consists of five detached bungalows on a campus setting with green areas to the back and front. Each bungalow has an open plan living room with a defined dining area. Each home has a kitchen and utility room with laundry facilities. Each resident has their own bedroom with access to numerous bathrooms and plenty of private and communal space. The centre is in a suburban area of Dublin close to a local village with easy access to shops and other local facilities. The centre is close to public transport links including a bus and train service which enables residents to access local amenities and neighbouring areas. Residents are supported by a staffing team 24 hours a day seven day a week and the team comprises of a person in charge, clinical nurse managers, staff nurses and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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
17 October 2019	09:20hrs to 18:00hrs	Marie Byrne	Lead
17 October 2019	09:20hrs to 18:00hrs	Liam Strahan	Support

What residents told us and what inspectors observed

The inspectors of social services judgments in relation to the views of the people who use the service, relied upon observations, review of documentation, brief interactions with residents and discussions with staff.

The inspectors had the opportunity to meet and very briefly engage with nine residents during the inspection. They had an opportunity to spend some time with one resident who showed them around their home and their bedroom which they felt necessary to keep locked in order to keep their belongings safe. They also had the opportunity to have a cup of tea and a chat with another resident. Whilst the majority of residents appeared comfortable with the supports offered by staff, there were a number of residents who were spending extended periods of time in their home and did not appear to be engaging in any activities. For example, the inspectors observed one resident communicating to staff that they wished to go for a bus drive during the morning and again in the afternoon. In one of the areas, two residents were being supported by one staff and were reliant on the arrangement in place with another house to support them to leave their home to go for a walk or engage in activities if they so wished.

There were areas for maintenance and repair which were negatively impacting on the homeliness and safety of residents' homes. For example, in one of the houses the front door could not be used. As a result of this, on two occasions during the inspection one resident was observed having difficulty accessing his home and to be reliant on staff to gain access. The inspectors acknowledge that this had been reported to the maintenance department. In a number of houses, residents could not access areas of their home such as relaxation rooms due to required repairs, leaks or these areas being used for storage of broken furniture and other items.

Capacity and capability

Overall, the inspectors found that the registered provider and person in charge were not adequately monitoring the quality and safety of the care and supports for residents in the centre. As a result of concerns in relation to information received by the Chief Inspector in the form of notifications and a compliance plan update, a provider assurance report was sought. Assurances were not provided in this report and this risk based inspection was then completed. The findings of this inspection were that significant improvements were required in relation to staffing, admissions, positive behaviour support, safeguarding and the premises in order to bring about compliance with the regulations and to improve residents' lived experience.

Following the last inspection in August 2018, an additional condition was attached to

the registration of the centre in relation to staffing. At this time, the provider had identified that they would move into compliance with this regulation by 10 October 2019. This was not found to be the case as 13 staffing vacancies remained at the time of the inspection.

At the last inspection in August 2018, the management team outlined improvements that had been made since the previous inspection and their future plans for further improvements which would positively impact on residents' lived experience. During this inspection, the inspector was shown detailed plans in relation to how the required actions from the annual and six monthly reviews by the provider would be completed. However, the inspectors found that these improvements had not been completed in line with the timeframes identified. For example, appropriate staffing numbers was due to be in place and the internal and external maintenance and repairs were due to be completed by October 2019.

During this inspection, the inspectors reviewed the latest six monthly unannounced visit by the provider or their representative. Of the 10 actions identified in this review, seven related to areas identified during this inspection. None of these had been completed at the time of the inspection despite the dates for completion having passed. The inspector acknowledges that the timeframe identified by the provider for four of these actions had not yet passed.

The person in charge was on leave on the day of the inspection and the person participating in the management of the centre (PPIM) facilitated the inspection. They were found to be knowledgeable in relation to residents' care and support needs and motivated to provide a good quality of care and support for residents in the centre. They were recognising areas for improvement, in line with the findings of this inspection. The person in charge and person participating in the management of the centre (PPIM) were meeting regularly and escalating their concerns in relation to the quality of care and support for residents to the management team. They were completing daily, weekly and monthly quality visits, audits, regular staff meetings and residents' meetings. However, the actions required to make improvements were not progressing due to a lack of resources.

