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:	Towerview
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	06 February 2019
Centre ID:	OSV-0005397
Fieldwork ID:	MON-0023404

About the designated centre

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

The provider describes the service as offering full time residential care for up to nine female residents with an intellectual disability.

The centre comprises two adjoined two storey semi-detached houses and an attached one storey, two bedroom apartment. The houses are situated in a quiet residential centre in close proximity to the local town.

The service has a vehicle for the sole use of the residents, and an additional vehicle in the evenings and at weekends. The centre is staffed full time, by nurses and health care assistants, and there is a full time person in charge.

The following information outlines some additional data on this centre.

Current registration end date:	16/10/2020
Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
06 February 2019	10:30hrs to 19:30hrs	Julie Pryce	Lead

Views of people who use the service

On the day of inspection there were four residents were present in the centre and the inspector met and engaged with three people, one resident asked specifically to have a chat with the inspector.

Some residents told the inspector that they love their house and particularly their own rooms, and talked about their best friend also living in the house. Residents said that staff help them in many ways, including visits to the graveyard and other outings that are important to them. Residents told the inspector which of the staff they had a particularly good relationship with.

Residents told the inspector about various activities they were involved in, including weekend sharebreaks, and smiled as they related their experiences.

Where residents expressed dissatisfaction with their current living situation, this was being addressed by the provider and plans to meet the preferences of the residents were underway.

Capacity and capability

Overall, the care and support provided to the residents by staff was of good quality. However the management and governance was not sufficiently robust as to ensure compliance with the regulatory process, and this resulted in poor outcomes for residents.

Many of the agreed actions from the previous inspection had not been implemented. These actions related mainly to maintenance of the premises, including works required to ensure the safety of residents. A further plan was presented in relation to the required work, however at the time of the inspection none of the agreed improvements had been made. Therefore systems in place to ensure required home maintenance were ineffective, and the processes and structures required to ensure compliance with the regulations and appropriate response to the regulatory process were ineffectual.

The provider did not demonstrate the capacity to identify areas for improvement and proactively address such issues. There was an annual review of the care and support of residents, and a six monthly unannounced visit on behalf of the provider which had been conducted in September 2018. These reports were not available on

site on the day of the inspection, and were submitted by the person in charge following the inspection. The annual reviews for both 2017 and 2018 had identified issues also found in the inspection in relation to the provision of well maintained and safe home for residents. No actions had been taken, meaning that the systems of unannounced visits and annual review were ineffective in these areas.

Regular audits were conducted in the centre, and improvements were evident following the implementation of some of the required actions identified during the audit process. However this was inconsistent, and some actions which had not been completed resulted in poor outcomes for some residents, including the failure to implement a changed medication prescriptions, and the failure to introduce a monthly balance check of residents' personal monies. In addition some audits lacked sufficient detail as to capture required improvements, which had resulted in lack of oversight of effectiveness of personal plans. Therefore the system of audit was not ensuring quality improvement in all areas.

The provider demonstrated good practice in relation to their management of the staffing resources. Appropriate arrangements were in place for the role of person in charge which is a key management position with responsibility for making decisions about the service. There was an appropriately qualified and experienced person in charge at the time of the inspection, who had responsibility for the day to day operation of the centre in areas such as staff supervision and communication, task allocation and conducting regular staff meetings.

The number and skill mix of staff was sufficient to meet the needs of residents. Consistency of staff was maintained by a core staff team, supplemented if necessary by agency staff who were familiar to the residents. Any new staff underwent a detailed induction, and did not work alone with residents. The inspectors found that staff were familiar with the residents' needs and endeavoured to ensure that they were met in practice. They were also knowledgeable in relation to safeguarding and fire safety, and could demonstrate the steps they would take in the event of an adverse event or emergency to ensure the safety of residents.

The provider had ensured that staff had the right training to meet the needs of residents. Staff had received mandatory training, some training was recently out of date, but dates had been booked. Day to day supervision was provided by the person in charge, and one to one supervision meetings had taken place to support staff perform their duties to the best of their ability.

