Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Hortlands
Name of provider:	Gheel Autism Services Company Limited by Guarantee
Address of centre:	Dublin 16
Type of inspection:	Announced
Date of inspection:	09 April 2019
Centre ID:	OSV-0003507
Fieldwork ID:	MON-0022533

About the designated centre

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

Hortlands and Hortlands Flat consists of two residential homes located in a suburb in Co. Dublin. These facilities can cater for eight residents, both male and female over the age of 18. There are currently six residents living in the designated centre. The designated centre is comprised of two buildings, Hortlands house has seven bedrooms, two bathrooms, a kitchen and a living area. In Hortlands flat there are two bedrooms, a kitchen, bathroom and living room. There is a prefabricated wooden building at the end of the garden that contains two additional communal rooms for residents. The designated centre specialises in providing residential services in a personalised and homely atmosphere. The designated centre has a low arousal philosophy, which is used to support adults with a diagnosis of Autism. Residents are supported by a team of social care workers and care workers. These staff are directly overseen by a location manager.

The following information outlines some additional data on this centre.

Current registration end date:	04/09/2019
Number of residents on the date of inspection:	6

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
09 April 2019	09:30hrs to 18:30hrs	Sarah Mockler	Lead

Views of people who use the service

The inspector met with all six of the residents on the day of the inspection. The residents in this centre used verbal and non-verbal communication, so where appropriate some residents' views were relayed through staff advocating on their behalf. Residents' views were also taken from house meeting minutes, the designated centre's annual review and various other records that endeavoured to voice the residents' opinions.

A resident showed the inspector around their bedroom and appeared happy and proud of their possessions and photos on display. With the support of staff the resident told the inspector the places they like to visit in their local community.

Another resident showed the inspector around their home and their bedroom, and explained to the inspector they had just moved into this room. They were very happy with their new room and were in the process of organising their personal possessions. This resident also spoke about the different activities they took part in with their local community centre including a food and nutrition class, and a mindfulness class. One resident spent time with the inspector discussing their favourite activities and interests, and discussed how they liked to cook for the resident they were sharing their home with.

Residents' views were also taken from the Health Information and Quality Authorities questionnaires for residents, and various other records that endeavoured to voice the residents' opinion, such as the annual review. Two of the questionnaires were directly filled out by residents and they indicated they overall were very happy with where they lived. One resident did note that there were aspects of the garden and home that could be improved upon. In the annual review residents and also there representatives had an opportunity to contribute through specific forums and key working session and questionnaires. Overall the findings of the annual review report found that the quality of care provided was excellent.

Staff advocated on the residents behalf described the residents as happy within their home and readily described many of the meaningful activities the residents took part on across the day. The inspector observed caring and respectful interactions between staff and residents across the day of inspection.

Capacity and capability

The inspector found that the registered provider and the person in charge were

effective in assuring a good quality service was provided to the residents. Due to the effective governance in the centre there were positive outcomes for residents, person centred care ensured that an inclusive environment was promoted where each residents' specific needs were considered. However, improvements were required in training and development for staff.

The governance and management systems in place ensured that high-quality, person-centred care was being provided in the centre. Recently within the organisation the management structure had been reorganised to promote a knowledge based service. The management structure was clearly defined with clear lines of accountability and authority. The person in charge was in a full time role and they directly reported into the Director of Services. The location manager was responsible for the centre. They were directly supervised and managed by the person in charge. Staff stated that they felt well supported in their roles and there was a culture of open communication within the organisation.

There were appropriate systems and processes in place that underpinned the safe delivery and oversight of the service. There was an annual review of the quality and safety of care and support in the designated centre as well as unannounced visits from the provider. There were systems in place to monitor the quality of care and support for the resident including a suite of audits which were completed regularly. The suite of audits included and were not limited to; medication, health and safety and finances. These reviews and audits were identifying areas for improvement, and actions from these reviews were impacting positively on residents care and support and their home. Supervision of staff was being completed at regular intervals, however, there were some gaps in the documentation process in relation to this.

There were enough staff with the right qualifications and experience to meet the assessed needs of the residents. On the day of inspection there were some agency staff being used. Although there were no vacancies in the centre, a recent emergency discharge out of the centre resulted in some staff now working with this individual in their new home. The provider and person in charge were striving for continuity of care for all residents and had ensured that this was in place for the individual who had to move out. They also ensured that the same agency staff were being used and were always supported by a permanent member of staff. There was an actual and planned rota in place. In Hortlands Flat the residents were consulted on the staff rota and had the opportunity to choose when to roster staff support in line with their needs and busy schedules. This was just recently introduced and the staff member and residents expressed that it was working very well. Interactions between staff and residents was caring and mindful of the residents individual needs and preferences. Staff facilitated a supportive environment and clearly recognised their role as advocates for the residents.

