Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Centre B1
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	21 January 2020
Centre ID:	OSV-0005389
Fieldwork ID:	MON-0024029

About the designated centre

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

Centre B1 is a designated centre based on a campus setting in West County Dublin. It consists of four units and an additional unit which is divided into two separate individual apartments. The centre supports up to 16 persons with intellectual disability with an aging profile through the 24 hour residential services it provides. The staff team comprises of staff nurses, care assistants, house hold staff, a clinical nurse manager and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Tuesday 21 January 2020	09:45hrs to 17:30hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

The inspector met and spent time with a number of residents throughout the course of the inspection. Overall, residents communicated their satisfaction with the service they were in receipt of, however, in the case of one resident there was some dissatisfaction with the level of supports they were receiving. Residents were complimentary of the staff team supporting them and a number of individuals spoke about recent changes which resulted in the introduction of cooking and baking within their homes. The inspector observed that staff members treated residents with kindness and provided care and support in a timely and sensitive manner.

Capacity and capability

This inspection was carried out as the second in a series of inspections to be completed in Peamount Healthcare as part of an escalated regulatory programme in response to failures by the registered provider to comply with the Regulations across a number of campus based centres for persons with disabilities.

Overall, there were mixed findings across the Regulations inspected against during this inspection. While there was clear evidence to demonstrate that the registered provider's quality improvement plan was being implemented in practice and was resulting in a better quality of life for residents, this remained at an early stage of implementation and there was a continued need for improvement across a number of key areas. The inspector was assured that the registered provider was committed to implementing the required improvements and sustaining the recent positive improvements.

The inspector reviewed the centre's staffing arrangements and found that there were discrepancies in the allocated staffing complement as outlined in the centre's statement of purpose when compared with actual staff rosters. For example, the centre's statement of purpose (version 11, dated December 2019) was found to state a full-time equivalent of 30.50 staff was in place, however, a review of staff duty rosters across a three week period between January and February 2020 found that the total full-time equivalents of staff members did not match this and during one week was only 25.38. This indicated that at that time, the registered provider had a shortfall of over 111 hours across a seven day period. The inspector also found that there was a reliance on relief staff members to supplement the centre's staff duty roster which resulted in a discontinuity of care and support for residents. For example, over a three week period reviewed by the inspector it was found that 20 different staff members worked a total of 51 shifts. This practice seemed to be at odds with the needs of residents whom required in some instances continuity of care and support from familiar staff particularly in the areas of positive

behaviour supports. A review of a random selection of staff files found that all required information outlined as required by Schedule 2 of the Regulations was in place and available.

Staff training records were reviewed by the inspector. All mandatory training programmes which were outlined to the inspector by the registered provider representative were found to be completed by all staff members. In addition, the inspector found that there had been additional training programmes provided across a number of areas including bespoke communication, person-centredness, dysphagia and speech and language therapy workshops. The inspector found that the staff team were appropriately supervised by the person in charge in both a formal and informal context. The person in charge worked along side staff members on a regular basis and completed formal one-to-one supervision meetings with all staff members at least once every six-months.

The inspector reviewed the arrangements in place for the governance and management of the centre. A new person in charge had recently been appointed and the inspector found that they were knowledgeable of the relevant legislation, Regulations and national policy. There were recent changes to the organisation's board also which had strengthened the oversight arrangements. While the inspector found that there were overall improvements in the governance and management of the centre, there remained a clear need for the continued development and implementation of effective management systems. There was evidence to demonstrate that the improved governance and management of the centre had positive outcomes in terms of the quality of care and support being delivered to residents.

A review of complaints management was completed by the inspector and it was found that the registered provider had established and implemented a system for the management of complaints. There was a complaints policy in place (dated April 2017) and this was available to staff members. The inspector found, however, that some complaints raised by residents had not been logged and as a result there was an absence of evidence of actions taken to resolve their concerns.

Regulation 15: Staffing

The inspector found that the staffing resources allocated to the centre across a three week period did not align to the staffing compliment which was outlined in the statement of purpose. On three consecutive weeks, the inspector found that the centre was under resourced by up to 111 hours per week. In addition, due to the considerable reliance on relief staff in the centre, the inspector found that there was a discontinuity of care and support for residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training needs of staff members were found to have been met though the provision of a comprehensive suite of mandatory and supplementary training courses. In addition, there were appropriate arrangements in place for the support and supervision of staff members.