Regulation 14: Persons in charge

There was a full time person in charge who was appropriately skilled, experienced and qualified, and showed leadership skills.

Judgment: Compliant

Regulation 15: Staffing

The numbers and skill mix of staff was sufficient staff to meet the needs of residents, and consistency of care and continuity of staff was maintained

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, and appropriate supervision was in place.

Judgment: Compliant

Regulation 23: Governance and management

There was a management structure in place with clear lines of accountability, and systems such as meetings,audits and unannounced visits had been conducted. However, the systems in place were not sufficient to detect areas requiring improvement, or to ensure the implementation of actions agreed as part of the regulatory processes.

Judgment: Not compliant

Regulation 31: Notification of incidents

All required notifications were made to HIQA within the required timeframes.

Judgment: Compliant

Quality and safety

Overall the provider had put arrangements in place to ensure that residents had support in leading a meaningful life and having access to healthcare, and were supported to make choices.

The provider had systems in place to identify residents needs and to put plans in place to address them. There was a process of personal planning in place, and each resident had a personal plan based on a detailed assessment of needs and abilities, each of which were regularly reviewed. Various assessments had been conducted which informed the plans in various areas of daily life, including introducing new activities and skills in relation to maximising the potential for each resident. The plans had been regularly reviewed and included some of the aspirations of residents. However, whilst goals had been identified for residents, these were sometimes vague, and lacked sufficient detail to guide practice, or were unclear as to whether residents needs were being met as opposed to staff availability being facilitated. Whilst an audit of personal plans had been conducted, it did not include this area, so that the need for improvements in the goals for residents had not been identified.

Healthcare was facilitated for residents in various areas, including access to the appropriate members of the multi-disciplinary team to ensure holistic healthcare. Healthcare plans were detailed and current, and any changing health care needs were met in a timely manner. Healthcare of a high standard was provided at all stages of life in accordance with the needs of residents.

The results of these processes were evident in the activities and daily lives of residents. Residents were involved in activities they enjoyed, and were offered support in various areas of daily life such as counselling.

There were structures and processes in place in relation to the safeguarding of residents. All staff had had appropriate training and there was a policy in place to guide staff. Staff were aware of their roles in relation to safeguarding residents. Issues in relation to safety from financial abuse had been followed up, and some improvements had been made in practice following an examination of practices and processes. However not all required improvements had been implemented, meaning that residents were not completely protected in relation to their personal finances.

There was a risk register in place which include many of the identified environmental risks. However the register was not up to date and included reference to risks which were no longer applicable, or which were not relevant to the centre. Risk ratings had not been reduced where circumstances had changed, so many of them were inappropriately rated. There were recently identified risks which were reported to have been mitigated by a change in practice, but were there was no documented risk assessment or entry in the risk register. There was therefore no effective oversight of risk throughout the centre.

Risks in relation to the premises which had been identified in the previous inspection had not been mitigated. A falls hazard in the garden had not been removed, and required changes to the structure of one of the bathrooms had not been implemented. Other actions in relation to the premises were also outstanding. The centre was not well maintained, and many areas were in a state of disrepair. There were signs in many parts of the house relating to guidance for staff, and not to the support of residents. This did not uphold the rights of the residents to have a home that is suitably decorated and kept in a good state of repair externally and internally.

There were some systems and processes in place in relation to fire safety.
A personal evacuation plan was in place for each resident, and staff were aware of their role in the event of a fire. There was appropriate fire equipment including fire doors throughout the centre which was appropriately maintained. Regular checks on all equipment were carried out. Fire drills had been conducted which indicated that residents could be evacuated quickly in the event of an emergency during the day. However there had been no drills under night time circumstances, and therefore no evidence that a safe evacuation could be managed in the event of an emergency during the night.

Residents were consulted about the running of the centre, and there were regular residents meetings at which a variety of issues were discussed. Residents had a knowledge of their rights, and where residents had expressed dissatisfaction with the living arrangements this had been heard by the provider and plans for alternative arrangements were underway.

Regulation 13: General welfare and development

Residents were supported in activities and involvement in the community. They were supported to have outings and holidays.

