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:	47/48 Towerview
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Short Notice Announced
Date of inspection:	09 July 2020
Centre ID:	OSV-0005397
Fieldwork ID:	MON-0023604

About the designated centre

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

Towerview offers full time residential care for up to nine female residents with an intellectual disability. The residents are supported on a twenty-four hour basis by a team consisting of staff nurses and care assistants. The centre comprises of two adjoined two-storey semi-detached houses and an attached one-storey, two bedroom apartment. Both houses have 3 bedrooms, one kitchen/dining room, one sitting room and one small office and bathroom. The apartment contains two bedrooms, one sitting room/kitchen, one utility room and one bathroom. The houses are situated in a quiet residential centre in close proximity to the local town. Residents have access to local restaurants, cafes and shopping centres.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Thursday 9 July 2020	10:15hrs to 16:30hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspector was greeted by the person in charge on arrival to the centre. The person in charge showed the inspector the improvements to the premises that had been completed in response to the February 2019 inspection. Works had been completed to the exterior and interior of both houses that made up the designated centre.

The inspector met with six residents at different stages of the inspection process. Two of the residents came to speak with the inspector independently at separate times. The inspector met with the other four residents in their garden.

Some of the residents spoke of issues they were having with fellow peers and there was evidence of incidents where residents had impacted negatively upon one another. Another resident spoke of their wishes to move out of the centre and the inspector reviewed minutes of meetings where this process was being discussed and progressed.

Residents showed the inspector some of the projects they had been engaging in during the COVID-19 healthcare crisis including gardening and art projects. Another resident spoke of an individual project they were engaging in. The residents were very proud of the works they had completed and they appeared at ease in their interactions with the staff team supporting them.

There was evidence of residents being supported to engage in activities of their choosing and that those supporting the residents were promoting and respecting their individual rights. However, the provider had failed to fully address all of the actions agreed following the previous inspection in February 2019.

Capacity and capability

Overall, residents were receiving good quality service, however; improvements were required to the ensure the monitoring of centre and the completion of tasks following audits was effective. There were also improvements required in relation to ensuring that all notifiable events were being submitted to the Chief Inspector as per the regulations.

The provider had ensured that the centre was appropriately resourced and that there was a clearly defined management structure in the centre. There was a schedule of audits being completed by the person in charge, but improvements were required in regard to the documentation, effective monitoring and follow up on completion of actions. There was evidence of actions arising following audits, but

the completion or progress of the actions was inconsistent and was impacting the provider's ability to ensure effective delivery of care to all residents.This was identified as an area for improvement in the last inspection, therefore the provider had failed to address the issue effectively.

The provider had ensured that an annual review of the quality and safety of care and support provided to residents had been carried out for 2019 and that a written report had been developed. The report identified actions to be completed. Following a review of the action plan, the inspector requested the person in charge to outline what actions had been completed and which were still in progress as this was not evident. The person in charge provided evidence that a number of actions had been completed and that the outstanding goals were being progressed but there were improvements required in regards to the systems in place to monitor the progress of actions and this was discussed with the person in charge on the day of inspection.

There were systems in place to respond to adverse incidents. The inspector reviewed minutes of meetings where senior management and the person in charge had reviewed adverse incidents that had occurred in the centre. Learning from theses reviews was then shared with those supporting the residents. For the most part, the person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. However, it was found that there were some improvements required to the systems in place and the person in charge was requested to submit a retrospective notification.

There was a staff team in place that was appropriate to the number and assessed needs of the residents. The staff team was made up of staff nurses and care assistants. A review of the planned and actual rosters highlighted that residents were receiving continuity of care as there was a consistent staff team supporting them. There were staffing vacancies but consistent agency staff members were being utilised to cover the vacancies. The review of the roster also displayed that the provider and person in charge had progressed actions from the centres annual review and had recruited further nursing staff.

Residents were aware of the provider's complaints procedure and there was evidence of residents and their representatives raising issues with the provider and the person in charge. Complainants were assisted to understand the complaints procedure and there was evidence of complaints being addressed.