Judgment: Compliant

Regulation 23: Governance and management

There was evidence to demonstrate that the improved governance and management of the centre had positive outcomes in terms of the quality of care and support being delivered to residents, however, there remained a clear need for the development and implementation of effective management systems in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Some concerns raised by residents were found not to have been recorded by the registered and as a result there was an absence of evidence to demonstrate the follow-up actions taken to address these matters.

Judgment: Substantially compliant

Quality and safety

The inspector found that improvements had been made in the supports being provided to residents relating to their general welfare and development. Residents were found to be engaging in a wider variety of activities and opportunities as a result of the increased focus on their social care needs by staff members. However, the inspector found that the vast majority of these activities remained centre and campus based. In addition, many of the 'meaningful activities' recorded in resident files were found not to be meaningful in nature. These included activities such as 'chatting with staff', 'watching TV', 'leisure time at home' and 'DVD movies'. Despite this, the inspector found that there was clear evidence of a coordinated effort to provide the services of the centre in a more person-centred manner and both the

person in charge and senior management team had a clear vision on progressing this further in the future.

The inspector completed a full walk through of the premises of the centre in the company of the person in charge. All areas were found to be clean, well maintained throughout and spacious. The registered provider was in the process of installing laundry facilities in each of the individual units of the centre to facilitate residents to be supported to launder their clothing. All residents were found to have their own individual bedrooms and there were sufficient bathroom and showering and toilet facilities to meet their needs.

A review was completed of the arrangements in place for the preparation of meals. In the time since the last inspection, the registered provider had facilitated the cooking of some meals in the individual units of the centre and partially moved away from the use of centralised kitchens. The inspector spoke with residents and staff about this who communicated that it was a "...much loved improvement". The inspector spoke with a speech and language therapist who was supporting the staff team with this matter and provided an example of a person-centred approach to this new development in the centre. They outlined how a resident was supported by the staff team to use natural thickening agents to facilitate a resident to occasionally have a glass of beer which they had been previously restricted from drinking due to their swallowing. A number of other similar examples of positive outcomes for residents were shared with the inspector.

The arrangements for protecting against fire in the centre were reviewed by the inspector. It was found that there were regular fire drills completed which demonstrated that the residents and staff members could evacuate the centre with ease. There was a fire alarm and detection system in place which had been serviced and maintained on a regular basis. There was emergency lighting fitted to illuminate all exit routes. Two emergency exit routes were found to be locked and there was an absence of keys which were within easy access to open these doors. Personal emergency evacuation plans were in place for each resident, however, the inspector found that these did not provide clear guidance on the supports required by some residents in the event of a fire or similar emergency. While there were fire doors fitted throughout the centre, there was an absence of self-closing devices to ensure the containment of fire.

The inspector reviewed the arrangements in place in the centre to support residents with their behaviours of distress. The majority of residents with identified needs in this area had up-to-date positive behaviour support plans. In addition, stress reduction programmes had commenced in the cases of some residents and mapping exercises had been completed to identify causes of anxiety, signs of stress, effective coping strategies, and how staff members can provide assistance. While there was evidence of significant development in this area, the inspector found that there remained a need for further improvement. For example, a number of personal emergency evacuation plans made reference to residents' positive behaviour support plans and guidance on how to support individuals who may refuse to evacuate the centre in the event of a fire. However, when checked the positive behavioural

support plans did not contain any information on this matter.

The arrangements for protecting residents from experiencing abuse were reviewed by the inspector. While in the time since the last inspection there had been a significant number of incidents of a safeguarding nature, the inspector found that registered provider had responded to these in line with procedures outlined in national policy. There were, however, improvements to be made to safeguarding plans which were put in place in response to these incidents - particularly in relation to assessing the effectiveness of these plans. In addition, the inspector found that there was a general absence of assessment of compatibility of residents who were sharing services. The inspector identified this as one reason for the recurring nature of these incidents.

