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:	Delta Oaks
Name of provider:	Delta Centre Company Limited by Guarantee
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	14 August 2019
Centre ID:	OSV-0004712
Fieldwork ID:	MON-0022578

About the designated centre

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

Delta Oaks is a designated centre located close to the town of Carlow. The centre provides residential care for 11 adults, male and female, with intellectual disabilites aged 18 years and upwards. The centre comprises of three buildings; Tintean Dara, Tintean Eala and Tintean Rua. Residents have individual bedrooms in all three houses with shared kitchen and living areas. All three houses have access to open garden areas. Local amenities in Carlow include shops, café's, restaurants, a bowling alley, salons, GAA clubs and a cinema. Delta Centre day services and sensory gardens are also located close by. The staffing team consist of social care workers and support workers. Residents also have access to a staff nurse in the Delta centre if needed.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
14 August 2019	09:30hrs to 18:00hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet and speak with two residents. The residents residing in two of the houses were visiting family or on holidays on the day of inspection. Therefore the inspector did not have the opportunity to meet with these residents.

The inspector observed residents eating their breakfast and getting ready for the day ahead on the morning of the inspection. Residents appeared relaxed and comfortable in each others company and in the staffs company. Choice was offered for breakfast options and residents and staff were observed laughing and joking together.

One resident spoke with the inspector about the various activities they enjoyed. These included going bowling, going to the pub, going shopping and meeting friends. The resident also spoke about some independent living skills they had developed with support from staff. Another resident told the inspector that they felt safe, when asked. The resident spoke about going to Cork on a shopping trip, working in a local cafe and gardens, regularly going to get their hair and nails done and competing in the special olympics. Both residents communicated that they like the staff supporting them and they enjoyed living with their friends in the house. They also spoke about an upcoming holiday and how they were looking forward to this. Both residents knew who to contact should they have a complaint or concern.

Six satisfaction questionnaires were completed prior to the inspection date, these all detailed a high level of satisfaction with the service being provided in areas including the premises, food, residents rights, activities, care and support, and staffing. One resident commented that they would like to do more dance classes.

Capacity and capability

The purpose of the inspection was to inform the renewal of registration of the designated centre. Overall, the inspector found that all actions from the previous inspection had been addressed. The provider, person in charge and people participating in management were striving to implement a person centred and safe service to the residents living in Delta Oaks.

The staffing team consisted of social care workers and support workers. Residents also had access to nursing support in the Delta Centre if needed. Staff numbers and skill-mixes were meeting the assessed needs of the residents living in the designated centre. Residents spoken with were were happy with the level of staff support in place. One resident, expressed in their satisfaction questionnaire that

they like Delta staff and staff were good with helping them achieve their goals and objectives. There was a staff rota in place that was maintained by the person in charge. This accurately recorded staff on duty. There were no staffing vacancies on the day of inspection. The centre used an internal relief system to cover periods of staff illness or annual leave. Staff spoken with were familiar with the needs and preferences of the residents. Supervision of staff was completed by line managers every three months.

Up-to-date mandatory training had been completed by staff. This included training in areas like safeguarding, fire safety, manual handling, epilepsy management, infection control, data protection, first aid, medication administration, children's first and autism training. The person in charge and people participating in management were completing a regular training needs analysis and were highlighting training deficits or refresher training needs.

The inspector reviewed a number of staff files. While all Schedule 2 documents were in place, satisfactory employment history was not accurately recorded for one staff member. The inspector was assured from speaking with management that they were aware of all reasons for employment gaps and this had not been accurately recorded in the staff file. It was also noted that a number of staff members did not have an up to date contract of work in place.

There was a clear management structure and team in place. There was a person in charge (PIC) that had a full time position and was actively involved in the running of the centre. Good oversight and knowledge of the residents needs was evident. Appropriate systems were in place to ensure management and oversight of the centre, in the absence of the person in charge.The PIC had completed an annual review of the service provided. Six monthly unannounced audits were also being completed by a person nominated by the provider. The person in charge and persons participating in management were also completing regular thematic audits in all three houses. These audits included checking fire safety issues, residents finances, service policies, meeting minutes and residents care plans. The service nurse did a monthly medication audit. However, audit systems in place were not always identifying all areas in need of improvements at times. This was evident through the inspections findings. The management team expressed they had plans to change their format of audits to included more sustainale, measurable, attainable, relevant and timely (SMART) systems.