The staff team reported to the person in charge who in turn reported to the PPIM. There was an on-call system in the absence of the person in charge. The inspectors found that there were insufficient staff numbers to meet residents' assessed needs. In addition, the skill mix of staff was not appropriate to meet residents' assessed needs and there was a lack of continuity of care due to the large volume of shifts covered by different agency staff. In addition to the agency usage, there were also occasions when there were insufficient numbers of staff on duty in line with residents' assessed need or the centres' statement of purpose. For example, at the time of the inspection, there were six agency staff on duty which was 40% of the total staff on duty in the centre. In addition, three of the five areas were short staffed for a number of hours due to the fact that staff were on training. This resulted in reduced opportunities for residents to engage in meaningful activities. Regular staff members who spoke to the inspectors were found to be knowledgeable in relation to residents' care and support needs and motivated to support residents to engage in meaningful activities. However, in a number of areas

there was only one regular staff on duty with agency staff and and their priority was to keep residents' safe and comfortable for the day.

The inspectors reviewed rosters for the months of August and September 2019. In August 2019, 43% of the required shifts for staff nurses were covered by agency staff and 47% of the required shifts for care staff were covered by agency staff. In September 2019, 39% of the required shifts for staff nurses and 50% of required shifts for care staff care were covered by agency staff. From reviewing the minutes of the latest meeting between the registered provider representative and the management team in the centre, there were plans in place to expedite the recruitment of new staff to fill the current staffing vacancies. The provider outlined that they were attempting to use regular agency staff. However, due to the volume of shifts that were required, this was not proving possible. The inspectors found that planned and actual staff rosters were not properly maintained in the centre. The rosters did not accurately reflect who was on duty in each house. For example, the names of agency staff were not recorded on the actual rosters. The inspectors reviewed a sample of staff files and found that the majority of the information required by the regulations was available. Some of the information was sourced before the end of the inspection and one outstanding piece of information was forwarded to the inspector after the inspection.

The inspectors reviewed the admissions policies, procedures and practices in the centre and found that a planned admission was not being completed in line with the statement of purpose. It was found that the provider was not fully considering the need to protect residents and ensure their care and support needs could be fully met due to the current concerns relating to staffing and available supports and resources in the centre. This was discussed at the closing meeting with the manager representing the provider in relation to assuring themselves that the admission was safe and appropriate at this time. Through the review of documentation and discussions with staff, there were identified compatibility issues between a number of residents living in the centre. The provider had recognised this and there were a number of residents identified to transition from the centre due to this, or in line with their changing needs. However, these transitions were not progressing in a timely manner with one resident waiting three years to transition in line with his wishes and preferences. The inspectors acknowledge that this resident had been supported to access an advocate to support them and that a referral had been made to the Office of the Ombudsman.

There was a complaints policy and procedures in place which had been recently reviewed and updated. The complaints procedure was available and on display in an accessible format in each home. In line with the findings of the last inspection, there was evidence that complaints were logged, investigated and followed up on. However, the satisfaction level of complainants were not recorded in a sample of complaints reviewed by the inspectors. The inspectors were informed at the opening meeting that a complaint which was open at the last inspection, remained open due to the fact that it had not been resolved to the satisfaction of the complainant. Advocacy information was available and on display. There was evidence that residents were supported to access an advocate in line with their

wishes.

In response to the provider assurance report, there had been a recent meeting between the registered provider representative, PPIM, person in charge, and a principle social worker from the safeguarding team. During this meeting a review of the matters outlined in the provider assurance report submitted to the Chief Inspector were discussed. This meeting reviewed the areas for improvement in relation to staffing, governance and management, positive behaviour support and protection. It outlined the providers plans to put the resources in place to make the required improvements in these areas.

