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:	Orchid Lane
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	20 March 2019
Centre ID:	OSV-0005052
Fieldwork ID:	MON-0024057

About the designated centre

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

Orchid Lane is a designated centre for people with intellectual disabilities and is operated by Sunbeam House Services Company Limited by Guarantee. The centre is located in a town in County Wicklow. The centre comprises of four single occupancy apartments within a residential complex that also consists of self-directed living apartments and day services. The designated centre currently provides designated centre supports for three adults with intellectual disabilities. The provider has applied to change the footprint of this designated centre by incorporating another apartment into the designated centre which will increase the capacity of the centre to four. The centre is managed by a full time person in charge, they report to a senior services manager who has operational oversight of a number of designated centres and other support services within Sunbeam House Services.

The following information outlines some additional data on this centre.

Current registration end date:	13/05/2021
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
20 March 2019	10:00hrs to 17:40hrs	Ann-Marie O'Neill	Lead
20 March 2019	10:00hrs to 17:40hrs	Eoin O'Byrne	Support

Views of people who use the service

Inspectors met and spoke with residents present in the centre on the day of inspection. One resident spoken with, and identified to transition into the centre, told an inspector they were happy with the transition planning in place and were looking forward to moving into their new apartment. They also expressed satisfaction with the refurbishment of the apartment and arrangements made to make accommodations to toilet and bathing facilities to meet their assessed mobility needs.

Another resident spoken with however, was not satisfied with aspects of the the service they received and had recently reported a safeguarding incident to the person in charge. They also expressed disappointment at the loss of their employment and were dissatisfied with the progress being made to help them secure new employment

Capacity and capability

Previous inspections of this designated centre had found an absence of governance and management oversight arrangements. Equally, residents' needs were not being met to an acceptable standard resulting in a poor quality of service provision to residents with safeguarding risks a feature in this designated centre. A notice of proposal to refuse and cancel registration of this designated centre was issued to the provider by the Office of the Chief Inspector in November 2017.

The provider submitted a representation to the Office of the Chief Inspector in response to the Notice of Proposal. As part of their representation the provider submitted an organisational governance and management improvement plan. The Office of the Chief inspector thereafter, applied a restrictive condition to the registration of this designated centre enforcing the provider to adhere to the plan. This was to ensure appropriate governance, management and oversight arrangements for the designated centre in order to improve the quality of service provision to residents and compliance with the regulations and standards.

As part of the governance and management improvement planning for the centre, the provider instated a full-time person in charge in 2018. The findings from this inspection noted this governance arrangement had been maintained and had brought about improved compliance and governance oversight of the designated centre.

Further governance oversight enhancements included meetings between the senior services manager and person in charge in Orchid Lane on a two monthly basis. It was found on this inspection that these meetings had occurred. Specific key quality indicators were reviewed during the meeting with actions identified following each meeting and persons accountable identified.

Further improvements noted was the establishment of a core staff team and a reduced reliance on agency workers which was previously a non compliance. Inspectors reviewed Garda vetting arrangements and noted all staff working in the centre, including management staff, had received up-to-date vetting.

The provider had also re-assessed the needs of residents living in the centre. Following the assessment of need, the provider identified some residents required different service provision and as a result had supported those residents to transition to self-directed living services to meet their assessed needs. In other instances, the provider had supported residents to change service provider in order to better meet their assessed needs. This had resulted in a reduced capacity size of the designated centre, with remaining residents assessed as requiring designated centre support needs.

Overall, the enhanced centre specific governance and management oversight, updated assessment of needs for residents and subsequent reconfiguration of the service provided, had brought about improved compliance with the regulations and quality of service provision for residents living in the designated centre.

The provider had effective arrangements in place to carry out a six-monthly provider led audit and provider led annual report as required by the regulations. These audits were of a good standard and identified an action plan, person responsible and time-line following each audit. While an annual report for 2018 had been completed, consultation and feedback from residents and families was not documented or demonstrated in the report, which is a regulatory requirement.