There were no complaints communicated with the inspector on the day of inspection regarding the service being provided. The complaints process was prominently displayed in the designated centre and residents spoken with were aware of who to speak with if they had a complaint regarding the service. Any complaints or concerns from residents or their representatives were appropriately recorded and treated in a serious and timely manner.

Regulation 15: Staffing

Staff numbers and skill-mixes were meeting the assessed needs of the residents living in the designated centre. There was a staff rota in place that was maintained by the person in charge. This accurately recorded staff on duty. However, it was noted a number of staff members did not have an up to date contract of work in place and one staff member did not have an accurate employment history record in their staff file.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Up-to-date mandatory training had been completed by staff. The person in charge and people participating in management were completing a regular training needs analysis.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place. The person in charge had completed an annual review of the service provided. Six monthly unannounced audit were being completed by a person nominated by the provider. The person in charge and persons participating in management were also completing regular thematic audits in all three houses. However, audit systems in place were not always identifying all areas in need of improvements at times. This was evident through the inspections findings.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place that contained all items set out in Schedule 1 and accurately described the service being provided.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no complaints communicated with the inspector on the day of inspection regarding the service being provided. Any complaints or concerns from residents or their representatives were appropriately recorded and treated in a serious and timely manner.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had ensured that all policies and procedures set out in Schedule 5 were in place. These were available to staff and were subject to review at intervals not exceeding 3 years.

Judgment: Compliant

Quality and safety

All actions from the previous inspection had been addressed. The inspector found that the provider was ensuring the provision of a safe and effective service to the residents living in the designated centre, although some improvements were needed in areas including premises, medication management, healthcare and positive behavioural support to ensure compliance with the regulations.

All residents had a comprehensive assessment of need in place. This then guided staff to devise a person centred support plan. This was subject to regular 6 monthly reviews or more frequently if required and these reflected residents most current needs. A key working system was in place and residents had access to a photo of their key worker at the front of their file. Key workers were responsible for maintaining residents documentation, updating social goals and supporting residents to achieve social goals. Plans in place guided staff to support residents with their activities of daily living. Specific communication care plans were also in place for residents with communication needs. A "passport" care plan was also in place with a synopsis of the residents day to day needs.

In general, the inspector found that residents healthcare needs were being met. Residents had access to nursing support when required and all staff had training in first aid. Assessment tools were used by staff to assess residents risk of malnutrition and residents tissue viability. Referrals were made to relevant healthcare professionals if concerns were identified following these assessments. An appropriate assessment tool was also used to assess residents pain levels. Dementia screening was completed and reviewed annually. Residents had access to a general practitioner (GP) and were supported to attend their GP for regular check ups and

annual bloods. However, it was observed that one resident was receiving an altered textured diet following the residents family identifying a swallowing risk. This had not been recommended or reviewed by a registered speech and language therapist. The inspector also reviewed one residents protocol for bowel care and found that staff were not always administering medication as required (PRN) as per the protocol. Following discussion with the staff and the person in charge, it was evident that the residents bowel care was not always recorded during times when the resident was not in the designated centre and therefore the protocol in place needed further review.

All staff had received appropriate training and were competent to administer medication safely. Appropriate systems were in place for the storage of medication, including out-of-date or unused medication. Keys for the medication press were stored securely. A number of residents prescriptions were reviewed along with residents medication and it was found that prescriptions were accurately reflecting medicines being administered. All prescriptions were signed by a general practitioner (GP) and were subject to regular review. However, following a review of medication administration records (MAR's) it was noted that these were not always accurately reflecting medicines administered by staff. Particularly for medications that were prescribed to be administered on alternative days. This posed a risk of a medication error occurring.

All staff had received up to date training in the safeguarding and protection of vulnerable adults. There was a designated officer in place who responded to any safeguarding concerns in a serious and timely manner. Staff spoken with were familiar with safeguarding measures and national policy. All staff had up-to-date Garda vetting in place. Residents spoken with expressed they felt safe living in the centre when asked. There were no safeguarding concerns identified on the day of inspection.

The registered provider had ensured the provision of adequate fire fighting equipment in the designated centre. Staff had received suitable training in fire safety and 6 monthly evacuation drills were completed. Residents and staff spoken with had a good knowledge of fire evacuation procedures and knew where the fire assembly point was located. There was a fire procedure review completed 6 monthly. This included a review of residents evacuation plans, call points, emergency lighting, escape routes, the fire panel smoke detectors and the fire policy. Staff also completed weekly fire safety checks. However, appropriate fire containment measures were not in place in one of the houses in the designated centre. This posed a risk to staff and residents in the event of a fire.