Overall, there were improvements required to the centres management systems to ensure that the service being provided was effectively monitored and that actions arising from audits and compliance plans were being completed in full.

Regulation 15: Staffing

The provider had ensured that the number, qualifications and skill-mix of staff was appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to fully address all of the actions identified from the previous inspection in February 2019.

There were improvements required to ensure that the management systems in place led to the consistent and effective monitoring of the centres and residents information.

Judgment: Not compliant

Regulation 31: Notification of incidents

For the most part, the person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. However, it was found that there were some improvements required to the systems in place and the person in charge was requested to submit a retrospective notification.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had ensured that there was an effective complaints procedure in place and that it was presented in a manner that was accessible to residents.

Judgment: Compliant

Quality and safety

Residents were receiving a good quality service, there were, however, some areas that required improvement including the management of safeguarding concerns as per the provider's own policies and procedures. There were further improvements required to the systems in place to reduce negative impacts some residents were having upon one another. There were also developments required to ensure that all

residents' personal goals were reviewed and that their progress towards these was monitored effectively.

The person in charge had ensured that assessments of residents' health and social care needs had been carried out. The inspector reviewed a sample of the residents' personal plans and found them to be detailed. Audits were being carried out by the person in charge but the completion of actions identified following the audits was inconsistent with some actions not being completed.

The previous inspection report identified that there were improvements required to the monitoring of residents' individual goals, in regards to their progress and achievement. There was evidence of improvements being made in regards to the development of goals, however, there were again inconsistencies in the monitoring and progress of the goals. Individualised goals had been set for resident's pre the introduction of COVID-19, travel restrictions some residents had been supported to develop alternative goals whereas other residents goals had not been revisited or adapted in recent months.

A review of a sample of residents' nursing notes and care plans identified that the staff team and person in charge were seeking to provide a person-centered approach to each resident. There was also evidence of those supporting residents adapting to the changing needs of some residents and that the person in charge was accessing the provider's multi-disciplinary team to seek support.

Residents were being assisted to develop the knowledge, self-awareness, understanding, and skills needed for self-care and protection. Safeguarding measures were discussed at each resident meeting and residents were given information regarding the providers safeguarding mechanisms.Residents had been kept informed of the impact of the COVID-19 healthcare crisis and the steps they could take to protect themselves. Some residents had raised issues with the restrictions and the staff team supporting them had discussed the impact of the restrictions and the reason for their implementation with the residents.

For the most part safeguarding concerns were being addressed appropriately. However; a review of the management of safeguarding concerns in the centre showed that the provider and person in charge had, on one occasion failed, to adhere to their own safeguarding policy when responding to any concerns or allegations of abuse. While there was evidence that the person in charge had immediately ensured the safety of all residents following receiving notice of an allegation, the safeguarding processes was not managed in accordance with the provider's own policies and procedures and within the identified time line. Following the inspection, the person in charge ensured that the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures were being adhered to.

A review of the centre's adverse incident log demonstrated that there were a number of occasions where some residents' behaviours had impacted negatively upon one another through verbal aggression or threatening behaviors. Safeguarding plans had been developed in response to these incidents and the Chief Inspector had been notified of the incidents as per the regulations. These incidents were short

in duration and were under review but continued to occur. The person in charge discussed proposed plans to reduce the negative impact of some residents upon one another but these plans had yet to be finalised and the incidents continued to occur.

The provider had arrangements in place to identify, record, and investigate, adverse incidents. The inspector reviewed individualised risk assessments and found them to be detailed. The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority. The COVID-19 risk assessments developed for residents, the staff team, and visitors were detailed and developed in line with the Health Protection Surveillance Centre's guidelines.

Overall, residents were receiving a service that was promoting and respecting their rights as individuals. Residents' views and preferences were respected and a review of documentation displayed that the provider and person in charge were supporting a resident to seek a more independent living arrangement as per their requests. Residents had access to advocacy services and meeting minutes also displayed that the person in charge and providers senior management had acted as advocates for residents when required.