With regards to ongoing centre specific auditing of the quality of service provision, improvements were required to enhance medication management audits to ensure a root cause analysis was conducted following a medication error to establish the cause of the error and provide information on how to improve medication administration systems.

The provider was also required to review governance arrangements in place for periods of time when the the person in charge was not present in the centre, to ensure the quality of service provision was sustained and consistent in their absence. While the provider had implemented an on-call system for staff to utilise in the absence of the person in charge, it was not demonstrated that this was an effective system for ensuring safeguarding incidents were addressed or reported in a timely way.

The provider was required to further revise the statement of purpose to more accurately describe the configuration of the designated centre and provide a clearer description of the operational oversight responsibilities of the person in charge and persons participating in management of the centre. The designated centre was located within a residential complex which also included self-directed living services and day services

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to increase the footprint of the designated centre by incorporating an already existing apartment into the current configuration of the designated centre. The registration application had been received in full. Outstanding prescribed information was submitted within a short time frame following the registration application.

Judgment: Compliant

Registration Regulation 7: Changes to information supplied for registration purposes

Following submission of the registration application the provider notified the Office of the Chief Inspector regarding changes to persons participating in management of the designated centre. Required prescribed information, to accompany the notification, was submitted within the required time frame in order to make changes to the registration application.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a person in charge that met the requirements of regulation 14. The person in charge had recently returned from long term pre-planned leave at the time of inspection. They presented as a fit and competent person to manage the designated centre. They were found to be knowledgeable of their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The provider had improved staffing arrangements in this designated centre since previous inspections which had found the workforce had been heavily reliant on agency workers.

A planned and actual roster was in place and staffing resources identified on the roster were in line with the staffing whole-time-equivalent numbers as set out in the statement of purpose for the centre.

All staff working in the designated centre had received up-to-date Garda Vetting.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured up-to-date insurance arrangements were in place for the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

Overall, it was demonstrated the provider had strengthened the governance and management systems within the designated centre which in turn was providing residents with improved service provision. Risk management, localised operational management systems and auditing had been enhanced since previous inspections. Some improvements were still required.

Some improvements with regards to medication management audits were required to ensure they included a root cause analysis for medication errors if and when they occurred.

The provider was also required to review supervision arrangements for staff during times when the person in charge was not present in the designated centre.

Some improvement was required to ensure the provider's annual report for the designated centre included consultation and feedback from residents and families.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider was required to make some revisions to the statement of purpose to clearly and accurately describe the configuration of the designated centre and provide a clearer description of the operational oversight responsibilities of the person in charge. This was required as the designated centre was located within a residential complex which also included self-directed living services and day services.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From a sample of incidents reviewed, required notifications had been received.

Judgment: Compliant

Quality and safety

The provider had improved the quality of service provision for residents living in Orchid Lane designated centre. Enhanced operational management oversight of the centre and the instating of a core staff team had brought about these improvements. Transition planning and arrangements to meet residents' assessed mobility needs had been considered as part of this transition process. Risk management arrangements had also improved with evidence of improved risk oversight within the centre.

However, improvements were required in relation to safeguarding reporting procedures within the centre to ensure where such incidents occurred they were reported in a timely way by both staff and residents where applicable. While it was evident improved positive behaviour support planning was in place, it was not evident that they had been developed by an appropriately qualified allied health professional in positive behaviour support. Some residents expressed dissatisfaction with the support they were receiving in seeking new employment.

Inspectors viewed the apartment the provider proposed to incorporate as part of the footprint of this designated centre. It was noted that the provider had made appropriate arrangements to upgrade the toilet and bathing facilities of the apartment to meet the assessed needs of the resident identified to transition there.

