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:	Ferndale
Name of provider:	Redwood Extended Care Facility Unlimited Company
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	24 August 2022
Centre ID:	OSV-0002430
Fieldwork ID:	MON-0028514

About the designated centre

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

Ferndale provides a residential service for adults both male and female over the age of 18 years with intellectual disabilities, acquired brain injuries who may also have mental health difficulties. The centre is a detached two-storey building, consisting of six bedrooms, a kitchen, two living rooms, dining area, staff office and two bathrooms. The centre can support a maximum of five residents and is situated a short distance from a town in Co. Meath. The centre is staffed by a person in charge, team leaders and direct support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 (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
Wednesday 24 August 2022	09:00hrs to 17:00hrs	Julie Pryce	Lead
Wednesday 24 August 2022	09:00hrs to 17:00hrs	Sarah Barry	Support

What residents told us and what inspectors observed

This was an announced inspection conducted in order to monitor compliance with regulations and standards, and to inform the renewal of a registration decision.

The centre was a clean and spacious home for five residents, situated just outside a campus based setting operated by the provider. Each resident had their own bedroom, and there were both communal and private areas available for their use. There was an enclosed garden area surrounding the centre for residents use.

During the course of the inspection, inspectors observed residents utilising different areas of their home. Some people utilised the gardens and the smoking area while others were engaged in home-based activities with the support of staff. Some residents were coming and going throughout the inspection either on shopping expeditions or drives out.

The layout of the centre supported the variety of preferences of residents, for example, there was a small living room which was mainly used by a resident who preferred to have their own space. There was also a large living room/dining room that was enjoyed by those residents who preferred the company of others.

The inspectors met and spent time with some of the residents, and some people were happy to have a chat with the inspectors. Others who did not communicate verbally were observed going about their day, and interacting with staff members. Residents appeared to be comfortable in their home and to be well supported by staff. Residents said that they were happy living in this designated centre, and did not wish to move anywhere else. However, they did comment on the fact that there were a lot of changes to staff, and this was also acknowledged in the annual review of the care and support of residents prepared by the provider.

One of the resident's had a pet cat, and discussed this with the inspectors. The resident was clearly very fond of their pet, but was concerned about the cost of the upkeep. This was discussed at the closing meeting of the inspection and the provider gave assurances that the resident was being supported in maintaining their pet.

Each resident had their own personal bedroom, these rooms were nicely decorated in accordance with the preferences of each person, and personal effects were evident throughout. Residents said that they had chosen the colour of their paint. Some residents invited the inspectors to visit their bedrooms, and showed pride in their personal spaces. They spoke about their previous living experiences, and how their current conditions were a significant improvement on their past circumstances. They mentioned the supports that were now available to them, and indicated that they felt better in terms of support and safety.

Others spoke about current medical issues, and indicated within their

communication abilities that these needs were being met. For example, a resident told the inspector that the staff were 'good people', and with the support of staff who were familiar to them indicated that they felt supported and safe in their current home.

The inspectors observed residents who did not communicate verbally to be engaged in activities with staff, and from their non-verbal communication appeared to be content and occupied. They were observed to be smiling and engaging in the activities. There was evidence of supports for the individual communication needs of residents throughout the centre, including pictorial information and the use of signing. Residents meetings were offered to residents each week, and residents decided on each occasion whether they wished to attend.

Overall, the inspectors found that residents were well supported, although some required improvements were identified as outlined further in this report.

Capacity and capability

There was a clearly defined management structure in place with clear lines of accountability. The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who had the required skills, experience and qualifications. They were knowledgeable about the needs of residents, showed clear oversight of the centre and demonstrated an understanding of the importance of quality care and support.

An annual review of the care and support offered to residents had been prepared by the provider in accordance with the regulations. This review consisted of an audit, and included a synopsis of the views of residents. It was documented in this review that residents had concerns about the frequency of outings, and that there was an inconsistency in the staff team. This review included an overview of notifications reported to HIQA in relation to allegations of abuse, but did not include an overview of the notifications required in relation to residents going missing, which had been a significant issue whereby there had been repeated incidents of residents absconding.

All the policies required under Schedule 5 of the regulations were in place and had been reviewed within the required timeframe. A sample of the policies was reviewed by the inspector, and they were found to be evidence based and to provide guidance to staff.