Regular resident meetings were taking place and residents were being consulted and participating in the organisation of the designated centre. The inspector reviewed correspondences between residents and the person in charge in regards to the running of the centre and found that the residents' issues had been addressed.

The provider had ensured that the actions identified form the previous inspection had been addressed in regards to the premises both externally and internally. The house the inspector visited was well-maintained and there was evidence that the premises were under regular review and that further improvements had been identified following the annual review but had been delayed due to COVID-19 restrictions.

Overall, residents were receiving a good standard of care and support. However, there were improvements required to aspects of the service being provided in regard to residents' impact upon one another, the monitoring of actions following audits, and the systems in place to ensure that all safeguarding concerns were addressed appropriately.

Regulation 10: Communication

Residents were being assisted and supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

The residents had opportunities to participate in activities in accordance with their interests, capacity and ability.

Judgment: Compliant

Regulation 17: Premises

The provider had ensured that the actions from the previous inspection had been addressed and that the centre was desinged and laid out to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The centre had appropriate risk management procedures in place.

Judgment: Compliant

Regulation 27: Protection against infection

The provider was taking necessary steps to protect residents at risk of healthcare associated infections.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were inconsistencies in the setting and tracking of goal achievements for residents. There were also improvements required to the tracking and completion of actions following audits of residents personal plans.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were systems in place to meet the behavioural support needs of the residents.

Judgment: Compliant

Regulation 8: Protection

There were improvements required to aspects of the service being provided in regard to residents' impact upon one another and the systems in place to ensure that all safeguarding concerns were addressed appropriately.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider was ensuring that the rights of residents were being promoted and respected.

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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for 47/48 Towerview OSV-0005397

Inspection ID: MON-0023604

Date of inspection: 09/07/2020

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The monitoring systems in place will be reviewed to ensure clear oversight of all areas and actions identifed for improvement; The actions identifed in the annual report on the quality and safety of care and actions arising from the monthly audit schedule will be fully reviewed to clearly identfiy outstanding actions for completion. The progress on these actions will be monitored and tracked to ensure they are progressed. The Person in Charge will audit personal goals set for all residents to ensure they are progressed and liaise with key workers to support resident achieve their goals. Notifiable events will be discussed at our team meetings to ensure learning for all on matters reqiring notification to the office of the Chief Inspector . • Proposed time scale: 01/09/2020.	
Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The notifable event identifed on inspection and following discussion with the inspector has been retrorespectively notified to the Chief Inspector as per the regulations. This notifiable event has been discussed at our team meeting to ensure learning for all on matters reqiring notification to the office of the Chief Inspector .	

• NF07 submitted via HIQA Portal on the 14/07/2020.

• Staff team meeting held on the 15/07/2020.

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:
• Each resident's individual goals will be reviewed with the objective to adapt goals set prior to the travel restrictions and public heath guidance to ensure alternative aspirational goals are in place.
• The Person in Charge will audit personal goals set for all residents to ensure they are progressed and liaise with key workers to support resident achieve their goals
• A monthly review of personal goals will take place with CNM2 in conjuction with each residents key worker. The CNM2 will carry out an audit of personal goals every 3 months.

• Proposed time scale: 01/09/2020.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The safeguarding concern reported has been fully reviewed by the Person in Charge with the advise and input of the Safeguarding team Social Worker to ensure all procedures are in line with the National and local Policy on Safegaurding Vulnerable Adults. The safeguarding policy will be discussed at 6 weekly meetings with the staff team to ensure all staff are familiar with the policy and associated procedures and timeframes.

• Complete :15/07/2020.

• There are safeguarding plans in place to guide staff to respond and manage any potential impact by residents towards each other or peer on peer concerns that may arise. CNM2/PIC and ADON with review all safeguarding plans on a monthly basis.

• Complete :15/07/2020.

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 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	01/09/2020
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 safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	01/09/2020
Regulation 31(1)(f)	The person in charge shall give the chief inspector	Substantially Compliant	Yellow	15/07/2020

	notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	01/09/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	15/07/2020
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	14/07/2020