Regulation 15: Staffing

The provider was in breach of the additional restrictive condition of the registration of the centre due to the fact that they had not moved into compliance with this regulation in line with the timeframe identified in this condition. There were not enough staff to meet residents' needs due to 13 staffing vacancies at the time of this inspection. The provider was attempting to minimise the impact of these vacancies for residents by using regular agency staff. However, this was not always proving possible and was leading to lack of continuity of care and poor outcomes for residents living in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider was not ensuing that residents were in receipt of good quality and safe care due to the combined impact of the non compliance with the regulations on residents' lived experience in the centre. Resources were not available to provide person-centred care and supports for residents in line with their assessed needs or the centres' statement of purpose. The provider was failing to act on the key concerns highlighted in their own reviews of the centre and this was leading to negative outcomes for residents in relation to the environment they were living in and the supports available to them.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There were admissions policies and procedures in the centre. There was evidence of compatibility issues between a number of residents and that a number of residents

living in the centre were due to transition to other service in line with their changing needs. The inspectors reviewed evidence in the centre that indicated that a planned admission to the centre was not being completed in line with the organisations admissions policy or the centres statement of purpose.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents were protected by the complaints policies and procedures in the centre. There was evidence that complaints were logged, escalated and followed up on in line with these policies and procedures. However, there was not documentary evidence of the satisfaction levels of the complainant in some of the complaints reviewed.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found the provider was not ensuring that the quality of the service provided for residents was safe and of a good quality. Through discussions with staff and review of documentation it was evident that staff and the local management team were striving to ensure that residents lived in a caring environment. However, this was not proving possible due to a lack of resources and a lack of progress on actions identified by the provider to make the centre a nicer and safer place to live.

Significant improvements were required in relation to staffing numbers, admissions, safeguarding and the premises. These areas for improvement were contributing to residents not living in a safe, comfortable or homely environment.

The inspectors completed a walk around the five houses during the inspection and found that significant improvements were required in relation to the maintenance and upkeep of the premises. There were areas in the centre which were not clean during the inspection including interior and exterior areas. There was no toilet seats or toilet paper available for residents in a number of bathrooms. In one of the shower rooms there was black mould on the ceiling. The inspectors were informed that one resident prefers not to have a toilet seat on their toilet which accounted for the reason one of the toilets having no toilet seat. In one premises, there were a number of damaged doors with missing door handles and this was found to be leading to an immediate risk for residents as there was the possibility of getting locked into the bathroom or bedroom when the door closed. In addition,

there were a number of pieces of broken furniture with sharp edges found. An immediate action was issued in relation to addressing the safety issues identified by the inspectors. This was escalated to the maintenance department who visited the centre to deal with the safety issues causing immediate risk to residents. The areas which required maintenance, repair, decoration and cleaning were found to be negatively impacting on the homeliness of the centre. There had been a leak in one of the houses and the repairs had not been fully completed leaving the room unavailable for residents' use. In addition, works had been started in a number of areas and not fully completed leaving exposed holes, plaster missing and areas requiring painting. The inspectors viewed evidence that the areas for repair, maintenance and decoration had been reported to the maintenance department via the weekly referral system. However, in some cases items had been reported and not acted on in a timely manner. For example, an item reported to the maintenance department in August 2019, had not been fixed at the time of the inspection. In addition, areas for improvement in relation to the premises which were identified on the last inspection in 2018 remained in place. For example, the doors on the kitchen and utility presses required repair or replacement and they had further deteriorated since the last inspection.

Residents who required them had positive behaviour support plans in place. The provider had identified that these plans required review in line with the fact that incidents/adverse events and safeguarding concerns were increasing in the centre. Staff who spoke with the inspectors were knowledgeable in relation to residents' support plans. However, on reviewing incident reports, positive behaviour support plans, risk assessments and through discussions with staff, the inspectors found that staff were not in a position to fully implement residents' positive behaviour support plans due to lack of regular staff in the centre. There was evidence from a review of a sample of residents' risk assessments, that incidents were rising quarter on quarter in 2019.