In general, the premises were designed and laid out to meet the needs of the residents living there and were maintained to a good standard. The centre comprised of three houses. All three had individual bedrooms and shared living and kitchen areas. All three houses had surrounding garden areas. Regular staff cleaning schedules were in place and maintained. However, the inspector noted outstanding paintwork in all three buildings in the designated centre.

Residents had a positive behavioural support plan in place when needed and this

was subject to regular review with a member of management who had completed a course in behaviour management. The inspector observed one resident used a visual planner that helped them to mitigate some anxieties that may cause behaviours to escalate. Staff spoken with were familiar with this planner and with the residents needs. Staff were utilising a tool to assess the antecedent, behaviour and consequence following incidents of challenging behaviour. However, the service had no access to a behavioural support professional and not all staff working with residents with behavioural support needs had completed training in positive behavioural support. It was identified that there was a need for this at times.

In general, appropriate systems were in place for the management of potential and actual risks in the designated centre. Management had identified potential risks in the centre and individualised risk assessments were completed for residents which included assessing the risk of falls, choking, burns and financial loss. Measures were in place to mitigate risks secondary to lone workers and plans and measures were in place for in the event of an emergency.

Regulation 17: Premises

In general, the premises were designed and laid out to meet the needs of the residents living there and were maintained to a good standard. However, the inspector noted outstanding paintwork in all three buildings in the designated centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that appropriate measures were in place for the management and mitigation of actual and potential risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured the provision of adequate fire fighting equipment in the designated centre. Staff had received suitable training in fire safety and regular evacuation drills were completed. However, appropriate fire containment measures were not in place in one of the houses in the designated centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

All staff had received appropriate training and were competent to administer medication safely. Appropriate systems were in place for the storage of medication, including out-of-date or unused medication. However, following a review of medication administration records (MAR's) it was noted that the administration were not always accurately reflecting medication administered by staff.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All resident had a comprehensive assessment of need in place. This then guided the division of a person centred support plan. This was subject to regular review and reflected residents current needs.

Judgment: Compliant

Regulation 6: Health care

In general, the inspector found that residents healthcare needs were being met. Residents had access to nursing support when required. However, it was observed that further review and improvements were required regarding speech and language therapist assessment/review and bowel care review.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents had a positive behavioural support plan in place when needed and this was subject to regular review with a member of management who had completed a course in behaviour management. However, the service had no access to a behavioural support professional and not all staff working with residents with behavioural support needs had not completed training in positive behavioural support.

Judgment: Not compliant

Regulation 8: Protection

All staff had received up to date training in the safeguarding and protection of vulnerable adults. There was a designated officer in place who responded to any safeguarding concerns in a serious and timely manner. Staff spoken with were familiar with safeguarding measures and national policy.

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
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Delta Oaks OSV-0004712

Inspection ID: MON-0022578

Date of inspection: 14/08/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All staff will have a contract on their personnel files. Staff members who commenced employment pre-March 2019 were supplied with contracts, but some have declined to sign these on the advice of FORSA union. Any staff employed from March 2019 are required to sign the contracts of work before commencing employment. Delta Services are unable to enforce the signing of contracts to any staff employed pre-March 2019 and this matter has been discussed with the WRC in January 2019. It is hoped that the issue will be resolved with FORSA union and new contracts issued to all staff over the coming months.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Audit systems have been adjusted to include more sustainable, measurable, attainable, relevant and timeless systems.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

Painting will be completed in all three premises by March 31st, 2020.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Door closures will be placed on all internal doors by 31/11/2019

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Prescription sheets have been updated.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: PRN medications protocol for bowel care has been reviewed and updated. A referral has been made to Speech and language therapist.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A behavioral therapist is now available one day a fortnight and commenced on 2-10-2019. All staff completed positive behavior support training on 23rd on 24th September 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 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/06/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/03/2020
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'	Substantially Compliant	Yellow	21/10/2019

	needs, consistent and effectively monitored.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	21/10/2019
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	21/10/2019
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-	Not Compliant	Orange	21/10/2019

	escalation and intervention techniques.			