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:	Ravenswell
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	15 May 2019
Centre ID:	OSV-0003581
Fieldwork ID:	MON-0022535

About the designated centre

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

Ravenswell is a designated centre comprising of two separate residential units located in a larger building within a campus-based setting. Ravenswell provides residential and respite services to eleven adults (male and female) with disabilities. Each resident has their own bedroom decorated to their individual assessed needs and personal preferences. Communal areas within the designated centre include sitting rooms, dining areas, kitchens and a relaxation room. The centre is located within walking distance to a town in Co. Wicklow where residents have access to a range of community based facilities to include cafes, hotels, pubs, parks, shops and shopping centres. Transport is also provided for residents to avail of day trips, outings and holidays. The staff team consists of a person in charge, a deputy manager to the person in charge and a team of qualified social care professionals and nurses. All residents have personal plans in place detailing their social care goals, daily routine and healthcare needs. Residents also have regular and as required access to a range of allied professionals which include GP services, mental health services, occupational therapy, physiotherapy and speech and language therapy. The provider has identified the premises are not suited for their stated purpose and has plans to de-congregate the centre and support residents to transition to community based houses in a phased transition process, which at the time of inspection, was at an advanced stage.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

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
15 May 2019	10:20hrs to 17:45hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

The inspector met and spent some time with residents present on the day of inspection. Residents communicated through a number of different ways which included facial expressions, body language and some verbal interactions. Residents appeared happy and content in their home. Residents did not provide specific feedback about their views of the service. The inspector did review feedback questionnaires completed by families of some residents as part of the inspection process. Overall, the feedback received was very positive. Families praised the staff team that worked in the centre, they expressed satisfaction with the management of complaints and complimented the pleasant atmosphere in the centre when they visited. Some feedback questionnaires indicated the recent refurbishment of the centre was a welcome improvement. Some feedback received also discussed the pending transition of residents and families wish for this process to occur as soon as possible. Over the course of this inspection it was observed that residents seemed at ease and relaxed in the centre and staff interaction with residents was observed to be pleasant, patient and supportive.

Capacity and capability

This inspection found improvements since the previous inspection in relation to governance and management. The provider had made governance improvements within the centre at a local operational management level which in turn were having a positive impact on the quality of care and support provided to residents. While no residents had yet transitioned from the service to a community based residential home since the previous inspection, it was noted, on this inspection, that transition planning was at an advanced stage and tendering processes had begun.

Similar to the previous inspection findings, a full time person in charge was in place in the centre. The provider had made some governance improvement arrangements by appointing a deputy manager to support the person in charge in their role. This improved governance arrangement supported increased supervisory oversight of both residential units that comprised the designated centre. A senior person participating in management to whom the person in charge report to, also had operational management oversight of the centre.

It was demonstrated the provider had further enhanced their governance oversight arrangements by introducing a governance and quality overview system which reviewed key performance indicators of quality and safety within the centre. The person in charge and deputy manager used this system to oversee the quality of care and supports in place in the centre and had used this process effectively to

make improvements to the service provided to residents. Some examples of this included a comprehensive review of restrictive practices in the centre, fire safety measures, maintenance audits and risk management arrangements.

As required by the Regulations, there was an annual review of the quality and safety of care available in the centre along with six-monthly auditing reports. Each six monthly audit completed reviewed the provider and person in charges' compliance with meeting the regulations and standards and provided an action plan following each review. It was also evidenced the information gathered during each audit formed part of an overall governance assurance and oversight arrangement of the provider regarding the quality of care and support provided in the centre.

Improved staffing resource arrangements were also in place and it was noted a more responsive staff roster was being implemented to better support residents currently availing of respite and for residential residents to have better opportunities for evening activities, for example. This staffing arrangement had resulted in a reduced number of compatibility incidents between residents occurring in the centre demonstrating more effective staff resource management to meet the assessed needs of residents.

Staff training and development arrangements were effective. Staff had received appropriate training to meet the needs of residents and to also comply with mandatory training requirements. Some staff training gaps were noted in relation to behaviour support management. This is further discussed in the quality and safety part of the inspection report. Staff files were not reviewed on this inspection however, the inspector requested evidence to demonstrate all staff had received up-to-date Garda Vetting. It was found that appropriate arrangements were in place and all staff working in the centre had been appropriately vetted.

Overall, this inspection found that the management and staff of this centre were skilled and trained professionals providing good quality care and support to the residents. However, the centre was not appropriate or conducive in meeting some of the assessed needs of residents. Compatibility of residents remained a feature despite improved governance and oversight arrangements managing to mitigate potential incidents from occurring. The provider was required to implement the proposed transition plan currently underway to ensure a more optimum service and quality of care for all residents using this service.