Judgment: Compliant

Regulation 17: Premises

The premises were of an adequate structure and layout to support the needs of the six residents currently living in the centre. However the houses were not maintained to an acceptable standard.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a risk register in place, but the information was not all current, and not all identified risks were included. Risk assessments did not all have appropriate risk ratings in accordance with the providers own procedures and policy. There was a system of reporting and recording accidents and incidents, but identified actions required following incidents were not all implemented. A risk identified as part of the previous inspection had still not been mitigated.

Judgment: Not compliant

Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and evidence that residents could be evacuated quickly in the event of an emergency during the day, but no evidence that a safe evacuation could be managed under night time circumstances..

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident in sufficient detail as to guide practice, including detailed health care plans, which had been regularly reviewed. However where goals had been set in relation to maximising the potential of residents, they were vague and did not include any steps towards achievement, or monitoring of progress.

Judgment: Substantially compliant

Regulation 6: Health care

Provision was made for appropriate healthcare, and for end of life care where required..

Judgment: Compliant

Regulation 8: Protection

There were systems were in place in relation to safeguarding of residents including staff training. Improvements had been made following identified difficulties in the management of personal finances of residents, however there were still insufficient checks in place.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were upheld, and the privacy and dignity of residents was 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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Towerview OSV-0005397

Inspection ID: MON-0023404

Date of inspection: 06/02/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The actions from the previous inspection have been addressed (see specific information under Premises) with the exception of painting of the premises which will be addressed by 31 December 2019. The system for ensuring the actions identified in Annual Reviews has been reviewed. Actions which are outside of the remit of the person in charge will be escalated to the Assistant Director of Nursing and the Regional Director of Nursing for action. The Regional Director of Nursing will escalate any actions which cannot be addressed by the Operational Management Team to the Provider. The person in charge will review all actions regularly to ensure that actions are addressed and continue to escalate issues which cannot be resolved by the person in charge. The system for ensuring the findings and identified actions from audits has been reviewed. Each action will have a timeline for completion and will be reviewed by the person in charge on a monthly basis until all actions have been addressed. Any barriers to the completion of actions will be identified and escalated to the Assistant Director of Nursing to ensure actions are addressed.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Level access pathways and ramps have been installed in both houses in the designated	

centre. Completed: 01/04/2019.

A Concrete pathway has been laid at the rear of one of the houses at the designated centre. Completed: 01/04/2019

Two new front doors have been installed in both houses in the designated centre. Completed: 15/03/2019

New flooring has been installed to the ground floor hallways of both houses in the designated centre. Completed: 18/03/2019.

Repairs to ceiling at first floor and fitting of a stira stairs have been carried out in one of the houses in the designated centre. Completed: 26/03/2019

The bathroom gradient has been rectified to the required building standard. Marmoleum flooring has been fitted. Completed: 04/04/2019.

All signs relating to guidance for staff have been removed and placed in a folder in the staff office. Completed: 06/02/2019

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A review has been undertaken of the risk register for the centre on the 15/02/2019. All risks that that are no longer relevant have been removed.
The falls risk identified as part of the previous inspection which had not been addressed has now been addressed on 01/04/2019.
Risk rating on all risk assessments will be reviewed and appropriately rated.
A monthly review will be undertaken by the person in charge of the risk register on the 1st of every month.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A night time fire drill was carried out at in the designated centre on the 25/02/2019 and on the 24/04/2019. All residents were safely evacuated within two minutes.
Simulated fire evacuation drills will be carried out on the 26th of each month.

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: The person in charge will complete an audit of all care plans. A PCP goal monitoring template will be included in the monthly audit template in order to ensure that all goals are reviewed and progress is monitored.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The person in charge has commenced completing the financial audits in the designated centre. Monthly financial audit checks have been completed.	

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/12/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/12/2019
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	Not Compliant	Orange	04/04/2019

	monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	12/04/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/07/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre	Substantially Compliant	Yellow	25/02/2019

	and bringing them to safe locations.			
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	28/06/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	07/02/2019