There were a number of restrictive practices in the centre and evidence that restrictive practices were recorded and regularly reviewed. However, from reviewing documentation in the centre it was evident that restrictive measures were being put in place due to lack of staffing support available for residents. Staff were attempting to use the least restrictive measures for the shortest duration. However, due to low staffing numbers and lack of consistency, this was not always proving possible. For example, in one month a restrictive practice was put in place on 12 occasions due to lack of staff resources. While prescriptions and protocols were clear that as required medicines were for the treatment of conditions, staff described their use in the context of controlling residents' behaviour for reasons such as protecting them or other residents from harm. In addition, the inspectors reviewed a log of restrictions which also clearly recorded these reasons for the use of these medicines.

There were policies and procedures in place in relation to safeguarding residents in the centre. There was evidence that safeguarding concerns were reported and followed up on in line with the organisation's and national policy. Staff had received training in relation to their roles and responsibilities. However, through discussions with staff and review of documentation such as safeguarding plans and risk assessments, it was evident that there were compatibility issues between a number

of residents in the centre. The provider was aware of this and had put additional measures in place in an attempt to keep residents safe such as 1:1 staffing for a number of residents. However, they could not fully implement some residents' safeguarding plans due to lack of resources such as staff who were familiar with residents' needs. For example, the inspectors reviewed a number of residents' risk assessments and safeguarding plans which clearly stated that regular staff were required to implement them. In addition, there was evidence in a number of risk assessments, that there was quarter on quarter increases in the risk rating attached to them in 2019 due to the fact that incidents and safeguarding concerns were still occurring.

Overall, inspectors found that residents were not being protected by appropriate risk management systems. There were policies and procedure to guide staff practices and a risk register in place which was reviewed and updated regularly. Residents had individual risk assessments and there was evidence that they were also reviewed and updated regularly. However, the inspectors found that the control measures listed in a number of residents' risk assessments could not be fully implemented as a number of them related to the need for residents to be supported by regular staff. In addition, there was a lack of evidence to show follow up and actions to reduce the number of incidents despite monthly audits. There was evidence that the three vehicles in the centre were regularly serviced and insured.

In line with the findings of the last inspection, it was evident that efforts were being made by staff to ensure that residents were engaging in meaningful activities in line with their wishes. Staff were supported by activation staff to bring residents to activities in their local community and there were also planned group activities. However, the inspectors reviewed a sample of residents' activity records and found that whilst some residents were regularly engaging in activities both on campus and in their local community, a number of residents had limited opportunities to engage in activities and were remaining at home and carrying out activities such as short walks.

Regulation 13: General welfare and development

Efforts were being made to support residents to engage in activities in line with their wishes and preferences. However, due to a lack of resources this was not proving possible for all residents in the centre.

Judgment: Substantially compliant

Regulation 17: Premises

Significant improvements were required in relation to the maintenance and upkeep

of the premises to ensure that residents were living in a safe and homely environment. The premises was unclean in areas and not kept in a good state of repair as outlined in the body of the report. There were a number of safety issues identified in relation to the premises during the inspection which required to be immediately addressed by the provider. Items were stored in areas that were intended for use as relaxation and sensory rooms for residents which was leading to these areas not being available for residents' use.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were policies and procedures in relation to risk management available in the centre to guide staff to manage identified risks. There was a risk register and individual risk assessments in place and evidence that these were reviewed and updated regularly. However, due to lack of resources there was evidence that the control measures in a number of risk assessments could not be fully implemented. There was also a lack of evidence to show follow up and actions to reduce the number of incidents in the centre despite monthly audits.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had recognised the need to review residents' positive behaviour support plans in the centre to ensure they were effective. These were due to be fully completed by January 2020 and were due to include a review of incidents and the development of a set of planned actions and interventions unique to each resident. From a sample of residents' support plans staff were not in a position to fully implement the current behaviour support plans due to lack of resources in the centre. Restrictive practices were recorded and regularly reviewed and there was evidence that staff were attempting to use the least restrictive measures for the least amount of time. However, this was not always proving possible due to a lack of available resources such as staffing.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding concerns were reported, escalated and followed up on in line with the

