Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Office of the Chief Inspector

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

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| Name of designated centre: | St Peter's Services 3 |
| Name of provider: | Health Service Executive |
| Address of centre: | Westmeath |
| Type of inspection: | Unannounced |
| Date of inspection: | 09 May 2019 |
| Centre ID: | OSV-0004904 |
| Fieldwork ID: | MON-0021183 |

## About the designated centre

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

This Designated Centre comprises two detached bungalows each located in close proximity to the nearest small town. Each house accommodates five residents each having their own bedroom.

The provider describes the service as providing residential support including nursing support to both male and female residents on a 24 hour, seven days a week basis to individuals with an intellectual disability.

The centre is staffed over the 24 hour by a core staff team, including nursing staff on a daily basis.

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

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| Number of residents on the date of inspection: | 10 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### 1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### 2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| 09 May 2019 | 10:00hrs to 17:30hrs | Julie Pryce | Lead |

## What residents told us and what inspectors observed

There were ten residents at the time of the inspection, and the inspector met and spent time with eight of them. Residents did not all communicate verbally, but made their needs known in other ways. Some residents approached and greeted the inspector in their own ways, and it was clear the staff were very familiar with their ways of communicating, and were observed interacting with them. Some residents were clearly indicating their current contentment by vocalisations and body language.

Some residents showed the inspector around their homes and into their bedrooms, and showed the inspector some of their hobbies and things they had made. They told the inspector about upcoming events that they were looking forward to.

The inspector spoke with some of the relatives of residents during the course of the inspection, and relatives all said that they were happy with the service their relatives received, and praised the staff for the support they gave to residents.

Where residents were not happy living in the centre for personal reasons, this had been responded to, and transition plans were underway to accommodate moves to centres of residents' choice within the organisation. Residents were able to tell the inspector about the planned move, and were clearly looking forward to their new home

## Capacity and capability

The inspector found the centre to be effectively managed, with a clearly defined management structure in place with explicit lines of accountability and various governance processes in place, although some improvements were required to ensure consistency of oversight.

The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who was appropriately skilled, experienced and qualified. This person in charge was based full time in the centre and demonstrated her ability to lead the staff team and to support good practice. She was knowledgeable about the care and support needs of residents.

The provider had put systems in place to ensure the staff team could effectively meet the needs of residents for the most part. The number and skills mix of staff was appropriate to meet the needs of residents. There was a core team of staff

which included nursing staff on a daily basis in accordance with the needs of residents. Both staff and the person in charge reported that additional staff were always available to support extra activities if required.

Staff were in receipt of regular training which was found to be up to date, and monitored by the person in charge by the use of a training matrix. Staff were knowledgeable in relation to the needs of residents and were observed to be providing care and support in accordance with the identified needs of residents. Staff supervision was informally managed by the person in charge on a daily basis, however the schedule of formal supervision conversations as required by the organisation's policy was not up to date. Therefore, whilst overall staff were providing support to residents in accordance with their needs and preferences, the provision of formal supervisions was not in place.

The provider demonstrated the capacity to identify and address areas for improvement. There was an annual schedule of auditing in place which covered all areas of care and support, including a very detailed audit of financial management within the centre. Six monthly unannounced visits had been conducted on behalf of the provider, and an annual review of the care and support of residents had been prepared. The inspector reviewed a sample of actions required following these processes, and all actions had been completed, so that identified improvements had been put in place.

While there were some systems in place to ensure communication between staff and management, improvements were required to ensure consistency. There was a schedule of monthly staff meetings in place, but not all scheduled meetings had taken place, and there was no adequate system of ensuring that staff who were unavailable to attend a meeting received the information discussed. Monthly quality and assurance meetings were held between the persons in charge in the area and the regional managers. Many of the actions agreed at these meetings were complete, however where issues were to be brought back to staff team meetings this had not always taken place, meaning that it was unclear whether this information was always made available to staff.

The provider had put systems in place to receive and respond to feedback about the service. There was a complaints procedure in place which was clearly available, and any complaints were reviewed and recorded. Any steps taken to rectify any issues raised in a complaint were recorded, and the satisfaction of the complainant was recorded. It was therefore clear that feedback was responded to in a timely manner, and that all steps were taken to resolve any identified issues.

## Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight

of the care and support in the centre.

Judgment: Compliant

## Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff were in receipt of all mandatory training and additional training specific to the needs of residents, however supervision conversations were not being held.

Judgment: Substantially compliant

## Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were effective monitoring systems in place, however the communication of information via a system of meetings was not always effective.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required

timeframes.

Judgment: Compliant

## Regulation 34: Complaints procedure

There was a clear complaints procedure in place which was available in an accessible version. A complaints log was maintained, and residents and their families were aware of the procedure if they wished to make a complaint.

Judgment: Compliant

## Quality and safety

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and were supported to communicate and to make choices.

Residents were supported to maintain friendships and family relationships. Some residents were supported to communicate with their families via technology in a very effective way. Some residents had close friendships within the centre, and these were supported.

There was an effective personal planning system in place which included detailed assessment and regular review. Each resident had a personal plan in place based on a detailed assessment of needs and abilities, including both social and healthcare needs. Residents were supported to maximise their personal potential, in that meaningful goals had been set for each person, and the personal planning process supported the provision of a meaningful day for each resident.

