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:	Sonas Bungalows - Sonas Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Announced
Date of inspection:	11 and 12 March 2020
Centre ID:	OSV-0003738
Fieldwork ID:	MON-0022982

About the designated centre

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

In Sonas bungalows, residential care and support is provided on a 24 hour basis for up to 36 residents over the age of 18 with an intellectual disability. The centre consists of six purpose built bungalows on a campus in an outer suburb of Dublin. Each house has six single bedrooms and suitable private and communal space to meet the needs of up to six residents. Residents are supported by a person in charge, clinical nurse managers, care staff and household staff. Residents have the option to attend day activity sessions on the campus, or they are supported to partake in meaningful home or community based activities in line with their wishes. There are good public transport links and local access to restaurants, shops, cinema, churches and libraries.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	32

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
Wednesday 11 March 2020	09:30hrs to 17:15hrs	Marie Byrne	Lead
Thursday 12 March 2020	09:15hrs to 15:30hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

During the two days of the inspection, the inspector of social services had the opportunity to meet and briefly engage with twenty two of the residents who lived in the designated centre. The remaining ten residents were out engaging in activities either on campus or in the community when the inspector visited their home.

Residents were observed participating in a range of activities with the support of staff throughout the inspection, both in the centre and in the community. For example, some residents was completing home-based activities such as art work and knitting, other residents were attending mass or other activities on the campus and a number of residents were being supported by staff to attend appointments or activities in their local community.

The inspector saw kind, caring and respectful interactions between staff and residents throughout the two days of the inspection. Staff were observed supporting residents to make decisions in relation to how they wished to spend their time and what they wished to eat or drink. Residents at all times appeared comfortable in the presence of staff and with the levels of support offered to them.

Residents who spoke with the inspector stated that they were happy and felt safe in their home. A number of residents spoke with the inspector about the complaints process. One resident spoke about how useful they have found the process over the years and how they were supported to resolves issues or concerns during the process. One resident spoke about how the food was not always nice but they stated that if they didn't like something staff would offer them an alternative.

A number of residents spoke about a party that had been held over the weekend for one residents' birthday. They spoke about how much they enjoyed it and told the inspector about the music, balloons and the cake. The inspector spoke briefly with the resident for whom the party was held. They told the inspector it was a big birthday and talked about the cake and the cake topper which they had kept as a momentum. They stated that they loved the music and really enjoyed the party.

One resident showed the inspector around their bedroom and showed them pictures on their digital photo frame of events they had attended or activities they had taken part in. They also showed the inspector pictures in relation to their goals on their tablet computer. Another resident showed the inspector around their home including a tour of their bedroom. They showed the inspector all the things in their bedroom which were important to them including personal items such as pictures, postcards and their television and radio.

The inspector reviewed the minutes of recent residents' advocacy meetings and found that a lot of very positive conversations were happening in relation to residents' care and support and that actions from these meetings were leading to

positive changes for residents. Residents were discussing things that were going well, but also identifying areas for improvement. For example, a number of residents had raised concerns at the meetings in relation to staffing levels and the impact of this for them in relation to access to activities and outings.

Capacity and capability

Overall, the inspector found that improvements were required to bring about compliance with the regulations and to improve residents' lived experience. They included staffing, staff training and development, complaints, record keeping and documentation, residents' rights and personal possessions and in relation to residents accessing their local community. The registered provider and person in charge were recognising areas for improvement in line with the findings of this inspection, in their own audits and reviews. However, they were not progressing the required actions to bring about the necessary improvements in a timely manner. For example, the provider had identified a timelines in 2019 to move into compliance with staffing numbers and staff training following the last inspection in the centre. However, at the time of this inspection, a number of staffing vacancies remained and a number of staff had not completed mandatory trainings or refreshers. The inspector acknowledges that improvements had been made in relation to residents' assessment of need and personal plans, including their healthcare plans in line with the provider's compliance plan from the last inspection.

