Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Waxwing 1
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	12 February 2019
Centre ID:	OSV-0004918
Fieldwork ID:	MON-0020891

About the designated centre

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

This designated centre is comprised of one detached single storey premises located in a small, pleasant housing development in a rural location but in relatively close proximity to the city; transport is provided. Residential services are provided to a maximum of six residents and the house is open and staffed on a full-time basis. The provider aims to provide each resident with a safe, homely environment and safe, quality care and supports appropriate to their individual requirements; this is achieved through a process of individual assessment and planning. The provider aims to support residents of all abilities but who are experiencing a need for increased care and support in relation to their disability or increasing age. Residents are supported to enjoy a quieter pace of life but to have continued access to the day service and the wider community in line with their preferences and ability. The model of care is a social model and the staff team is comprised of social care and care support staff led by the person in charge who is based in the house. However, given the stated purpose of the house access to healthcare services and professionals including nursing advice and support is facilitated.

The following information outlines some additional data on this centre.

Current registration end date:	31/01/2021
Number of residents on the date of inspection:	6

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
12 February 2019	10:00hrs to 18:00hrs	Mary Moore	Lead

Views of people who use the service

The inspector engaged with residents and staff as they went about their normal daily routines. Two residents attend the day service on a daily basis and the inspector met them when they returned in the evening to the centre. All residents communicated their well-being and comfort in the house, with staff and with the presence of the inspector in their home either verbally or by gesture in line with their personal means of communication.

The inspector found the atmosphere in the house to be easy and pleasant with all residents in good form and enjoying good access to staff including the person in charge. Residents clearly demonstrated to the inspector their ability to exercise their personal choices and preferences and the inspector found that these were facilitated in the observed daily routines of the house. Residents spoke of their happiness of having ongoing access to their day-service and peers; a resident invited the inspector to read a birthday card they had just received; the inspector noted that staff gave the card to the resident themselves to open. A resident invited the inspector by gesture to view their room and confirmed their unrestricted access to their personal belongings.

The inspector enquired as to the well-being of their cat and residents confirmed that he was well and that they all really enjoyed his company.

Capacity and capability

Overall the inspector found that the service was well governed on a day to day basis and that the provider had arrangements to ensure that there was consistent oversight. The provider had over the course of inspections of this centre by HIQA (Health Information and Quality Authority) demonstrated incremental improvement; the inspector found that this improvement continued and was sustained. This improved governance resulted in positive outcomes for residents that will be discussed in detail in the next section of this report.

The management structure was clear and these inspection findings support the finding that each person involved in the management of the service understood and exercised their individual roles and responsibilities; reporting relationships and accountability operated in line with the agreed governance structure.

For example the inspector found that the person in charge had sound knowledge of her role and her regulatory responsibility for the quality and safety of the care and support provided to the residents. The person in charge had ready access and good

support from the area manager and the head of community services. The person in charge had the autonomy required to exercise her role while matters were appropriately escalated and good oversight was maintained by the provider of the general operation and administration of the centre.

For example the inspector found that the provider was undertaking the formal unannounced visits to the centre as required by the regulations at a minimum six-monthly; the inspector reviewed the findings of the most recent provider review undertaken in December 2018. While the provider did self-identify areas that did require improvement, for example in relation to personal planning processes, overall the findings were positive and reflected a service that was effectively managed; the requested actions (seven in total) focussed on ensuring full-compliance but also driving improvement and quality. The inspector reviewed a sample of the actions that issued such as staff training and risk assessments and found that the required actions were completed.

The inspector found that staffing levels and arrangements were adequate; however, staffing is referenced again in the next section of this report in the context of evacuation procedures. Changes had been made to staffing arrangements in late 2018 and there was explicit evidence that these changes were made based on objective assessment of resident's needs and risks. The changes allowed for an increased staffing presence at times when residents needed most support, for example in the morning to facilitate a later and slower start to the day. The provider operated a personal assistance programme; the inspector was satisfied that the use of this programme was effectively monitored and overseen so that its operation did not conflict with staffing obligations but residents could still enjoy their personal monies.