organisation's and national policy. Safeguarding plans and risk assessments were developed as necessary and the provider had put additional control measures in place such as 1:1 staffing for a number of residents. However, due to a lack of resources safeguarding plans were not being fully implemented leading to them not proving effective at times.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Hawthorns OSV-0003359

Inspection ID: MON-0027925

Date of inspection: 17/10/2019

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. The Registered Provider Representative (RPR) has sought and achieved approval for 15 posts for Hawthorns Designated Centre. These posts are as follows,

Clinical Nurse Manager 2 x 1 post
Clinical Nurse Manager 1 x 2 posts
Registered Nurse Intellectual Disabilities x 3 posts
Care assistant Intellectual Disabilities x 8 posts

Currently; three Staff Nurse positions have being offered from the rolling RNID panel with NRS. Offers have gone to an additional four Care Assistants Intellectual Disability (CAID) from the local SSIDS panel. Further outstanding vacancies (4) CAID to be filled through the NRS on foot of Healthcare assistant Panel.

The competition for the 2 x Clinical Nurse manager 1 positions is underway within NRS

The post of CNM 2 indicated above has been expressed to the appropriate panel and the offer has been accepted. This post has moved to contracting stage.

2. In the interim to filling all vacancies as outlined above, the Provider will continue to utilize regular agency staff. These staff will be identified by name on the roster providing a more consistent allocation to provision of care thereby better meeting the needs of the residents. Completed

3. The PIC is working with regular staff in relation to their work patterns to achieve greater consistency and blending with regular agency staff. Completed

4. The PIC will ensure that all new staff will continue to receive a comprehensive induction to the service and be supported while becoming familiar with the needs of the residents and strategies in place to assist them to have a good quality of life. Completed

5. The PIC has commenced work on the roster (planned and actual) to ensure it accurately reflects the staff including agency that are on duty in each house on a given day. Completed

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Management system in Hawthorns have been strengthened to ensure that the service provided is safe, appropriate to residents needs and effectively monitored.

1. The PR has prioritised fifteen posts for Hawthorns. Currently; three Staff Nurse have being offered posts from the rolling RNID panel with NRS. Offers have gone out to four Care Assistants Intellectual Disability (CAID) from the existing panel. Further vacancies to be filled include two Staff Nurse and four CAID.

2. In the interim vacancies continue to be filled by regular agency staff. These staff are included on the roster providing a more consistent allocation to providing continuity of care thereby better meeting the needs of the residents. Completed

3. The PIC will ensure that all new staff will continue to receive a comprehensive induction to the service and be supported while becoming familiar with the needs of the residents and strategies in place to assist them to have a good quality of life. Completed

4. Work is ongoing with regular staff in relation to their work patterns to achieve greater consistency and blending with regular agency staff. Completed

5. A pathway to provide a more robust open communication between the PR and the PIC has been implemented; the Designated Centre Management Meeting and Quality & Risk Meeting Minutes with identified actions put in place and any actions requiring further attention or decisions will be forwarded directly to the PR following the meetings. The PIC is an integral part of the Social Care Quality & Risk Forum and will ensure that all risks escalated to the PR are fully inclusive of appropriate local control measures while clearly advocating intervention in respect of actions required on behalf of the Provider. Completed

6. The PR has requested a full maintenance assessment of each house from the CH East Maintenance Officer to determine the immediate actions required with a plan in place for essential maintenance upgrades. The Provider Representative is advised that all but one action is completed in respect of the schedule of works. This remaining action is to be completed by the 29th of November. Completed

7. Environmental issues have been identified with Estate Management, Maintenance

Department and the Maintenance Officer. The key areas identified: bathrooms, toilets, kitchen and utility areas have been prioritized for remediation. Tenders have been received in respect of these upgrade works for 5 houses with an agreed start date of the 5th of December 2019.