The inspector reviewed how the rights of residents were protected in the centre and found that the registered provider had recently established an equality and human rights committee and was due to meet for the first time on the day after the inspection. The inspector was informed that one of the roles of this committee was to place a focus on upholding the rights of residents. In addition, the inspector found that residents were supported through internal self-advocacy groups and external independent advocacy supports.

Regulation 13: General welfare and development

While the inspector found that there had been improvements in the supports being provided for residents relating to their general welfare and development, there remained a focus on providing activities for residents within the centre and on the campus.

Judgment: Substantially compliant

Regulation 17: Premises

The premises of the centre were found to be very clean, spacious and well maintained throughout.

Judgment: Compliant

Regulation 18: Food and nutrition

The inspector found that residents were supported to eat a varied and nutritious diet

and were communicated with about their meals and preferences.

Judgment: Compliant

Regulation 28: Fire precautions

Two emergency exit doors were found to have been locked and the keys for these were not easily accessible at the time of the inspection. Personal emergency evacuation plans did not provide clear guidance on the supports required by some residents in the event of a fire or similar emergency. While there were fire doors in place, the inspector found that appropriate fire containment measures were not in place due to the absence of self-closing devices.

Judgment: Not compliant

Regulation 7: Positive behavioural support

While the inspector found that there had been improvements in the supports being provided to residents relating to their positive behavioural support needs, further improvements were required in the supporting documentation to ensure that all resident associated risks were appropriately managed.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that there was a need for an improved oversight of the safeguarding and protection of residents in the centre particularly in the area of the effectiveness of safeguarding plans which were in use and in the assessment of compatibility of residents who were sharing accommodation.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that there was an increased focus on the personal rights of residents in the centre and an overall cultural awareness for the need to deliver

services through a human rights based approach.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Centre B1 OSV-0005389

Inspection ID: MON-0024029

Date of inspection: 21/01/2020

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The ADON and PIC have reviewed the rosters and are currently recruiting to fill the vacancies in the Centre. This will reduce the reliance on relief staff in this Centre. The relief panel is being reviewed to ensure that there is consistency in the staff that are assigned to the Centre. The PIC will continue to ensure that where relief is required that induction and monitoring is in place.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The person in charge in the center will have oversight of complaints management as part of the governance arrangements in the Centre. 1) A register for complaints will be maintained and complaints that are not resolved at a local level will be escalated to the Complaints officer for review in line with policy. 2) All learnings will be implemented and shared at the team meetings with staff.	
Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • The PIC has commenced the registering of complaints from residents in the format of a complaints log which is kept in the Centre. • All follow up and actions from these complaints is followed up by the PIC in the center. • Any learning or outcomes from these will be communicated by the PIC to staff through their staff meetings or supervision.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: • The Residents' Interests Checklists will be reviewed and community based activities will be explored with the residents according to their personal wishes and preferences. • Education for staff on how to record social engagement with residents in their personal plans • Peamount will organize regular community-based activities for residents with the support of the key worker which is in line with their personal plan	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Peamount will install self-closing mechanisms on fire doors in the Bungalows. Peamount has applied HSE for funding for this project. • Emergency exit doors now have keys located on wall beside door so that they are easily accessible. • All PEEPs have been reviewed to ensure that all necessary supports are included in their evacuation plan.	
Regulation 7: Positive behavioural	Substantially Compliant

support	
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • All Behavioural Support plans will be reviewed to ensure that they contain guidance for staff where a resident may refuse to evacuate from the center during a fire.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • The safeguarding team and PIC will review the 4 safeguarding plans in the center in relation to their effectiveness and will implement any further safeguarding measures if required. • The PIC will undertake an impact assessment and resident survey in regards to the compatibility of the residents sharing accommodation in the Centre. • The PIC and safeguarding team will review any outcomes from this assessment.	

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(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	30/04/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/04/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with	Substantially Compliant	Yellow	30/04/2020

	their wishes.			
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.	Not Compliant	Orange	30/04/2020
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/04/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/04/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is	Substantially Compliant	Yellow	24/02/2020

	safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/12/2020
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	24/02/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	24/02/2020
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	28/02/2020
Regulation 08(2)	The registered provider shall protect residents	Not Compliant	Orange	31/03/2020

	from all forms of abuse.			
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	28/02/2020