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:	Sugarloaf Lodge
Name of provider:	RehabCare
Address of centre:	Dublin 18
Type of inspection:	Unannounced
Date of inspection:	18 July 2019
Centre ID:	OSV-0005045
Fieldwork ID:	MON-0021544

About the designated centre

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

Sugarloaf Lodge provides community residential services to three residents, over the age of 18. It is located in a suburban area in Dublin city and is operated by Rehabcare. The designated centre is a bungalow and consists of a sitting room, kitchen/dining area, a sensory room, a staff sleep over room, an office, a bathroom and three individual bedrooms. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge, social care workers and care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
18 July 2019	09:55hrs to 17:55hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with two of the residents living in the designated centre during the course of the inspection. One resident was not in the centre on the day of the inspection. The inspector observed care practices and staff interactions with residents over the course of the inspection.

Overall, residents appeared relaxed in their home. The inspector observed residents preparing to access the community and take part in activities of preference and interests. Throughout the course of the inspection, positive interactions were observed between residents and staff.

Capacity and capability

Overall, the centre's governance arrangements provided effective oversight of the service and ensured that the service provided was of a good quality. The governance systems in place identified areas for improvement and implemented measures to address these areas, for example, staffing arrangements. However, some improvements were required in relation to the annual review, staffing arrangements and staff team training.

The inspector found there was a clearly defined management structure in place. The centre was managed by a person in charge in who was found to be suitably qualified and experienced. The person in charge demonstrated a good understanding of the residents' care and support needs. The person in charge was full-time, supernumerary and was supported in their role by deputy team leaders. Quality assurance audits in place included annual reviews and the six monthly unannounced provider visits. However, it was not evident that the annual review for 2018 provided for consultation with residents or their representatives where appropriate.

The person in charge maintained a planned and actual roster for the centre. At the time of the inspection, the centre was operating with four whole-time equivalent vacancies. However, a review of rosters demonstrated continuity of care was maintained by the covering the vacancies through the existing management and staff team and the use of regular relief staff. The provider was in the latter stages of recruitment to fill these vacancies. In addition, the provider had self identified that at times there was insufficient staffing to meet the assessed needs of residents and a business case had been prepared and submitted to the funding body regarding staffing levels in April 2019. The arrangements in relation to staffing required review to ensure there was sufficient staff to meet the

assessed needs of residents. Throughout the inspection, staff were observed treating and speaking with residents in a dignified and caring manner.

There were systems in place for staff team training and development. The inspector reviewed the staff team training records and found that it was not evident that all mandatory training was up-to-date. For example, it was not evident from records reviewed that all of the staff team were up-to-date in fire safety. There was additional training provided for the staff team in line with residents' needs including training in epilepsy awareness and cardiac first responder.

Regulation 14: Persons in charge

The designated centre was managed by a person in charge who was employed on a full-time basis, suitably qualified and experienced. The person in charge demonstrated good knowledge of the residents and their support needs.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned and actual roster for the centre. At the time of the inspection, the centre was operating with four whole time equivalent vacancies. The provider had self identified that at times there was insufficient staffing to meet the assessed needs of residents and a business case had been prepared and submitted to the funding body regarding staffing levels in April 2019. The arrangements in relation to staffing required review to ensure there was sufficient staff to meet the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. However, it was not evident from training records reviewed that all staff had up-to-date mandatory training.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined management structure in place. There were systems in place to monitor and evaluate the quality of care provided to residents. However, it was not evident that the annual review of quality and safety of care and support for 2018 provided for consultation with residents or their representatives were appropriate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Office of the Chief Inspector was notified of incidents as required by Regulation 31.

Judgment: Compliant

Quality and safety

This inspection found that systems and arrangements were in place to ensure that residents received care and support that was person centred and of good quality. However, improvements were required in the personal plans, oversight of restrictive practices, fire safety and medication management.

The inspector completed a walk-through of the centre and found that the house was homely and well maintained. The designated centre is a bungalow and consists of a sitting room, kitchen/dining area, sensory room, a staff sleep over room, office, a bathroom and three individual bedrooms. The bedrooms viewed were decorated in line with residents taste and preferences. There was a well maintained garden to the rear of the centre.

There was an up-to-date assessment of need completed for each resident. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. However, on the day of the inspection one personal plan viewed had not been reviewed in a timely manner. The plan was in the process of being reviewed. In addition, some personal plans did not accurately guide the staff team. For example, one plan outlined that the resident should be weighed weekly. This was not taking place and the inspector was informed that this was an error in the personal plan.

The residents had access to a General Practitioner and a range of allied health

professionals as appropriate. The inspector found some health care plans did not appropriately guide staff to ensure that residents were supported to experience their best possible health. In addition, the inspector found that a health care plan was not in place for a identified health care need. This issue is referred to above under Regulation 5: Individual Assessment and Personal Plans.

There were positive behavioural supports in place for residents where required. Behaviour support plans were up-to-date and guided the staff team in supporting residents manage their behaviour. The person in charge maintained a restrictive practice log and all restrictive practices in place were subject to regular review. However, some restrictions were not reviewed in line with a review timescale, as set by the provider, to ensure the practice is the least restrictive procedure used.