There was an emphasis on communication, and detailed guidance for staff as to how best to communicate with each resident. Where residents could not communicate verbally, or had limited expressive verbal communication, there was clear information detailed in the personal plans, including a 'communication dictionary' for some residents which identified what residents were communicating by their actions and vocalisations. The inspector observed this guidance in practice, and it was clear that all efforts were made to ensure that the voice of each resident was heard.

Healthcare plans were in place where needed and implementation of them was recorded. Residents had access to various members of the multi-disciplinary team, and their recommendations were recorded and clearly implemented. All staff engaged by the inspector demonstrated clear knowledge of needs and interventions. Interventions in relation to health care were effective for residents, and as such a previously recurring healthcare issue had not occurred for over a year. It was therefore evident that healthcare needs were addressed and managed.

Where restrictive interventions were in place there was a detailed rationale and a record maintained of the implementation of these interventions. The implementation of these interventions was in accordance with best practice, was notified to HIQA as required and was kept under regular review. There was a supporting risk assessment in place for each intervention.

Risk assessments and management plans were in place for all identified risks in the centre, both generic in the centre and individual to each resident. However there was no risk register which listed all the risks in the centre clearly for review, and the restrictive practices, whilst recorded individually were not recorded in a log as required. Therefore information about every risk and every restrictive practice was not readily available to facilitate oversight and escalation if necessary in the centre.

Accidents and incidents were reported and recorded, and the person in charge undertook and recorded a monthly review of all incidents. It was therefore clear that there was robust oversight and trending of accidents and incidents.

Fire safety practices and equipment were in place for the most part. Fire safety equipment including fire doors, extinguishers, fire blankets and emergency lighting were in place and were regularly maintained and there were fire doors throughout. There was a personal evacuation plan in place for each resident, and regular fire drills had been undertaken. However, there was no evidence of a fire drill having been undertaken under night time circumstances. The provider had therefore not assured themselves that residents could be evacuated in the event of an emergency at night.

There were structures and processes in place in relation to the safeguarding of residents. All staff had had appropriate training and there was a policy in place to guide staff. A detailed audit of finances through the centre had been recently undertaken, and had found good practice. There were no current issues relating to safeguarding of residents. Staff and the person in charge were aware of their roles in relation to safeguarding of residents.

Behaviour support was offered to those residents who required this input. There was clear guidance to staff in relation to response to behaviours of concern. A previously high level of behaviours of concern had been reduced both in frequency and intensity, and this had been maintained for a significant period of time, indicating that strategies in place in relation ot behaviours of concern were effective..

There was an emphasis in the centre and among the staff on upholding the rights of residents. Residents were supported in choice making, and were included in

decisions about their lives. Residents' dignity was upheld, and all interactions between staff and residents were respectful. While privacy was maintained within the houses, the layout of the centre was such that any visitors to the houses had a direct view into the bedrooms, and therefore residents' personal spaces were not private. This was discussed with the person in charge and staff members, who began to consider solutions. It was therefore clear that respect for residents was paramount.

## Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

Judgment: Compliant

## Regulation 11: Visits

Visits were facilitated and welcomed.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with their assessed needs and preferences.

Judgment: Compliant

## Regulation 17: Premises

The design and layout to the premises was appropriate to meet the needs of the

residents.

Judgment: Compliant

## Regulation 26: Risk management procedures

Processes were in place to assess and mitigate identified risks, however the information relating to risk was not recorded in a manner that facilitated oversight of risk in the centre.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Precautions had been taken against the risk of fire, however the provider had not demonstrated that residents could be evacuated in a timely manner in the event of an emergency at night.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs which had been reviewed regularly

Judgment: Compliant

## Regulation 6: Health care

Provision was made for appropriate healthcare.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Appropriate systems were in place to respond to behaviours of concern.

Judgment: Compliant

## Regulation 8: Protection

There were systems in place to ensure that residents were protected from all forms of abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

There was an ethos of upholding and respecting the rights of residents, however not all personal spaces ensured privacy.

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** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | 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 St Peter's Services 3 OSV-0004904

## Inspection ID: MON-0021183

## Date of inspection: 09/05/2019

**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 | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>A supervision schedule has been developed. The person in charge will complete formal supervision with all staff in the centre by 30/06/19. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A staff meeting took place on 06/06/19. Minutes of the Quality Assurance meeting dated 07/05/19 were discussed. Quality Assurance minutes will be a standing agenda item at every staff meeting. Minutes of the staff meeting will include actions and dates for implementation of all actions identified. | |

| Regulation 26: Risk management procedures | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The person in charge attended training on the completion of a risk register on 04/06/19. A risk register has been implemented in the centre which will facilitate oversight of risk in the centre. The risk register will be reviewed monthly by the person in charge.

The person in charge has implemented a restrictive intervention register in the centre. The restrictive intervention register will be reviewed and updated every three months by the person in charge.

| Regulation 28: Fire precautions | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A night time emergency evacuation took place on 09/05/19. All residents were evacuated in two minutes and thirty seconds.

The person in charge has implemented a fire drill recording template in the centre. The template will record monthly day time and night time fire evacuations drills and the effectiveness of the fire drill evacuation.

| Regulation 9: Residents' rights | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Additional window dressings have been fitted in personal spaces in order to uphold and respect the privacy of individuals residing in the centre.

## 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)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 30/06/2019 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Substantially Compliant | Yellow | 10/06/2019 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for | Substantially Compliant | Yellow | 19/06/2019 |

| | | | | |
|---|---|---|---|---|
| | responding to emergencies. | | | |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 09/06/2019 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is 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. | Substantially Compliant | Yellow | 18/06/2019 |