During the inspection, the management team outlined improvements that had been made since the previous inspection and discussed their future plans for further improvements which would positively impact on residents' lived experience. In addition to the existing staff vacancies, they had identified that in line with residents' changing needs they required to further increase staffing numbers in the centre. Their last two, six monthly reviews had action plans in place identifying actions relating to the management of complaints, residents' personal plans and their access to activities.

A new person in charge had commenced in the centre in January 2020. They were on leave during this inspection. The required information had been submitted by the provider to demonstrate that they had the qualifications, skills and experience to fulfill the role of person in charge. They had systems in place to ensure oversight of the centre including management meetings, staff meetings and daily communication with residents and staff.

The provider had systems in place to monitor the quality and safety of care for residents such as the annual review and six monthly reviews. The annual review for 2019 was made available during the inspection but it was in draft format and did not include recommendations or an action plan. The inspector was informed that it was due for completion by the end of March 2020. The provider had recognised in this review that the annual reviews needed to be done in a more timely manner as the

annual review for 2018 had been completed in March 2020. This review also recognised the need for more involvement of residents and their representatives in the annual review. The local management team informed the inspector that a survey had been developed and sent out to residents and their representatives and that a number of these had now been returned. They stated that these surveys would be used as part of the 2019 annual review. Within the 2018 annual review there were limited recommendations and actions identified, with the rationale being that due to the lateness of the review, these sections were not reviewed. These sections included residents' and their representatives input, residents' assessment of need and personal plans, risk management, medicines, and staff training. This review also demonstrated that a number of actions had not been completed from their last reviews and from the last inspection in the centre. One of the recommendations from their latest annual review was to combine the actions from their annual review, six monthly reviews and from inspections in the centre into one document so that they could track all of the required actions to bring about the required changes.

The person in charge was on leave on the day of the inspection and the person participating in the management of the centre (PPIM) and clinical nurse manager 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.

As identified by the provider in their own audits and reviews, there were insufficient staff numbers to meet residents' assessed needs. In addition to the five staffing vacancies identified by the provider on day one of the inspection, the provider had identified that they required an additional 8.5 whole time equivalent (WTE) staff to meet the changing needs of residents in the centre. The provider was holding interviews during the inspection and on day two of the inspection, the inspector was informed that they had successfully recruited to fill the 1.5 WTE care staff vacancies in the centre. This meant that there were now 3.5 WTE nursing vacancies in the centre

The inspector reviewed a number of planned and actual rosters and viewed evidence that the provider was attempting to minimise the impact of these staffing vacancies on the continuity of care for residents, by regular relief and agency staff covering the required shifts. However, this was not always proving possible and a number of shift were being covered by different relief and agency staff every month. There was a system in place for staff in some houses to support other houses with lower staffing numbers. There were times where only one staff was available to support up to six residents, some of whom required the assistance of two people in relation to some of their care and support needs. From speaking with staff, it was evident they were working hard to ensure resident' care and support needs were being met and that they were kept safe. Staff who spoke with the inspector were highly motivated to ensure residents were living a good life and engaging in activities of their choice. They were also found to be knowledgeable in relation to residents' care and support needs. However, the lack of staffing numbers was at times resulting in delays for some residents receiving support and leading to

reduced opportunities for residents to engage in meaningful activities.

There were complaints policies and procedures in place which were available in an accessible format. The inspector spoke to one resident about their satisfaction with the use of the complaints process, They described how they were supported through the process a number of times resulting in improvements for them in relation to their care and support. Overall, there was evidence that complaints were logged, investigated and followed up on. However, in some complaints reviewed, the measures and actions for improvement were not fully outlined and the satisfaction level of the complainant was not always recorded. There were a number of open complaints at the time of the inspection and the inspector viewed evidence that the provider was in the process of completing the required actions and follow-ups to resolve these complaints to the satisfaction of the complainants. The provider had recognised the need for all staff to read the complaints policy and ensure they were recording all complaints in their latest six monthly reviews. Advocacy information was available and on display and the inspector viewed evidence that a number of residents were being supported to access advocacy services.