Staff had received relevant training, demonstrated knowledge and competence in these areas and had implemented the training into practice, however, some staff members had not completed refresher training. These had been scheduled over the coming weeks, however some staff members were due to complete this training early in 2018. Although staff were being supervised, it was not always in line with

the organisations policy and there were some gaps in the documentation process in relation to this.

The registered provider had established and implemented effective systems to address and resolve issues raised by residents and or their representatives. The residents were encouraged and supported to express any concerns safely and were assured that there were no adverse consequences for raising an issue of concern. There was an open complaint on the day of inspection and documentation was reviewed in relation to this. The complaint was responded to appropriately in line with the organisations policy and records were maintained as required.

Regulation 15: Staffing

There were enough staff with the right skills, qualifications and experience to meet the assessed needs of residents. There was an actual and planned rota. Information and documents specified in Schedule 2.

Judgment: Compliant

Regulation 16: Training and staff development

Gaps were identified in the supervision documentation but did not impact upon residents. Staff had received relevant training, demonstrated knowledge and competence in these areas and had implemented this into training resulting in positive outcomes for residents, however some staff members had not completed refresher training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure was clearly defined and identified the lines of authority and accountability, specified roles and detailed responsibilities. There was an annual review if the quality and safety of care and support in the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was in place and included all information set out in associated schedule.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints process was user friendly, accessible to all residents and displayed prominently. Complaints process was well managed and recorded appropriately.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was person centred and suitable for the assessed needs of the residents. Staff were very knowledgeable about the residents' preferences, needs and communication style. However, improvements were required in relation to the premises, individual personal planning process and fire containment.

The premises consisted of one seven bedroom house and one double apartment. The inspectors were invited to look around some of the residents' bedrooms. The bedrooms were evidently decorated to each individuals taste and had many of their favourite possessions were on display and were proudly shown to inspectors. Some residents chose to collect different types of items and keep or display them in their homes. It was evident that the provider was balancing the risk management element of a residents who liked to collect items with the homeliness of the centre and residents' wishes for their own homely environment. However the premises required significant maintenance and remedial work both inside and outside. This continued to be an ongoing issue following the previous inspections. A long term plan has been put in place in order to address this and it was hoped that within the next two years a suitable premises would be available for the residents.

Residents were supported to bring their own belongings into their rooms. There was enough space for each resident to store and maintain clothes and other important possessions such as their individual collectable items.There was a list of personal possessions kept on each individuals' personal plan and this was reviewed

and maintained as necessary.

A sample of individual personal plans were reviewed on the day of inspection. There was evidence to indicate that this process was person-centred and enabled the staff to provide the necessary care to the residents. Residents had access to meaningful activities and on the day of inspection some of the residents readily spoke about the activities they attended in their local community. There was a positive approach to risk taking which maximised the residents' independence in their day. However improvements where required in the review of the personal plan. Some aspects of the personal plan where not reviewed on an annual basis.

Residents who are eligible, by means of gender, age or condition, are made aware and supported to access, if they so wish, the National Screening Services. Residents' health care needs were appropriately assessed. They had the appropriate health care assessments and support plans in place. Each resident had access to appropriate allied health professionals in line with their assessed needs. The provider and person in charge were actively liaising with the relevant health care providers to ensure that any recommended health care intervention was completed in the least intrusive way for the resident.

Residents were protected by appropriate policies, procedures and practices in relation to the ordering, receipt, storage and disposal of medicines. Staff had completed safe administration of medication training and practical administration prior to administering medications. Regular stock checks were completed in relation to medication. Monthly medication audits were also completed and any learning identified from these audits was implemented into practice.

Where required residents had positive behaviour support plans support from relevant allied professions. The plans identified identified proactive and reactive strategies to support the resident. Function based assessments were completed to determine the possible functions of behaviours and data was used to monitor the effectiveness of the plan. Staff were very knowledgeable on individual needs and could readily describe the supports residents required.

Since the previous inspection in 2017 there were substantial improvements in relation to fire safety. Staff had received suitable training in fire prevention and emergency procedures. The registered provider had ensured that all fire equipment was maintained and serviced at regular intervals. There was adequate means of escape, including emergency lighting. All escape routes were clear from obstruction. The mobility and cognitive understanding of residents had been considered and appropriate emergency plans had been developed. Fire drills were completed with staff and residents at suitable intervals. However on the day of inspection the provider failed to have adequate arrangements for suitable fire containment in one of the houses. A fire door was found to be wedged opened in the main house. This fire door was fitted with an automatic closer which also failed to work. This fire door was located in a high risk area. The inspector sought immediate assurances in relation to this on the day of inspection. The location manager immediately removed the wedge from the door.