Currently nursing support and advice was provided predominantly by the clinical nurse specialist in age related care. The person in charge was also seen during this HIQA inspection to arrange access to community based nursing services. The inspector saw that each resident's requirement for nursing care was monitored and discussed by the multi-disciplinary team (MDT). It was acknowledged that resident's needs fluctuated and were likely to increase but the inspector found that while the staff skill-mix did not currently include nursing staff, access to nursing care was facilitated and residents' needs were met in the centre.

The inspector reviewed staff training records and found that all staff had attended baseline mandatory training, for example safeguarding and fire safety training; the person in charge was aware of and was managing refresher training requirements. Staff were also provided with training that equipped them with the knowledge and skills to meet specific resident needs; much of this training was provided by members of the multi-disciplinary team such as psychology or the clinical nurse specialist in age related care.

To form a view of how others viewed the service the inspector reviewed the complaints log. This review indicated that residents knew how to complain and who to complain to, that their complaints were listened to and addressed to their satisfaction. However, the complaints procedure while discussed with residents was

not prominently displayed. Also based on a specific example discussed at verbal feedback, a review was required to ensure that where a complaint was received by, for example senior management, but was related to the quality and safety of the service, the complaint procedure supported the consistent provision of feedback to centre based staff including the person in charge.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs, of the role and associated responsibilities and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, skill-mix and arrangements were appropriate to and reflected the current assessed needs of the residents. The inspector found that the provider continuously assessed the adequacy of staffing and skill-mix and sought to ensure that residents received continuity of care and supports. For example there was currently no reliance on agency staff and a core small number of relief staff were employed.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframes. Attendance at refresher training was monitored. Staff were also provided with training that supported them to safely and appropriately meet specific resident needs.

Judgment: Compliant

Regulation 21: Records

The inspector found that any of the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 that were requested were in place. The requested records were retrieved for the inspector with ease; the required information was readily extracted from the records; the records were well maintained.

Judgment: Compliant

Regulation 23: Governance and management

The centre was effectively and consistently governed and resourced so as to ensure and assure the delivery of safe, quality supports and services to residents. The provider had comprehensive systems of review and utilized the findings of reviews to inform and improve the safety and quality of the service. The provider had sustained and continued to develop the improvement achieved in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had sound knowledge of incidents and events that had occurred including those that required notification to HIQA; for example any injury sustained by a resident or the use of restrictive practices. Based on the sample of incident records seen, the inspector was satisfied that the regulatory responsibility to notify HIQA of such events was met.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was not prominently displayed.

Monitoring was required to ensure that where a complaint was received by for example senior management, there was consistent provision of feedback to centre based staff including the person in charge.

Judgment: Substantially compliant

Quality and safety

Overall the inspector found that the provider achieved its objective to provide each resident with safe, quality care and support appropriate to their individual needs. The appropriateness of the care and support provided was consistently monitored and there was evidence of improved outcomes for residents individually and collectively. However, while the provider had taken action to improve their fire safety measures, a deficit was identified in the provider's evacuation procedures.

Residents living in the centre presented with a diverse range of needs, ability and interests; different levels of support were provided in accordance with the assessed needs and requirements of each resident. This meant for example that if some residents required a slower or quieter pace of life, this was provided but did not impact negatively on others with perhaps more physical ability and who wished to access, for example the day service on a daily basis; staffing levels and transport arrangements provided for this.

This individualised approach was based on the on-going assessment of resident ability, choices and needs; a plan of support was devised based on the findings of this assessment. The person in charge reviewed and maintained these plans but described her systems for communicating to staff any changes, for example at staff meetings and the use of a daily communication board. The inspector reviewed a representative sample of resident's personal plans and found that they provided a clear picture of each resident, the areas where support was required and what that support was. There was evidence of regular MDT review and overview of the care and support provided to each resident; there was good, representative MDT attendance at these reviews.

The personal plan included resident's personal goals and objectives; residents and as appropriate their representative were consulted with and participated in the development and review of the plan. The provider review of December 2018 had found that improvement was needed in this area to ensure that each resident had opportunities to explore more meaningful goals; the inspector did find that some records in this regard were generic and overarching. The inspector would add, that based on the practice observed, records did not always reflect what residents participated in and achieved on a daily basis, or the understanding staff had of the importance of maintaining physical and cognitive well-being.