There were a number of volunteers in the centre, who were supporting residents to engage in activities of their choosing. The inspector spoke to residents and staff in relation to the positive impact of these volunteers. The volunteers had access to the support and supervision of a volunteer coordinator. They had their roles and responsibilities in writing, had signed a confidentiality agreement and had completed Garda vetting prior to commencing in their role as a volunteer.

The provider had submitted an application to the Chief Inspector to renew the registration of the designated centre. As part of this application the provider had submitted all of the information required by the regulations. This included the statement of purpose, valid insurance, a fully completed application form, the required fee, floor plans, a residents guide and other documents required under by the regulation.

The provider had systems in place to ensure staff had access to training and refreshers in line with residents' care and support needs and in line with the organisation's policies. The provider had recently completed a training gap analysis and identified dates for upcoming training for staff. However, in line with the findings of the last inspection, at the time of this inspection a number of staff had not completed training or refreshers. These included safeguarding, fire, manual handling and hand hygiene training. Formal staff supervision had recently commenced in the centre. It had been completed with the majority of staff in 2019, and plans were in place to ensure all staff were in receipt of regular formal supervision in 2020. From speaking with staff and reviewing documentation, it was evident that supervision was in its infancy and required time to further develop to ensure staff were being fully supported to carry out their roles and responsibilities to the best of their abilities.

There were gaps and inconsistencies noted across a number of documents reviewed during the inspection. Some of these gaps and inconsistencies related to residents' care and support needs and some related to day-to-day documentation

in the centre. Some documents required review to ensure were factually accurate and clearly guiding staff to support residents. These gaps and inconsistencies were not found to be contributing to significant risk for resident and the PPIM and CNM showed the inspector evidence that some of these documents were reviewed and updated during the inspection.

Residents were protected by the admissions policies, procedures and practices in the centre. There were a number of vacancies for residents in the centre. From speaking with staff and reviewing documentation, it was evident that prior to any new admissions residents living in the centre were consulted and assessments were completed to ensure residents' admissions would not impact on the person being admitted, or the care and welfare of other residents living in the centre. There were contracts of care in place which contained information relating to support care and welfare for residents, the services to be provided and the fees and additional fees to be charged.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of the centre and they had submitted all of the required information in line with the requirements of this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge in January 2020 who had the qualifications, skills and experience to fulfill the role. They were working in the centre in a full-time capacity and had systems in place to ensure they were monitoring the quality and safety of care in the centre.

Judgment: Compliant

Regulation 15: Staffing

There were 5 WTE staffing vacancies in the centre on day one of the inspection. The provider was in the process of recruiting to fill these. They held interviews during the inspection which led to them filling the 1.5 WTE vacancies for care staff. This meant there were now 3.5 WTE staff nurse vacancies. The provider was attempting to minimise the impact of these vacancies on continuity of care for residents. However, this was not always proving possible. In addition to the staffing vacancies,

the provider had identified that they also required an additional 8.5 WTE staff to meet the changing needs of residents in the centre. These staffing changes were in the planning phase. Staff who spoke with the inspector were knowledgeable in relation to residents' care and support needs and motivated to ensure they were safe and enjoying a good quality of life.

Judgment: Not compliant

Regulation 16: Training and staff development

Training and refresher training was available for staff in the organisation in line with the organisation's policies. However, a training needs analysis recently completed in the centre identified that a number of staff had not completed some training and refreshers. A number of staff had not completed safeguarding, fire safety, hand hygiene or manual handling training. Formal supervision training had recently commenced in the centre. From reviewing a sample of staff's supervision records and speaking to a number of staff, it was evident that supervision was in its infancy and required further time to bed in to ensure that staff were being fully supported to carry out their roles and responsibilities to the best of their abilities.