On review of documentation within the centre there was significant evidence to indicate that the provider and person in charge were actively trying to protect residents from all forms of abuse. The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where a resident was harmed or suffered abuse. Safeguarding plans, were required, had been put in place and were monitored to ensure there effectiveness.

Regulation 12: Personal possessions

Residents retained access and control over their own belongings were possible. Residents were supported to bring their own belongings into their room. There was enough space for each resident to store and maintain clothes and other possessions.

Judgment: Compliant

Regulation 17: Premises

The centre was not kept in a good state of repair.

- Paintwork was required throughout each of the homes on walls and ceilings.
- Taps were leaking in baths and sinks.
- Bath and sinks were discoloured.
- Wardrope doors were marked and chipped.
- Outside paved area was very uneven.
- There was mould on one of the ceilings in the bathroom.
- Tiles in bathrooms were broken.
- Tile grouting in bathrooms was missing or badly discoloured.
- Towel rails in bathrooms were missing with part of it left attached to a wall.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced when required. However a fire door was wedged open in a high risk area.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The practice relating to the ordering, receipt, prescribing, storing including medicinal refrigeration, disposal and administration of medicines was appropriate.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan that was reflected in practice but there were gaps in the documentation that did not result in a medium to high risk for the individual. Some aspects of the personal plan where not reviewed on an annual basis.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate health care was made available for each resident, having regard to the resident's personal plan. There was evidence that residents were consulted and participated in the National Screening Process.

Judgment: Compliant

Regulation 7: Positive behavioural support

Appropriate supports were in place were required. Staff had up to date knowledge and skills appropriate to their role. Where a resident's
behaviour requires intervention every effort is made to identify and alleviate the cause of of the behaviour that is challenging.

Judgment: Compliant

Regulation 8: Protection

The residents are supported to develop the knowledge, self awareness, understanding and skills needed for self care and protection. The person in charge had initiated and put in place an investigation in relation to any incident of abuse and takes appropriate actions.
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
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hortlands OSV-0003507

Inspection ID: MON-0022533

Date of inspection: 09/04/2019

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff Supervision.

It was noted on the day of our Inspection that there was a minimal gap in the Supervision document folder.

• All outstanding Supervisions will be completed in full by Friday the 31st of May.

Staff Training.

It was noted on the day of our Inspection that some members of the staff team were out of date with full compliance related to their refresher training.

• Safeguarding Training - will be completed for the full team on June the 11/06/2019. All staff will be fully compliant.
• Sam training - will be fully completed and all relief will be up to date on the 09/05/2019 and 10/05/2019. All staff will be fully compliant
• Fire training – all outstanding staff will complete their Fire Safety training 25/07/2019. Staff will be fully compliant.
• HACCP training - will be completed for all outstanding staff on the 27/06/2019, all staff will be fully compliant.
• Report Writing – all outstanding staff will complete their Report Writing training and be fully compliant 13/08/2019.
• First Aid – The full team will be attending First Aid Training on the 20/06/2019.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Gheel are in full negotiations with the HSE regarding the required refurbishment to the premises - Hortland's House.

• Bathrooms - Quotes for all the contracted work have been secured for the refurbishment of the bathrooms, and the fitting of an additional safety handrail at the back kitchen steps.
• Gheel have reviewed the quotes and agreed to finance the required works.
• The scheduled work is due to commence on the 07/05/2019.

We are please to confirm that the following works have been completed.

The bathrooms have been refurbished and - work completed on the 10/05/2019.
The safety handrail at the backsteps has been installed – work completed on 10/05/2019
The ground works (outside the Garage area) is scheduled to commence on the 27/05/2019.
The resurfacing of the back yard area is scheduled to be completed during week the 27/05/2019.
The interior painting of the premises is scheduled to be completed in June 2019 (As discussed with our HIQA Inspector on the 15/05/2019).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The noted issue on the day of our Inspection has now been fully resolved as follows.
• Removal of access to door wedges for the related resident.
• Social story has been implemented for the resident so that he understands the need for Fire Safety.
• MasterFire has repaired the faulty electrical switch on the identified door – repaired 02/05/2019
•

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Review of Individual Support Plans.
• All Individual Personal Plans will be fully reviewed and updated by the 24//06/2019.

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	13/08/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	07/06/2019
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	10/05/2019
Regulation 28(3)(a)	The registered provider shall	Not Compliant	Red	03/05/2019

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	24/06/2019