



## Office of the Chief Inspector

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

Name of designated centre:	Special Dementia Unit - Sonas Residential Service
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	15 May 2019
Centre ID:	OSV-0003746
Fieldwork ID:	MON-0021830

## About the designated centre

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

The designated centre is based on a campus setting in suburban area of North-West County Dublin and provides specialist dementia care to persons with intellectual disabilities some of whom have end of life support needs. The centre is comprised of one large building which was constructed in 2013 and currently operates as two separate units within the one premises. Services are provided through 13 long term beds and one respite bed. There is a staff team of clinical nurse managers, staff nurses, care assistants and household staff employed to support residents and additional supports are provided through volunteers.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	13
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## 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	09:00hrs to 13:30hrs	Thomas Hogan	Lead
15 May 2019	09:00hrs to 13:30hrs	Aileen Keane	Support

## Views of people who use the service

The inspectors met with a number of residents who were availing of the services of the centre. In addition, a number of family members were met with and time was spent observing care being delivered by the staff team. Individuals spoken with expressed very high levels of satisfaction with the care and support being provided and were very complimentary of the staff team.

## Capacity and capability

Overall, the inspectors found that this was a very good centre with appropriate systems in place to ensure that the services provided were of a high standard, safe and effective. There was a dedicated workforce in place who demonstrated a commitment and respect to the individuals they were supporting. The necessary resources were available to support the effective delivery of care and support. There was clear evidence to demonstrate that a strong culture of person-centredness had been established and promoted in the centre which resulted in positive outcomes for residents. While there were two regulations inspected which were found to be non-compliant, the inspectors found that the person in charge and management team were aware of these matters and had begun to address them prior to the time of the inspection.

The inspectors found that there was an appropriate number of staff employed in the centre and there was a suitable skill mix amongst the staff team to meet the identified needs of residents. Staff members were observed to treat residents with respect, kindness and a caring approach throughout the time frame of the inspection. There were actual and planned rosters maintained by the person in charge.

A review of staff training records demonstrated that there were a number of deficits in training and refresher training across seven categories described as being mandatory by the person in charge. There was plan in place to address these training deficits and this was reviewed by the inspectors. While there were strong arrangements in place for the informal supervision of staff members, improvements were required in the area of formal supervision. Only four staff members of the staff team of 22 had been met with in a one-to-one supervision meeting in 2019. The person in charge outlined plans to address this matter and presented a schedule of supervision meetings for the year ahead.

The inspectors found that there were effective management systems in place to ensure that the service provided was safe, appropriate to residents'

needs, and effectively monitored. There was a person in charge responsible for the centre and they were working in a full-time capacity with sufficient protected time to oversee the services provided. The person in charge demonstrated sufficient knowledge of the legislation and their statutory responsibilities and had an in-depth awareness of the needs of residents availing of the services of the centre. An annual review was found to have been completed and there were regular six-monthly unannounced visits to the centre carried out by persons on behalf of the registered provider.

A review of incident and accident records was completed by the inspectors and it found that the person in charge and registered provider had appropriately notified the Office of the Chief Inspector of incidents which had occurred in the centre.

The Inspectors reviewed the arrangements in place for the management of complaints and found that none had been made since January 2017. There was a complaints policy in place and there was information displayed in the centre on the complaints procedure, on how to contact the national confidential recipient and independent advocacy services.

A review of policies and procedures maintained in the centre found that a number of policy documents had not been reviewed within the required three year period as outlined by the regulations. In addition, there was no policy in place relating to communication with residents.

The inspectors were informed that there were a number of volunteers who contributed to supporting residents on a regular basis. Volunteers were found to have had their roles and responsibilities set out in writing and received supervision from the person in charge. All volunteers were found to have vetting completed and these records were made available to the inspectors for review.

## Regulation 15: Staffing

The inspectors found that there were enough staff with the right skills and experience deployed to the centre to meet the identified needs of residents.

Judgment: Compliant

## Regulation 16: Training and staff development

There were a number of deficits observed in staff training. These were as follows:

- one staff member had not completed training or refresher training in fire safety
- two staff members had not completed training or refresher training in manual

handling

- 10 staff members had not completed training or refresher training in food safety
- four staff members had not completed training or refresher training in hand hygiene
- two staff members had not completed training or refresher training in behaviour support
- two staff members had not completed training or refresher training in dementia care and
- four staff members had not completed training or refresher training in palliative care.

In addition, arrangements in place for the formal supervision of staff members were not satisfactory and did not comply with the organisation's policy on this matter.

Judgment: Not compliant

### Regulation 23: Governance and management

There were effective governance measures in place with positive outcomes for residents through care and support.

Judgment: Compliant

### Regulation 31: Notification of incidents

Notification of incidents were found to have been appropriately made to the Office of the Chief Inspector as required by the regulations.

Judgment: Compliant

### Regulation 34: Complaints procedure

The inspectors found that the registered provider had established and implemented effective systems for the management of complaints in the centre.

Judgment: Compliant

## Regulation 4: Written policies and procedures

The following policies were found not to have been reviewed by the registered provider at least once every three years:

- the prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies
- admissions, including transfers, discharge and the temporary absence of residents
- provision of behavioural support
- residents' personal property, personal finances and possessions
- visitors
- recruitment, selection and vetting of staff
- monitoring and documentation of nutritional intake
- provision of information to residents
- the creation of, access to, retention of, maintenance and destruction of records
- health and safety, including food safety, of residents, staff and visitors
- risk management and emergency planning
- medication management
- the handling and investigation of complaints from any person about any aspects of service, care, support and treatment provided in, or on behalf of a designated centre and
- access to education, training and development.