Registration Regulation 5: Application for registration or renewal of registration

All required information for the purposes of renewing registration of this designated centre were submitted by the provider.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge in a full time capacity to oversee and manage the designated centre in line with the requirements of regulation 14. The person in charge was an appropriately qualified person that held appropriate management experience and qualifications to meet the regulatory requirements of Regulation 14.

Judgment: Compliant

Regulation 15: Staffing

While it was noted there were some whole time equivalent shortages on the day of inspection there were arrangements in place to fill these resource gaps within a short space of time. One staff was due to commence working in the centre the week following the inspection with a second staff member appointed to start their position the week after. A planned and actual roster was in place. The provider had ensured all staff working in the centre had received up-to-date Garda Vetting.

The person in charge and deputy manager for the centre had made some revisions to the staffing roster arrangements to ensure it was more responsive to the assessed needs of residents. This in turn had resulted in a positive impact for residents and had contributed to a reduction in compatibility incidents occurring in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The provider and person in charge had made appropriate arrangements to ensure staff received mandatory and additional training to meet the needs of residents. The person in charge and deputy manager had reviewed staff training and had put in place arrangements to support staff to receive refresher training in the months prior to the inspection.

Appropriate supervision arrangements were also in place. Improved operational governance and oversight by the deputy manager and person in charge between both residential units that comprised the centre had commenced and had brought about an improved quality of service provision for residents. Staff supervision meetings were documented and securely stored in the centre.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted the most up-to-date insurance statement for the centre during the course of the inspection. The provider had ensured appropriate insurance arrangements were in place.

Judgment: Compliant

Regulation 23: Governance and management

Improved local management systems and governance quality oversight arrangements had brought about improved service provision for residents living in this centre.

Transition and de-congregation planning for this designated centre had begun in 2015 however, these plans had not yet come to fruition at the time of inspection. It was noted however, that the first stage of the de-congregation plan was at an advanced stage. The provider was required to implement the proposed transition plan currently underway to ensure a more optimum service and quality of care for all residents using this service.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A revised statement of purpose that outlined the centre's current conditions of registration was submitted to the Office of the Chief Inspector the day following the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Following a review of a sample of incidents, all required incidents had been notified to the Office of the Chief Inspector.

Judgment: Compliant

Quality and safety

The findings from this inspection demonstrated an improved quality service for residents with improved fire safety arrangements and a strive for improved person centred planning and opportunities for residents to engage in activities and pursuits in their local community at times of the day that suited residents. The provider had undertaken to improve residents' living environment and the inspector noted significant redecoration work had been undertaken since the previous inspection throughout the residential units that comprised the designated centre.

While these notable improvements had occurred, compatibility issues remained albeit they had been mitigated well through effective staff resource management and improved local governance arrangements by the person in charge and deputy manager. While improvements to the aesthetic of the premises had occurred throughout, the centre remained an institutional setting which could not provide residents with the most optimum living experience which would promote their best possible social care outcomes.

Comprehensive and up-to-date personal plans were in place for each resident which supported the consistent review of the quality and safety of care provided to the residents. As found on the previous inspection, residents' health, emotional and social care needs were supported and comprehensively provided for. Residents had regular, and as required, access to a range of allied professionals such as GP services, occupational therapy, physiotherapy, and speech and language therapy. Residents also had access to and support from mental health professionals such as psychiatry and psychology support. This ensured that residents were supported to enjoy their best possible health and overall well-being.

Where required, behaviour support planning was in place for residents. Residents with behaviour support assessed needs received regular psychology and behaviour support specialist review. Information and collected data was used to inform behaviour support plans ensuring they were evidence based and reflective of the changing needs of residents.

While effective behaviour support management systems were in place it was noted there were a number of gaps in staff training in positive behaviour support and management of potential and actual aggression. This training was required to ensure good quality and safe supports for residents. It was noted however, the person in charge and deputy manager had identified this and had begun to identify future dates for staff to receive this necessary training.

A number of restrictive practices were in use in the centre. Restrictive practices were recorded and reviewed regularly. It was noted some of the restrictions were required due to compatibility issues between some residents and the unsuitability of

the premises to meet residents' assessed needs. For example, access to some communal areas was limited at times. Some internal doors were locked to prevent residents' access to the upstairs area of the building which was utilised for non-residential purposes. While the premises could not effectively support residents to live in a restraint free environment, the inspector recognised these restrictions were necessary to promote and manage personal risks for residents.

The person in charge and deputy manager had made positive efforts to reduce some restrictions in the centre. For example, the elimination of bed rails for some residents and innovative ways to manage some residents' personal clothing preferences which were in line with their sensory needs. While further improvements to reduction of restrictions were required it was noted the premises impacted on this being possible and therefore a non compliance for this inspection was given for Regulation 17: Premises as it could not provide the most optimum environment to meet the needs of residents.