For example the inspector found residents despite increasing age, deteriorating health and cognitive decline were active and engaged; independence rather than dependence was encouraged and residents continued to be actively involved with their peers and their wider community and attended the day service daily if only for a short period of time. The range of activities enjoyed by residents varied from horse-riding to table-top activities. The person in charge discussed her plans to facilitate staff to attend Sonas training (a therapeutic training programme that involves stimulation of all five senses, using for example gentle exercise, relaxing music and memory-focused exercises). At verbal feedback of the inspection findings the provider confirmed its support for this initiative.

Measures to protect residents from harm and abuse included training for staff, policies and procedures and ready access to the designated safeguarding officer. The person in charge was based in the house and worked shifts (including alternate weekends) that corresponded to times when both residents and staff were present; this supported ready access to and for residents and the direct supervision of staff and their practice. The needs of residents were described as generally compatible and therefore residents were not at risk of harm or abuse from their peers. This compatibility and comfort in their home was evident on inspection.

Residents did infrequently present with behaviours that had a clinical basis but required intervention; there was evidence of good practice and a commitment to therapeutic rather than restrictive interventions. Improvement in practice was achieved through education and support for staff and staff willingness to learn. The inspector found that residents enjoyed minimal if any restrictions to their daily routines and only when required for their safety or the safety of others, for example when in the car. The support provided to residents by staff and the MDT, had based on records seen allowed residents to develop and enjoy positive relationships with their peers.

Residents were supported by staff to enjoy good health and there was an evident commitment to supporting residents to remain in their home for as long as it was safe and appropriate to do so. Staff monitored resident well-being and facilitated residents to access their choice of General Practitioner (GP). Access was facilitated to other healthcare services including optical, dental, chiropody, psychiatry, psychology, occupational therapy and speech and language therapy. As discussed in the first section of this report the model of care was social. The inspector saw that advice, support and guidance for staff was provided by the clinical nurse specialist in age related care; this support extended to the preparation of specific care plans such as supporting the person with dementia. The inspector found that these plans did guide daily practice with evidence of monitoring tools such as regular monitoring of body weight and daily monitoring of fluid intake and output.

The inspector reviewed medicines management systems and found improved practice that promoted resident safety. This improvement was facilitated by the provision of enhanced medicines management training for staff as previously committed to by the provider. The person in charge reported that the revised training equipped staff with the knowledge to make good medicines management decisions. Staff competency was formally assessed. There were systems for

identifying and reviewing medicines related errors with no concerning pattern noted in the records of such incidents reviewed.

Overall there was evidence that hazard identification and management of risk informed the general operation of the centre and promoted resident safety; this finding was based on the review of a purposeful sample of risk assessments maintained by the person charge. For example the staffing risk assessments referred to in the first section of this report and resident specific risks and their assessment such as increasing health needs or the risk of leaving the centre without staff knowledge.

The provider had taken measures to improve their fire safety management systems. Works completed included the provision of additional fire resistant door-sets to high risk areas, an additional final exit had been provided, corrective works to the fire detection system had been completed as had structural works in the attic; confirmation of this was on file from the fire safety consultant. The inspector saw certificates stating that emergency lighting, fire fighting equipment and the fire detection systems were inspected and tested at the required intervals and to the specified standard. All staff had completed fire safety training; night-staff had recently completed this training. Staff did undertake simulated evacuation drills with residents; good evacuation times were achieved and the person in charge monitored staff attendance at these drills to ensure that all staff participated.

However, while some works completed were designed to provide two compartments to support the progressive horizontal evacuation of residents, there were reported and observed deficits; self-closing devices that prevented fire resistant doors from closing correctly.