In addition, a policy was not in place in the centre regarding communication with residents as required by the regulations.

Judgment: Not compliant

## Regulation 30: Volunteers

The registered provider had ensured that there were appropriate safeguards in place with the volunteer team in the centre.

Judgment: Compliant

## Quality and safety

The inspectors found that the premises of the centre were constructed in 2013 and specifically designed to support residents with dementia care needs. Each resident



had their own bedroom with individual en-suite facilities and there was an appropriate number of sitting rooms, dining rooms, relaxation areas, and enclosed garden areas to provide both private and communal accommodation. The centre was very clean, homely and tastefully decorated throughout. There was appropriate equipment provided to support residents with individual needs and there was evidence to demonstrate that these were maintained and serviced on a regular basis.

A review of the arrangements in place for the management of risk found that all presenting risks had been identified and assessed. There was a central risk register maintained and there was a risk management policy in place to guide staff in this area. There was clear evidence available to demonstrate that appropriate action was being taken once risks were identified to ensure the safety of residents, staff and visitors was protected and promoted. For example, plans were presented to the inspectors for the widening of two emergency doors to allow for the evacuation of residents in their beds in the event of a fire.

The inspectors completed a full walk through of the centre in the company of staff members and reviewed fire safety precautions. There were fire doors in place in all required areas and there was emergency lighting fitted to illuminate all emergency exit routes. All fire doors were fitted with self-closing mechanisms and emergency exits were all clear of obstructions. There was a fire alarm and detection system fitted in the centre and records were available to demonstrate that this system along with the emergency lighting was serviced on a regular basis. Fire drills were completed on a regular basis in the centre and staff members spoken with demonstrated appropriate knowledge of the actions required in the event of a fire. All residents had individual personal emergency evacuation plans in place and these were found to provide the reader with clear and unambiguous direction on the supports required by each individual.

Medication management was reviewed by the inspectors found that there were safe practices in place relating to the ordering, receipt, prescribing, storage, disposal and administration of medication. A sample of resident prescriptions and administration records were reviewed and it demonstrated that medications were administered as prescribed to residents. Staff members spoken with demonstrated appropriate knowledge of the actions to take in the event of a medication error.

The inspectors found that there were personal plans in place to support residents' needs and these were of a high standard. The plans clearly outlined how to support residents with a wide range of matters. The plans were audited on a regular basis and were completed in a dementia approach and influenced by best practice in this area.

The healthcare of residents was reviewed by the inspectors and found that health and well being was promoted in a variety of ways including through diet, nutrition, recreation, and physical activities. Residents were supported through a wide team of allied health professionals including general practitioners and speech and language therapists. There was a high standard in end-of-life care for residents with a palliative approach taken which recognised and respected the unique identity of the

persons being care for and their loved ones.

As previously mentioned, the inspectors reviewed incident and accident records which were maintained in the centre. This review found that there were no incidents recorded which met the definitions of abuse. While there were some unexplained bruising incidents listed, the inspectors found that these had been appropriately managed and followed up on. Staff members spoken with were very knowledgeable of the types of abuse and the actions to take in the event of witnessing, suspecting or someone reporting abuse to them.

### Regulation 17: Premises

The premises of the centre were found to have been designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Judgment: Compliant

### Regulation 26: Risk management procedures

There were appropriate systems in place for the assessment, management and ongoing review of risk in the centre.

Judgment: Compliant

### Regulation 28: Fire precautions

The inspectors found that the registered provider had appropriate measures in place to protect against the risk of fire.

Judgment: Compliant

### Regulation 29: Medicines and pharmaceutical services

There were appropriate systems in place for the management of medication which ensured safe outcomes for residents availing of the services of the centre.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

Residents were found to have personal plans in place which detailed their needs and outlined the supports required to maximise their personal development and quality of life.

Judgment: Compliant

### Regulation 6: Health care

Residents were appropriately supported at times of illness and at the end of their lives in a manner which met their physical, emotional, social and spiritual needs and respected their dignity, autonomy, rights and wishes.

Judgment: Compliant

### Regulation 8: Protection

The inspectors found that the registered provider had ensured that residents were protected from experiencing abuse.

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
<b>Views of people who use the service</b>	
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 30: Volunteers	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Special Dementia Unit - Sonas Residential Service OSV-0003746

Inspection ID: MON-0021830

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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The PIC in accordance with the training department will ensure so far as possible that all staff members will advance to a completion status of their mandatory training as it falls due. The PIC so far as possible will ensure that all staff will advance to a completion status of essential training in the areas of Dementia care, Palliative care and syringe driver care. Two monthly updates and audits of staff training records will ensure the prompt identification of those staff members requiring refreshers and essential training. The PIC intends on training status to be nearer completion by 31st December 2019. The PIC will ensure a more robust and regular plan regarding staff supervision sessions, the PIC will meet with each staff member 3 times annually for supervision and will provide a more structured supervision/review process which will reflect performance in all areas outlined in the HIQA standards and regulations. The PIC will commence this system from 01st June 2019 to 01st June 2020 and recommence the 3 annual supervision/review sessions 01st June 2020- 01st June 2021 and so forth.</p>	
Regulation 4: Written policies and procedures	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>The PIC will commence a yearly audit of all policies and procedures onsite in the SDU and will inform the registered provider via email of discrepancies in any 3 year</p>	

reviews/updates. This will commence on 01st June 2019. In addition the policy regarding communication with residents issued in April 2019 has now been placed in the policies and procedures folder and read by staff members.

## 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.	Not Compliant	Orange	31/12/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/06/2019
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	11/06/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in	Not Compliant	Orange	11/06/2019



	paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
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