An inspector spoke with the resident and discussed their transition planning process. They said they were happy with the way the transition was being managed and felt involved in the process. They also said they were looking forward to moving into the apartment and liked the refurbishment works that had been carried out. Transition planning documentation was also reviewed and it was evidenced that the resident had been involved in all steps of the process. The resident had also been supported to visit the apartment on a number of occasions to see the refurbishment progress as part of the transition planning process.

Positive behaviour support plans were in place for residents where required. These plans were up-to-date and provided information and guidance to staff in a manner which promoted proactive management and de-escalation techniques. Some further improvement was required however. While these required plans were in place, they had not been developed in conjunction or with the oversight of an appropriately qualified allied health professional. This was required to ensure the plans in place where evidence based to ensure they could effectively support residents in line with

their assessed and presenting needs.

A system for review of restrictive practices was in place. The provider had created a centre specific restraint register which detailed the restrictive practices in place in the centre, a rationale for their use and control measures in place to ensure they were the least restrictive option. It was noted since the previous inspection some restrictions had been reduced and efforts were being made to further reduce other restrictions. While this progress was noted as a positive quality initiative, a corresponding restraint reduction plan was not in place to guide staff in how to implement this process and provide for review of progress being made.

The provider had created a risk management policy as per their regulatory requirement under regulation 26. There was evidence of it's implementation within the centre. The person in charge maintained a risk register and risk assessments were up-to-date. Identified risks were assessed using a risk analysis framework and corresponding control measures were documented to mitigate and manage those risks identified. This was evidence of improved risk management oversight within the designated centre and implementation of the provider's overall risk management systems.

While the provider had appropriate safeguarding policies and procedures in place it was noted there had been a delay in the reporting of safeguarding incidents which in turn had caused a delay in the implementation of safeguarding procedures, investigations and arrangements to support residents when they occurred. Similarly, it was evidenced that residents required further supports and knowledge in relation to self protection and reporting of safeguarding concerns. A resident spoken with informed inspectors they had experienced an alleged safeguarding incident but had waited a number of days to report the incident so they could inform the person in charge when they were back on duty in the designated centre. It was noted however, that the person in charge and persons participating in management took appropriate action when the incident was reported to them and had implemented safeguarding procedures on receipt of the information.

Some residents spoken with expressed their dissatisfaction with the progress being made with helping them to secure new employment after losing their job months previous.

Regulation 13: General welfare and development

During the course of the inspection a resident expressed dissatisfaction with the support they were receiving in securing new employment.

Judgment: Substantially compliant

Regulation 17: Premises

Inspectors reviewed this regulation in terms of the new apartment which was to be incorporated into the registration of the centre only.

It was noted the provider had redecorated the apartment and had provided for an upgrade to the bathroom and toilet facilities in line with the assessed needs of the resident intending to move into it. Inspectors met with the resident identified to move into the apartment and they expressed satisfaction with the measures being implemented.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Inspectors reviewed transition planning arrangements for a resident identified to transition into the designated centre. Transition meetings had occurred and it was evidenced the resident had been involved in all aspects of the transition planning arrangements. Inspectors met with the resident identified to transition and they said they were happy with the proposed move and how they had been supported during the process.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors reviewed if regulatory non compliances from previous inspections relating to risk management had been addressed. It was found, on this inspection, that improved risk oversight and assessment by the provider was in progress. A comprehensive risk register was in place which provided an overview of all presenting risks in the centre.

Informative and detailed control measures were also identified for each risk and appropriate risk ratings also applied. A risk management policy was in place and there was evidence of it's implementation within the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

A restraint register was in place which outlined all current presenting restrictive practices in the centre. It was also evidenced that attempts had been made to

reduce some restrictions for residents. However, a corresponding restraint reduction plan was not in place which would guide staff in how to implement this process and provide for review of progress being made.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had ensured safeguarding procedures in line with the National Safeguarding Vulnerable Adults policy was in place. However, improvements were required. It was noted that there had been a delay in the implementation of safeguarding procedures due to safeguarding incidents not reported in a timely way.