8. Replacement equipment and furniture has been identified and costings have been sought in this regard. The Provider Representative has committed to enabling the procurement of these items as part of the capital upgrade for Hawthorns Designated Centre.

9. Front door and internal door locks have been replaced. Completed

10. Net curtains have been approved and ordered where they were required across the houses. Completed

11. Deep cleaning has been completed across all houses and this included entrances and doorways. Completed

12. Toilet areas have been brought up to standard, with toilet seats replaced and toilet paper and hand washing facilities available for all residents. Regular monitoring by the PIC and maintenance officer is in place to ensure that items are repaired/replaced in a timely manner. Completed

13. Other areas included removal of equipment; broken furniture and equipment no longer in use were removed on 18/10/19. This has facilitated better storage for one resident's belongings and the provision of a relaxation room for a resident in another house. Completed

14. An ongoing leak in one house which has damaged the wall and floor is currently being addressed by the maintenance department. To be completed by the 30/11/2019

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
1. The PR has advised that the Admission Policy and Statement of Purpose be reviewed and updated to ensure that any admission to the Centre must be risk assessed and evaluated in terms of the potential impact on existing residents until a stable position has been achieved in terms of the staffing profile of the Centre.

a. Transition Plans for two residents were reviewed and re-prioritised following Safeguarding incidents resulting in a determination to move those residents out of Hawthorns to a more appropriate community residence. One resident transitioned to a

new community home on 16/11/19. Completed

b. Another residents' transition has been progressed to facilitate them to move to a service specific to their assessed needs by the 14/1/2020.

c. Work has commenced to identify an alternative accommodation for another resident to better meet their care and support needs.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. All complaints in the last year made by or on behalf of residents have been reviewed with the complainant and resolved to reflect their satisfaction with the outcome, where this had not already been completed at time of last Inspection. Completed

2. The PIC will ensure that all complaints will be audited to ensure they are completed fully at the end of each month. The PIC will also provide feedback via Management, Quality and staff meetings and ensure responses are reviewed in a timely manner and actions are put in place to improve practice. Completed

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• A review of Person Centred Support Plans (PCSP) to give a great focus on activities to facilitate community integration and social activities for residents with limited or reduced opportunities is taking place. Goals or activities identified will be supported by actions that ensure that requirements to support the activities; such as transport and or familiar staff are available to ensure they happen. To be completed by 13/12/2019

• Home based activities for residents who do not wish to be as active in accessing community activities will be sourced and provided to ensure they are offered regular access to activities they enjoy. To be completed by 13/12/2019

• The PR has prioritised fifteen posts for Hawthorns. Currently; three Staff Nurse have being offered posts from the rolling RNID panel with NRS. Offers have gone out to four Care Assistants Intellectual Disability (CAID) from the existing panel. Further vacancies to

be filled include two Staff Nurse and four additional CAID posts.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The PR has requested a full maintenance assessment of each house to determine the immediate actions required with a plan in place for essential maintenance upgrades. This work has been completed with the exception of one element of work which will be completed by the 29/11/2019

2. Environmental issues have been identified with the Estate Management, Maintenance Department and the Maintenance Officer. The key areas identified: bathrooms, toilets, kitchen and utility areas have been prioritized for remediation.

3. Tenders have been accepted for the upgrade of toilets and bathrooms, kitchen and utility area for the five houses. Contracts have been awarded with a commencement date of the 5/12/2019.