Judgment: Not compliant

Regulation 21: Records

There were gaps and inconsistencies across a number of documents in the centre. Some of these related to documentation regarding residents' care and support and some to other documentation relating to the day-to-day running of the designated centre. These were not found to be contributing to any significant risk for residents as staff were found to be familiar with residents' care and support needs.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider submitted valid insurance with the application to renew the registration of the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures which identified the lines of authority and accountability for each staff member. Staff meetings and management meetings were occurring regularly. However, the provider was not consistently implementing actions from audits and reviews to make the necessary improvements in relation to residents' care and support. The annual review of care and support had not been completed fully or in a timely manner and there was limited evidence of residents' or their representative's input in relation to this review. The provider had recognised this and they had plans in place to rectify this.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There were policies and procedures in relation to admissions to ensure they were planned and taking into account the residents' needs and wishes and that of residents already living in the centre. There were contracts of care in place which contained the required information.

Judgment: Compliant

Regulation 30: Volunteers

There were a number of volunteers in the centre and they were in receipt of regular support and supervision. They had clearly defined roles and responsibilities and had completed Garda vetting prior to commencing in their roles. Residents and staff described the positive contribution they were making.

Judgment: Compliant

Regulation 34: Complaints procedure

There were complaints policies and procedures which were available and on display in the centre. There was a local complaints officer and residents and staff who spoke with the inspector could describe the complaints process. Improvements were required in relation to recording the measures and actions for improvement following review of the complaints and in relation to recording the satisfaction level

of the complainant.

Judgment: Substantially compliant

Quality and safety

The inspector found that the provider was striving to ensure that the quality of service for residents was good. 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 and were in receipt of a good quality and safe care. However, this was not always proving possible due to a lack of resources and a lack of progress on actions identified by the provider in their audits and reviews. These actions included recruiting staff to fill vacancies, improvements to documentation relating to residents' care and support, their rights and possessions and in relation to residents' access to activities.

The inspector visited the six houses during the inspection and found that they were all clean, homely and well maintained. The provider had recognised the need for additional storage for large items in the centre but they had not yet identified a solution for this. A number of residents showed the inspector around their home including their bedrooms which were decorated in line with their wishes and preferences. Each house had access to a garden area. Improvements had been recently been made to one of the central gardens within the centre to make it more accessible and a more attractive place for residents to spend time. There were areas of the centre where residents could spend time with each other and areas where they could spend time alone or taking part in activities such as arts and craft is they so wish.

There were policies and procedures in place in relation to safeguarding. There was evidence that safeguarding concerns were reported and followed up on in line with the organisation's and national policy. Immediate actions were taken to keep residents safe and safeguarding plans were developed and implemented as required. The majority of staff had received training in relation to their roles and responsibilities. Residents had intimate care assessments and plans in place which were clearly guiding staff to support them in line with their wishes and preferences.

Residents were being protected by the policies, procedures and practices relating to risk management. There was 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. Incidents and adverse events were reviewed and there was evidence that the vehicles in the centre were regularly checked and serviced to ensure they were roadworthy.

It was evident that efforts were being made to ensure that residents were being supported and encouraged to connect with their family and friends and to be part of their local community. There was evidence of increased efforts to ensure residents'

had additional opportunities to engage in meaningful activities since the last inspection. Volunteers were supporting a number of residents to enjoy such activities and improvements had been made in relation to accessing vehicles to support residents to access activities in the community. In addition, a number of residents were using public transport more often. However, the inspector 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 spending a lot of time carrying out activities at home and on the campus.

From visiting the houses and speaking with residents and staff it was evident that residents' personal possessions were protected and respected. A number of residents showed the inspector around their bedrooms and showed them some of their favourite possessions. Each residents' bedroom had ample storage for their belongings and they had access to laundry facilities to launder their own clothes if they so wish. Where necessary, residents were provided with support to manage their finances and a number of residents retained control of their finances and had an account in their name in a financial institution. However, the majority of residents' finances were held in central account by the provider, that was not in their name. Residents had access to some money in the designated centre and when they required more they applied to get it from this central account. Staff informed the inspector that residents always had access to adequate funds for personal use and that if events were coming up additional money was readily available. The inspector reviewed a sample of residents' receipts and financial audits in the centre and found a number of documentation errors leading to incorrect balances. There were also a number of receipts shared between residents and some receipts viewed where it was not clear what the money was spent on. These were reviewed by staff who later clarified what the money was spent on by showing the inspector the items or documentary evidence relating to the activity involving the spending. The discrepancies in balances were explained and rectified by the provider during the inspection. The shared receipts related to items bought by residents which the provider informed the inspector should have been covered by centre's household budget. A member of the management team informed the inspector that arrangements were being made to reimburse residents for the money they contributed to these household items.