Consequently there was an open risk assessment for the effective evacuation of residents at night-time; the provider failed to demonstrate that it had effective arrangements if this was required. The risk of failure to effectively evacuate residents at night-time if necessary had been judged to have increased from low to moderate risk further to relatively recent changes made to night-time staffing arrangements; that is the change from one waking and one sleepover staff to one waking staff. There was no evidence that one waking staff was not sufficient to meet resident's physical, health, personal and social care needs. There was evidence in the form of the above risk assessment and the concerns of the provider's assessor who had completed the risk assessment that one staff potentially could not safely evacuate the six residents to a safe place. The accuracy of the risk had not been tested and validated by an evacuation drill that simulated the night-time scenario.

At verbal feedback of the inspector's findings the provider acknowledged the failings and gave a commitment to address them as a matter of priority. The day after this inspection confirmation was issued to HIQA that the fire-resisting doors were operating correctly; controlled (to reduce any risks to residents) simulated late evening and early morning evacuation drills were scheduled to establish the ability of one staff to safely evacuate all six residents to a safe location. The provider reverted with explicit evidence that the evacuation drills had been successful, that one staff had adequately implemented the progressive horizontal evacuation

procedure, and that the risk assessment referenced above was to be reviewed and once the revised level of residual risk was agreed by all parties, would also be shared with HIQA.

Regulation 13: General welfare and development

There is always scope for improvement as outlined in the provider review of December 2018 and records seen on inspection did not always adequately reflect practice in the centre. However, given the diverse and increasing needs of residents the inspector overall was satisfied that residents had opportunities for meaningful engagement, social participation and community integration. Access was determined by individual needs, abilities, risk, interests and choices and therefore supported well-being, functioning and independence rather than dependence. Residents were enabled to lead their lives in as fulfilling a way as possible; staff spoken with understood this and continued to promote it.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised.

Judgment: Compliant

Regulation 28: Fire precautions

Failings identified by this inspection were satisfactorily addressed as a matter of priority by the provider; this is reflected in the level of non-compliance found. However, the provider at the time of inspection failed to demonstrate by means of fire drills that it had adequate arrangements for evacuating at all times, residents and bringing them to a safe location.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There was evidence of improved medicines management practice. The provider had revised its medication management policies and procedures and had provided staff with enhanced training. Based on the records seen staff adhered to the procedures for the safe administration of medication; medication was administered as prescribed. Records were kept to account for the management of medicines including the administration of each individual prescribed medicine.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which detailed their needs and outlined the supports required to maximise their well-being and quality of life. The plan was developed based on the findings of a assessment and recommendations made by the MDT. The plan and its effectiveness was the subject of regular review by staff and the MDT. There was evidence of improved outcomes for residents further to the support and care that they received.

Judgment: Compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident had access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of improved practice, a positive approach to the management of behaviour and plans that detailed how preventative therapeutic interventions were implemented. The plan was tailored to individual needs.

There was policy, procedure and oversight of the use of restrictive practices.

Residents enjoyed routines and an environment free of unnecessary restrictions.

Judgment: Compliant

Regulation 8: Protection

The provider had effective procedures for ensuring that residents were protected from all forms of 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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Waxwing 1 OSV-0004918

Inspection ID: MON-0020891

Date of inspection: 12/02/2019

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Regulation 34(1) d : • Easy read complaints procedure is now on display in the center in a prominent area. Regulation 34 (2) f: • Complaints officer will ensure that Person in Charge will be kept up to date in writing with progress on formal complaints.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Regulation 28 (4) b • Three fire drills were carried out on February 14th and 15th. These drills were completed by one staff and tested different scenarios including horizontal evacuation using the compartment. All drills were carried out within a safe time frame. • The PIC will ensure that night time drills occur twice per annum to ensure that one staff is capable of safely evacuating the residents to a safe place. • PIC created a specific fire evacuation procedure in collaboration with the fire safety officer. This procedure incorporates the use of the fire compartments and documents different procedures dependent on where the fire is and where the residents are in the centre. The PIC has discussed this procedure with all staff at the March team meeting and it has been filed in the fire safety register and on the emergency action plan that is on display.	

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 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	15/02/2019
Regulation 34(1)(d)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall display a copy of the complaints procedure in a prominent position in the designated centre.	Substantially Compliant	Yellow	07/03/2019
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	27/03/2019