4. Replacement equipment and furniture has been identified and costed. Completed

5. Net curtains have been approved and ordered where they were required across the houses. Completed

6. Deep cleaning has been completed across all houses and this included entrances and doorways. Completed

7. Other areas included removal of equipment; broken furniture and equipment no longer in use were removed on 18/10/19. Completed

8. Meeting and walk about with the Maintenance Manager has taken place with the PIC. The PPIM has completed a walkabout with Estate Management and the PIC to identify all areas requiring action and this information has been advised to the RPR and the maintenance department. Completed

9. An additional unannounced service review has been completed across both day shifts and night shift by the Director of Nursing (PIC), CNM 2 for Infection Control, CNM 3 for Quality and Risk and a CNM 3 who provided feedback to staff and the PIC. An action plan has been put in place to address all areas including these not completed from previous unannounced have been clearly identified for remediation. Completed

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The PR has prioritised fifteen posts for Hawthorns. Currently; three Staff Nurse have being offered posts from the rolling RNID panel with NRS. Offers have gone out to four Care Assistants Intellectual Disability (CAID) from the existing panel. Further vacancies to be filled include two Staff Nurse and four CAID.

2. In the interim vacancies continue to be filled by regular agency staff. These staff will be identified on the roster providing a more consistent allocation to provision of care thereby better meeting the needs of the residents. Completed

3. The PIC is working with regular staff in relation to their work patterns to achieve greater consistency and blending with regular agency staff. Completed

4. The PIC will ensure that all new staff will continue to receive a comprehensive induction to the service and be supported while becoming familiar with the needs of the residents and strategies in place to assist them to have a good quality of life. Completed

5. Service risk assessments have been reviewed and updated and will be brought to the monthly Management/Quality meeting where they will be audited to identify and address the themes arising. Risk assessments uploaded to CHO 6 Social Care Register where appropriate. To be completed by 29/11/2019

6. The PR has facilitated a review of all behaviour support plans by EIST in conjunction with Studio 3 and this is currently taking place and due to be completed by 23/12/2019

7. The form for recording all Restrictive Practices has been updated to facilitate auditing and capture staff's comments on how it can be reduced. Completed

8. As part of education (Medicines Management Policy) around the use and implementation and recording of restriction's staff have been informed by the PIC that the use of PRN psychotropic medication is to be administered as a therapeutic intervention only. Completed

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. A review of all behavioural support plans by EIST in conjunction with Studio 3 is taking

place. This will inform practice and facilitate additional actions and support recommendations for individual residents to reduce the number of incidents occurring in the designated area.

2. The PR has prioritised fifteen posts for Hawthorns. Currently; three Staff Nurse have being offered posts from the rolling RNID panel with NRS. Offers have gone out to four Care Assistants Intellectual Disability from the existing panel. Further vacancies to be filled include two Staff Nurse and four Care Assistants Intellectual Disabilities.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The PR has prioritised fifteen posts for Hawthorns. Currently; three Staff Nurse have being offered posts from the rolling RNID panel with NRS. Offers have gone out to four Care Assistants Intellectual Disability from the existing panel. Further vacancies to be filled include two Staff Nurse and four Care Assistants Intellectual Disabilities.

2. A review of all behavioural support plans by EIST in conjunction with Studio 3 is taking place. This will inform practice and facilitate additional actions and support recommendations for individual residents to reduce the number of incidents occurring in the designated area.

3. Transition Plans for two residents, who have been re-prioritised following Safeguarding incidents to move out of Hawthorns to more appropriate community accommodation are in place, which will greatly reducing the number of incidents, reduce restriction's.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	13/12/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	28/02/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	28/02/2020

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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.	Not Compliant	Orange	31/01/2020
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	15/11/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	15/11/2019
Regulation 17(7)	The registered	Not Compliant		31/03/2020

	provider shall make provision for the matters set out in Schedule 6.		Orange	
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	28/02/2020
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.	Not Compliant	Orange	15/11/2019
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	15/11/2019

Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	15/11/2019
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	15/11/2019
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	15/11/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint	Substantially Compliant	Yellow	15/11/2019

	and whether or not the resident was satisfied.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	15/11/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	31/01/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/01/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where	Not Compliant	Orange	31/01/2020

	a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/11/2019