From meeting residents, reviewing documentation and speaking with staff it was evident that residents were consulted and participated in relation to the day-to-day running of the centre. There were regular residents' meetings and there was an advocacy group where a nominated residents from each house attended meetings. There was information on display throughout the centre in relation to advocacy and residents' rights. A number of residents were being supported to access independent advocacy services. Throughout the inspection, the inspector observed kind and respectful interactions between residents and staff. Staff were observed offering residents choices in relation to meals, drinks and how they wished to spend their time. Overall, residents privacy and dignity was respected in relation to their personal and living space, intimate and personal care and personal information. However, the inspector viewed documentary evidence of a residents' personal

information including information relating to their finances being shared by text message. The provider had become aware of this and put measures in place to ensure that each of the houses had access to a house mobile phone.

There was a residents' guide which was available in each of the houses. It clearly outlined the services and facilities provided, the terms and conditions relating to living in the centre, the arrangements for residents' involvement in the running of the centre, how to access any inspection reports, the procedure for complaints and the arrangements for visitors.

There were suitable arrangements in place to detect, contain and extinguish fires. The alarm system, fire safety equipment and evacuation routes were checked regularly and equipment was certified by relevant external bodies. Each resident had a personal emergency evacuation plan and risk assessments in place. A number of these required review and some were reviewed during the inspection and plans were in place to complete the others. These areas for improvement were not contributing to any significant risk for residents. The majority of staff were trained in fire safety procedures and fire drills were taking place regularly in the centre. These drills were ensuring that residents and staff knew what to do during an evacuation. There was an emergency plan in place and emergency numbers were readily available.

Whilst improvements were noted in relation to residents' assessments of need and personal plans, some areas for improvement remained. Work had been completed since the last inspection to ensure residents had an assessment of need and that care plans and interventions were developed in line with these assessed needs. This work was evident across a number of residents' personal plans reviewed. However, some residents' personal plans required review to ensure assessments and personal plans were fully reflective of residents' care and support needs and clearly guiding staff to support them. Overall, residents' personal plans were found to be person-centred. Each resident had access to a keyworker or keyworkers to support them to develop their goals and there was evidence that they were supported to achieve them. New accessible personal plans had been developed for residents since the last inspection. Some of these were in the early stages of development. They were person-centred and there was evidence of residents' input in relation to their likes, dislikes, goals and dreams. They included pictures of residents taking part in activities involved in reaching their goals. They clearly outlined what makes a good day for residents.

Residents were being supported to enjoy best possible health. Improvements were noted across residents' assessment and healthcare plans since the last inspection. Overall, residents' healthcare needs were appropriately assessed and care interventions were developed in line with these assessed needs. A number of residents' documents required review to ensure they were fully guiding staff to support residents and the inspector was shown evidence during the inspection that some of these had been reviewed and updated. Each resident had access to allied health professionals in line with their assessed needs. They had hospital passports in place in case of an emergency, which clearly outlined their care and support needs including their likes, dislikes and preferences. There was clear evidence that

residents' healthcare needs were reviewed and updated following appointments with allied health professionals and in line with their changing needs. Residents were being supported to access national screening programmes in line with their age profile and wishes and preferences.

There were a number of restrictive practices in the centre and there was evidence that these were reviewed regularly to ensure they were the least restrictive for the shortest duration. Residents were supported by the relevant allied health professionals and plans were developed and reviewed as required. They clearly guided staff to support residents using proactive and reactive strategies.