There was a planned and actual staff roster maintained, and evidence that staffing numbers were adequate to meet the needs of residents. However, of the eleven members of the staff team, six were new to the centre within the last nine months, and five within the previous 6 months, which had the potential to impact negatively

on the continuity of care delivered to residents.

However, a newly introduced induction programme which had been identified as a requirement in an inspection of another centre within the organisation had been implemented in this centre, and the inspectors had the opportunity to discuss this with a new member of staff. It was found to be an effective innovation. The staff member described the process which included the support needs of residents, and the inspectors found the new staff to be well informed and they knew the residents well.

Staff files were reviewed, and the inspectors found multiple errors and gaps in the information that is required to be maintained for each staff member. These gaps included gaps in employment history in several of the files, references were also missing, in particular the requirement for a reference from each staff member's previous employer. This had the potential to put residents at risk as the recruitment process was not robust.

Staff training was up to date, and there was a clear staff training and development policy in place.

Staff were observed to be interacting with residents in a respectful way throughout the inspection, and all staff spoken with were knowledgeable about their support needs.

A review of the notifications submitted to the Health Information and Quality Authority (HIQA) prior to the inspection indicated that there had been a number of times when residents absconded from the centre. However, records reviewed on inspection indicated an improvement in these incidents. Improvements in practice had been introduced and will be discussed further in the next part of this report.

There was a clear complaints procedure in place, and an easy read version of this was available to residents, and clearly displayed in the centre and there was evidence that, the procedure was discussed and explained at residents' meetings.

Registration Regulation 5: Application for registration or renewal of registration

All the required documentation to support the application to renew the registration of the designated centre had been submitted.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a

detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

A sample of staff files was reviewed, and there were multiple gaps in the requirements under Schedule 2 of the regulations. There were gaps in the employment history for some staff, and others were missing references, including a reference from the last employer in some cases.

The provider had failed to ensure a consistent staff team, more the half the staff team were new recruits in the months before the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place which identified the lines of accountability and authority. There were various monitoring systems in place.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All the necessary notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place. An easy read version was available and displayed in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

All the policies required under Schedule 5 were in place and had been reviewed within the required timeframe.

Judgment: Compliant

Quality and safety

There were detailed personal plans in place for each resident. These plans included goals towards maximising the potential of each individual. They also included plans in relation to the communication needs of residents which were incorporated into their positive behaviour support needs.

There had been several discharges and admissions to and from the centre, and at least one of the long term residents had become unsettled during these changes. This had now settled down, and the provider gave assurances that the stability of the centre would now be prioritised.

There was various documentation in relation to the safeguarding of residents. There were intimate care plans in place which outlined the guidance for staff in supporting the needs of residents, and staff were familiar with these plans. The management of residents' personal money was closely monitored and there was a robust system in

place to ensure the safe management. Where there had been safeguarding issues for residents, safeguarding plans had been put in place, and these had all been appropriately closed.

In the months prior to the inspection there had been repeated incidents of residents leaving the centre without staff knowledge, and whilst they were supposed to be closely supervised. The inspectors reviewed the management strategies that had been put in place to manage this, and found several improvements in practice. For example, spot checks were being completed, staff had all read the updated protocols, and 15 minute recordings had been introduced. Frequent short outings were offered to residents to ensure that their needs and preferences were met.

There was a risk management policy in place which had been regularly reviewed. Environmental risks were managed under the health and safety process, and individual risk assessments relating to the specific needs of residents were in place, and included control measures required to manage the risks. The risk assessment and management plan in relation to the resident going missing had also been updated.

There were detailed behaviour support plans in place which had been regularly reviewed and included both reactive and proactive strategies. Staff were familiar with the guidance in these plans. There were some restrictive interventions in place in relation to behaviour of concern, and there was a clear rationale in place for each. However, there was no overall restrictive practices register by which, oversight of all restrictions could be managed, and there was no daily recording of these interventions.

Whilst overall the premises were appropriate to meet the needs of residents, there were several items of maintenance that were outstanding. Some of these had been identified in the provider's auditing process, however, not all had been managed in a timely manner.

There were multiple infection prevention and control measures in place. There was a current infection control policy, together with a contingency plan to be implemented in the event of an outbreak of an infectious disease. A detailed audit of Infection control had been undertaken, and this was monitored on a weekly basis. The inspector observed throughout the inspection that current public health guidelines were observed.