There were systems in place to safeguard residents. Staff spoken with demonstrated they had the knowledge of what to do in the event of an adverse incident or allegation occurring in the centre and the appropriate reporting procedures. The inspector observed residents appearing comfortable and relaxed in the presence of staff and positive interactions were observed between staff and residents. The inspector reviewed a sample of incidents which demonstrated they were reviewed and appropriately responded to.

There were systems in place for the assessment, management and review of risks in the designated centre. The centre maintained a risk register which detailed centre specific risks including staffing, medication and lone working. In addition, there were individual risk assessments in place which included the controls in place to reduce risks associated with mobility, falls, feeding, eating and drinking.

In relation to fire safety management arrangements, the centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal Emergency Evacuation Plan (PEEP) in place which guided staff to support residents to evacuate the designated centre. Centre records demonstrated the fire drills were carried out regularly. However, improvement was required in the review of fire safety precautions as the last night time fire drill was carried out in June 2018. This was not in line with the provider's fire safety risk assessment which outlined that an night time fire drill would be completed annually.

There were suitable practices in place in relation to the ordering, administration and disposal of medicines. The inspector reviewed medication error forms and found that medication errors were reviewed and responded to appropriately. While, medication was stored in a locked press, the inspector found practices in place regarding the storage of medicines required review. For example, medication which was out of date and due for disposal was being stored with other medications and opening dates were not on medications where appropriate.

Regulation 17: Premises

The centre was homely, well maintained and decorated in line with residents preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and review of risks in the designated centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were arrangements in place for fire safety management. Centre records demonstrated the fire drills were carried out regularly. However, improvement was required in the review of fire safety precautions.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place in relation to the ordering, administration and disposal of medicines. While, medication was stored in a locked press, the inspector found practices in place regarding the storage and disposal of medicines required review.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need completed for each resident. However, some personal plans in place were not reviewed in a timely manner and some personal plans did not accurately guide the staff team. Not all identified healthcare needs had plans in place.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a General Practitioner and a range of allied health professionals as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behavioural supports in place for residents where required. All restrictive practices in place were subject to regular review. However, some restrictions were not reviewed in line with the timescale as set by the provider to ensure the practice is the least restrictive procedure used.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. The inspector observed residents appearing comfortable and relaxed in the presence of staff and positive interactions were observed between staff and residents over the course of the inspection. Staff spoken to demonstrated knowledge of what to do in the event of an allegation or concern.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sugarloaf Lodge OSV-0005045

Inspection ID: MON-0021544

Date of inspection: 18/07/2019

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: • The service has now appointed three new full time Care Workers and one full time Team Leader. • Currently there is one vacant 39 hour care worker post, which is presently being covered by regular relief and agency staff who are known to the residents. This post has been advertised, interviews will take place by 30/09/2019. • The Business Case has been submitted to HSE for the additional funding for Care Worker staff support of 0.6 WTE. • It is hoped that the implementation of phase 1 of pay restoration will help to contribute to improved Staff Retention and recruitment, this will be implemented by 30/09/2019.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training records have been updated to reflect staff training including mandatory training. This was completed by 02/09/2019.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC has raised this feedback with the Quality and Governance Directorate on 05/09/2019. Feedback will be addressed as part of upcoming review of the organisation's Annual Review process.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Night Fire Drill was conducted on the 22/07/2019 with all residents present. Dates have been allocated in the diary for all the fire drills due to take place in 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:
• A review of practices took place and all out of date medications have been disposed of and all medications are labelled with opening date as required. This was completed by 19/07/2019.

• Internal Mediation Audit conducted by the PIC on 29/08/19.

• Team Leaders conduct weekly checks of all medication procedures within the center (Medication Recording Sheet, Medication Count, Cross Checks of Medication administered, Renewal of Prescriptions, Medication Box, Expiry Dates, Mediation Dispose box). This commenced on 25/07/2019.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Personal plans identified have been updated to reflect continuity and clarity of information. This was completed by 31/07/2019.

• Healthcare Needs of each resident are identified within Individualized Medication Management Plans with detailed information on various aspects of their conditions and supports required. This was by completed by 31/07/2019.

• Healthcare needs plans have been incorporated into Individualized Medication Management Plans. Comprehensive guidelines on care delivery for each diagnosis/syndromes that residents present themselves with are also included in Individualized Medication Management Plans. This was by completed by 31/07/2019.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• A restrictive practice review meeting took place on 01/08/19 in order to ensure all restrictive practices were subject to regular review.

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/09/2019
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.	Substantially Compliant	Yellow	02/09/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred	Substantially Compliant	Yellow	05/09/2019

	to in subparagraph (d) shall provide for consultation with residents and their representatives.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	22/07/2019
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.	Substantially Compliant	Yellow	29/08/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which	Not Compliant	Orange	31/07/2019

	reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/07/2019
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	01/08/2019