Regulation 12: Personal possessions

Overall, residents were being supported to retain control of their own belongings and had access to support in relation to managing their financial affairs. However, the majority of residents' finances were held in a central account by the provider which was not in residents' names. The inspector found a number of discrepancies relating to documentation and receipts. The majority of these discrepancies were rectified during the inspection and arrangements were being made to reimburse residents for small amounts of money used to buy household products in error.

Judgment: Not compliant

Regulation 13: General welfare and development

There was evidence that improvements had been made since the last inspection in relation to residents' accessing meaningful activities. However, limited opportunities remained for some residents to access activities, particularly community based activities on a regular basis.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the six houses were designed and laid out to meet the number and needs of residents in the centre. They were clean, comfortable and well maintained. The provider had recognised the need to make improvements in relation to the storage of large items in the centre. In addition, plans were in place to make changes to the design and layout of one of the house to better suit one residents' needs.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide developed which contained all the information required by the regulations. It was available in each of the houses for residents and their representatives.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by the the risk management policies, procedures and practices in the centre. There was a risk register in place and general and individual risk assessments were developed and reviewed as necessary. There were systems in place to respond to emergencies.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements in place to detect, contain and extinguish fires and evidence of servicing of equipment in line with the requirements of the regulations. The majority of staff had appropriate training, fire drills were held regularly and residents had personal emergency evacuation plans.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had assessments of need and personal plans in place. There was evidence of improvements since the last inspection in relation to residents' assessments and personal plans. However, improvements were still required in relation to the review and update of a number of documents to ensure they were reflective of residents' needs and clearly guiding staff in relation to how to support them.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health. They were being supported to access allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices in the centre were kept under review to ensure that the least restrictive were used for the shortest duration necessary. Residents were supported by the relevant allied health professionals and support plans were developed and reviewed as required.

Judgment: Compliant

Regulation 8: Protection

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

Judgment: Compliant

Regulation 9: Residents' rights

Residents were participating in decisions relating to their care and support and in relation to the day-to-day management of the centre. They had access to independent advocacy services should they wish to avail of them. Overall, residents' privacy and dignity were maintained. However, the inspector viewed evidence of one residents' personal information being shared by text message. Once the provider had became aware of this, that they had ensured that each house in the centre had access to a house mobile telephone.

Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	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
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sonas Bungalows - Sonas Residential Service OSV-0003738

Inspection ID: MON-0022982

Date of inspection: 11/03/2020 and 12/03/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Centre has no care staff vacancies at present and has 3 SN vacancies However due to the current pandemic, the recruitment process is on hold for these posts are on hold. Recruitment will re-commence when the current crisis has passed. There is currently no agency usage in the Centre, due to redeployment of staff from other areas throughout the service. Interviews will be scheduled once restrictions have been lifted.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There are a number of new staff in the Centre. All new staff have been scheduled to complete mandatory training by December 31st 2020. Staff who require refresher training have also been scheduled to complete this by June 30th 2020. A supervision schedule has been put in place and senior staff have been given responsibility to carry out supervision with junior staff, guidelines for completing supervision have been devised by the PIC. The PIC has met with the Centre's two Clinical Nurse Manager 1's and outlined the scheduled, moreover the PIC has advised all staff of the schedule and timeframe. The supervision for all staff is expected to be completed by September 30th 2020, in addition to staff annual performance reviews.	

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Auditing has begun across resident records to ensure all gaps and inconsistencies identified during the inspection have been addressed. The PIC has begun education tool box sessions with staff to discuss and guide staff in completing and maintaining accurate resident records and centre documentation. Documentation relating to the day to day running of the centre has been reviewed and rectified, monthly auditing of documentation for the centre has commenced by the PIC.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC has emailed the Quality and risk officer for a date to have the annual review completed. The initial date for this was April 31st 2020, however this date has been pushed back until the end of the year due to the current pandemic. The PIC has discussed the review with the quality and risk officer and have put measures in place to ensure the residents and representatives are incorporated into the review. Surveys for the Centre have been sent out to all residents' representatives and will form part of the annual review for the Centre. Surveys have also been given to the residents to complete and these will also form part of the annual report for the Centre.
The PIC has commenced audits across the centre to ensure effective management systems are in place to monitor consistency and effective services.