The provider had ensured an up-to-date risk management policy was in place. Findings from this inspection demonstrated it's implementation by the person in charge and deputy manager throughout the designated centre. An up-to-date risk register was maintained which identified an overview of risks managed in the centre and control measures identified to mitigate risks identified. Where required personal risk assessments were maintained in residents personal plans with evidence they were regularly reviewed.

A significant personal risk managed in the centre related to choking and/or ingesting of non edible items. Risk assessments and arrangements demonstrated a number of control measures were in place, including environmental restrictions and high levels of supervision and oversight by managers and staff to reduce the risk. The inspector noted these control measures had been effective since the previous inspection and were under regular review by the person in charge.

To promote each resident's safety in the centre, adverse incidents were recorded, risk rated and reviewed in a timely way. Incident and risk information presenting in the centre was monitored and analysed and formed part of the provider's assurance and governance oversight arrangements for the designated centre.

In response to non compliant fire safety systems identified on the previous inspection, the provider had reviewed their fire safety arrangements with an appropriately qualified fire safety engineer. Following this review a number of fire safety improvement recommendations were identified. The provider effectively put arrangements in place to address fire safety deficits in the centre, in particular containment measures. This included installation of fire doors and fire compliant door closers throughout the premises. The inspector reviewed additional fire safety measures and it was found all fire safety equipment had received an up-to-date service. Daily fire checks were recorded and up-to-date. In addition fire safety audits were carried out by the person in charge and deputy manager. It was noted these audits were effective in identifying deficits and making arrangements to address them in a timely way.

Safeguarding arrangements were in place. The provider had ensured an up-to-date safeguarding policy was in place as required by the regulations. The matters of the policy were in line with National safeguarding policy guidelines. It was demonstrated, where required, safeguarding policies and procedures were implemented. Where required, safeguarding plans were in place and reviewed regularly. All staff working in the centre had received up-to-date safeguarding training. As referred to in the body of the report, compatibility issues between residents were a presenting feature in this designated centre. It was noted however, through effective and responsive staff resourcing and increased activity provision for residents, that compatibility safeguarding incidents had reduced. Decongregation of the centre was recognised, by the provider, however, as the most effective way of managing this presenting safeguarding issue.

The provider had made considerable efforts to refurbish and improve the home-like quality of the designated centre. It was noted the centre had been repainted throughout and residents' bedrooms had been redecorated. Bathing and toilet facilities were well maintained and provided residents with adequate space and assistive equipment to meet their assessed needs. While these improvements had occurred, overall the premises still presented as institutional and could not effectively meet the assessed needs of all residents resulting in required environmental restrictions throughout and compatibility incidents still occurring, which could be more effectively mitigated in a more optimum living arrangement that met residents assessed and presenting needs.

Regulation 17: Premises

The provider had made considerable efforts to refurbish and improve the home-like quality of the designated centre. It was noted the centre had been repainted throughout and residents' bedrooms had been redecorated.

While these improvements had occurred, overall the premises still presented as institutional and could not effectively meet the assessed needs of all residents

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had created an up-to-date risk management policy. This policy was effectively implemented by the person in charge and staff within the centre. All identified risks presenting in the centre were recorded, assessed and their effectiveness regularly reviewed against collated incident data information.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had addressed the not compliant findings from the previous inspection in a comprehensive and effective manner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an up-to-date personal plan which contained a detailed comprehensive assessment of needs and support planning for each need identified. Each plan also incorporated a high level of allied professional review and recommendations which ensured they were evidence based. It was also noted more effective person centred planning arrangements had begun and residents were engaged in activity sampling and more activities in the evening time than before.

Judgment: Compliant

Regulation 7: Positive behavioural support

Comprehensive behaviour support arrangements were in place. Restrictions in place were required to manage personal risks and compatibility issues for residents. It was noted that efforts had been made to reduce a number of restrictions and effective oversight arrangements were in place to ensure they were reviewed regularly.

Improvements were required to staff training in positive behaviour support and management of actual or potential aggression.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured an up-to-date safeguarding vulnerable adults policy and associated procedures were in place. There was evidence of the implementation of this policy in the designated centre. All staff had received up-to-date training in

safeguarding vulnerable adults.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ravenswell OSV-0003581

Inspection ID: MON-0022535

Date of inspection: 15/05/2019

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In line with the updated de-congregation plan submitted on 15.05.19. Transition plans are pending until a tangible timeline of commenced works are in place	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: In line with the updated de-congregation plan submit on 15.05.19. Plans for a full de-congregation for 3 of Ravenswell residents will be ready by May 2020.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Psychology team have also agreed to complete positive behaviour workshop by end December 2019	

All staff will have fully complete and/or refreshed MAPA training by November 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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	29/05/2020
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.	Substantially Compliant	Yellow	29/05/2020
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management	Substantially Compliant	Yellow	20/12/2019

	of behaviour that is challenging including de-escalation and intervention techniques.			