Fire safety precautions were in place, including fire detection and containment arrangements, fire safety equipment and fire doors. Fire drills had been undertaken, but did not include fire drills under night time circumstances, where residents were in their rooms and there would be a reduced staff contingency. This was discussed with the provider at the closing meeting, and assurances were given that this would be addressed as a matter of urgency. Satisfactory assurances were submitted by the provider on the day following the inspection that drills had been undertaken on the evening of the inspection, and that residents could be evacuated in a timely manner in the event of an emergency.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to meet the needs of residents, however the following maintenance issues were outstanding:

- bathroom floors which needed repair or replacement
- damage following a water leak had not been rectified
- an indelible seasonal sign was evident on the door of one of the bedrooms which had been left by the previous occupant of the room
- some of the painting in the kitchen required attention.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There as a risk register which included all identified risks, together with a risk assessment and risk management plan for each.

Judgment: Compliant

Regulation 27: Protection against infection

Effective infection prevention and control measures were in place, in accordance with current public health guidelines.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety equipment was evident throughout the centre, and was regularly maintained and certified. Fire drills had been undertaken during the day, but there was no evidence of an effective evacuation of residents under night time circumstances.

This was discussed with the provider at the closing meeting, and assurances were given that this would be addressed as a matter of urgency. Satisfactory assurances were submitted by the provider on the day following the inspection that drills had been undertaken on the evening of the inspection, and that residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place based on an assessment of needs. Plans had been reviewed regularly.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were in place which were detailed and provided guidance to staff.

Any restrictive practices had a clear documented rationale, however the implementation of these was not recorded on a daily basis, and there was no overall register maintained of these practices.

Judgment: Compliant

Regulation 8: Protection

Appropriate systems were in place in relation to safeguarding of residents.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ferndale OSV-0002430

Inspection ID: MON-0028514

Date of inspection: 24/08/2022

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:
A review of all Schedule 2 information pertaining to the Designated Centre has been completed. Any Gaps identified have been addressed. Going forward HR will ensure all pertinent information is in place to any staff commencing their employment. The PIC will liaise with HR to ensure staff folders are kept up to date. This will include the PIC completing sample reviews of Schedule 2 information every six months or as required, with a focus on any new staff.
The importance of updating HR documents is to be discussed in the staff and supervision meetings. HR to include the required documents checklist in the Induction booklet.

To ensure that residents receive continuity of care and support, the following measures have been embedded into The Talbot Groups processes. Each new staff member completes a detailed staff induction programme. This includes ensuring staff are familiar with the care and support arrangements in place for all residents within the designated centre. Additionally,

• All staff receive structured supervision in line with the Talbot Groups policies and procedures.
• The PIC will ensure all staff are aware of the Employee assistance program via Supervision and monthly staff meeting.
• EAP leaflets are in prominent areas. such as the office notice board.
• The Talbot Group is committed to staff development and offers professional development opportunities to staff, these development opportunities include facilitating funded undergraduate and postgraduate programs in social care, nursing undergraduate degrees and PMCB
• To aid retention flexible working arrangements are supported, including relief, permanent part time arrangements.
• Structured pay and renumeration scales in place.
• Annual staff satisfaction survey in place and the development of a staff feedback policy is underway.
• Exit interviews are completed with staff to identify and respond to trends.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A full review of the premises has been completed. Any maintenance issues identified have been logged with the maintenance department and will be addressed in order of priority. The issue's identified during the inspection such as damaged wallpaper in the corridor and an indelible seasonal sign on the resident's bedroom door were resolved on 29/09/22.

A maintenance plan is in place to address the following areas'

- bathroom floors which needed repair or replacement
- damage following a water leak had not been rectified
- some of the painting in the kitchen required attention.

The PIC will continue to complete daily rounds to identify and address maintenance issues of the house. PIC to maintain and review the maintenance log.

The tracking of maintenance issues will be completed via monthly Governance meetings between the PIC and their Assistant Director of Service. If particular concerns are raised at this meeting, they can be escalated to the Director of Operations for prioritisation. The Director of Operations meets with the Head of Facilities weekly, to ensure priority areas are completed in a timely manner.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	31/12/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	31/10/2022
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	Substantially Compliant	Yellow	31/12/2022

	internally.			