The PIC has combined actions from the annual review, six monthly review and inspections into one document in order to track progress and address actions required. This will be monitored and reviewed by the PIC on an ongoing basis.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Staff have been scheduled to complete training in complaints and the details required for closing off a complaint in a satisfactory manner. A review of all complaints will take place

and appropriate actions implemented. The PIC will oversee all complaints and ensure going forward all complaints are investigated and closed off with appropriate recommendations cited.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The PIC has devised a revised personal possessions document for each resident to be completed by keyworker and maintained in the resident's personal plan. These documents will be updated monthly or as soon as a resident is in possession of a new item or an item is discarded. This will be done in conjunction with the resident. Financial capacity assessments are in place for all residents, where residents have been deemed to have financial capacity they are supported to manage their own finances. For residents who do not have financial capacity advocacy services are available to the residents.

The PIC has contacted the Director of Finance in relation to individual bank accounts for the residents- this was previously put on hold due to guidelines and protocols surrounding who would retain the information in accessing the financial account. Progress in this matter is currently on hold due to the current health crisis. This will be addressed when the pandemic has passed.

The PIC has devised guidelines for staff in the centre in relation to financial recordings to ensure accurate and transparent recording and monitoring of finances.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The PIC has commenced an audit in relation to activities and has made individual recommendations to ensure the general welfare and development of each resident. The PIC has given each house a list of possible community hubs/ participation groups that residents may enjoy and a process of trialing these had begun. The PIC met with the staff team to devise home based activities that are appropriate and enjoyable to the residents and a process of activity sampling had begun and was ongoing.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The PIC has emailed the Director of Property and estates (PES) to address the issue of storage the plan to rectify same. However due to the current health pandemic any \`proposed works cannot proceed. The PIC and the PES director will meet in 3 months time to devise a plan and timeframe to have same completed.

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:
The PIC will ensure all residents have comprehensive assessments completed by the appropriate health professional. Through auditing the PIC has identified these areas and has contacted the relevant health professional for input. All residents will have a completed plan within 28days of admission to the centre.
All residents had annual MDTs in 2019 and a schedule for same is planned for 2020 incorporating input from relevant members of the MDT. Staff are scheduled to undertake tool box sessions in relation to comprehensively completing resident personal plans.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC has met with staff in relation to resident's rights and the communication of personal information relating to the resident. All requests to access information are to be applied for under FOI. Guidelines have been put in place for staff when updating family members on the residents, a house mobile phone has been put in place in each house to ensure when staff communicate with residents representatives it is done in a transparent process. The PIC will link with all resident representatives for matters of sensitive nature and will ensure same is documented accordingly.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/03/2021
Regulation 12(4)(b)	The registered provider shall ensure that he or she, or any staff member, shall not pay money belonging to any resident into an account held in a financial institution unless the account is in the name of the resident to which the money belongs.	Not Compliant	Orange	30/03/2021
Regulation 13(2)(a)	The registered provider shall	Substantially Compliant	Yellow	31/12/2020

	provide the following for residents; access to facilities for occupation and recreation.			
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	31/12/2020
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	31/12/2020
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	31/12/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of	Not Compliant	Orange	30/03/2021

	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.	Substantially Compliant	Yellow	30/03/2021
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.	Not Compliant	Orange	31/12/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/07/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for	Substantially Compliant	Yellow	31/07/2020

	inspection by the chief inspector.			
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	30/03/2021
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	30/03/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	31/12/2020
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their	Substantially Compliant	Yellow	31/12/2020

	representatives.			
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.	Substantially Compliant	Yellow	31/12/2020
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Substantially Compliant	Yellow	31/05/2020
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 and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/05/2020
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Substantially Compliant	Yellow	30/09/2020

	appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/09/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/09/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is	Substantially Compliant	Yellow	30/03/2020

	respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			