Following conversations with some residents and review of a recent safeguarding incident that had occurred, the provider and person in charge were required to make improved provisions for supporting and informing residents of safeguarding reporting procedures and self protection measures in line with regulation 8 (1).

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

With regards to support planning for the management of behaviours that challenge, some improvement was required to enhance the quality of these plans. It was not evidenced that these plans had been developed through a multi-disciplinary allied health professional framework.

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
Views of people who use the service	
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant

Compliance Plan for Orchid Lane OSV-0005052

Inspection ID: MON-0024057

Date of inspection: 20/03/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC has created a new local medication audit form; this is now in place in Orchid Lane and it includes the root cause analysis of the medication errors. This audit is completed on a twice monthly basis by a staff member and PIC. Outstanding actions are communicated to the team by the PIC either at the team meeting or in person. The PIC will investigate cause of error and will communicate remedial action to be implemented by staff with specific timelines for completion.

- A Local on call procedure is in place for when staff is on site when a manager is not on site. The PIC on shift, is identified on the roster. Staff report issues of concern on CID and the senior manager also has oversight of all issues of concern when a PIC is on leave.

-Consultation and feedback from families and residents will be included in the internal report. This has been noted in terms of organizational learning.

The PIC currently conducts twice monthly residents' meetings. 'How to make a complaint' will be on the agenda monthly. The importance of understanding how to make a complaint and communicating this to any staff member on duty will be discussed. They will be informed they can contact the on-call manager by phone call, text message or email if that is their preference.</td></tr>
<tr><td>Regulation 3: Statement of purpose</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose is now reviewed and updated a copy has been sent to the authority on 18th/4/19</td></tr>
</table>

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Following a local investigation and recent case review for one resident, a meeting is scheduled for the 29th of April 2019 with the resident, PIC, and supported employment specialist to further discuss their employment preference and outline supports required to achieve their goal, The SSM will oversee this process. A plan will be developed following the meeting with specific timeframes and actions. The organization is in the process on fully re developing how SHS, provide supported employment to our service users.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The pic will continue to review the rights restrictions that are currently in place. Where possible, a restraint reduction plan will be created with plans in place to gradually reduce the restriction to give clear guidance to staff. This effectiveness of the plan will be monitored on a monthly basis.

All positive behavioral support plans will be reviewed by an external clinical psychologist on the 14/5/19.

Staff have been provided with PBS training prior to the March 20th inspection and this will continue on a yearly basis.

The provider is currently recruiting a clinical psychologist to work directly for the organization and enhance the organization’s Multi-Disciplinary approach.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
- The PIC met with the residents on the 2nd of April 2019 and will continue to meet with the residents every two weeks to enhance their understanding so that they are aware of the safeguarding procedure and how to report allegations. There is evidence since April 2nd meeting that this action has been effective.
- The PIC also discussed the safeguarding procedure on April 2nd and how to report complaints and allegations to the staff team and that they can inform the PIC and Senior Services Manager.
- A poster is currently displayed in the resident’s apartments indicating the CSM and SSM’s email and contact number if they are unhappy and want to report to a manager instead of a staff member.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
- Team meetings will have an increased focus on support planning by connecting the rights restrictions and risk register,
- The PIC has designed a new key-working recording template and key-working session which covers this area of support.
- The PIC has oversight of personal outcomes measures processes within the center.
- The PIC will utilize circles of support and encourage families, and those people who are important in the residents lives to be involved in personal outcomes meetings in line with the residents will and preference.
With regard to Positive Behavioral Support, an external Clinical Psychologist has been contracted to the organization and will review the Positive Behavioral Support Plan's on the 14th May 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 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	29/04/2019
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	24/04/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their	Substantially Compliant	Yellow	24/04/2019

	representatives.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	24/04/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	24/04/2019
Regulation 05(6)(a)	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 be multidisciplinary.	Substantially Compliant	Yellow	14/05/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Substantially Compliant	Yellow	24/04/2019

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	24/04/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	24/04/2019