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

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| Name of designated centre: | Sonas Services |
| Name of provider: | Ability West |
| Address of centre: | Galway |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 14 May 2021 |
| Centre ID: | OSV-0004073 |
| Fieldwork ID: | MON-0031394 |

## About the designated centre

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

Sonas Services is located in a large city in the west of Ireland. The centre currently accommodates three residents who have an intellectual disability and display behaviours of concern, two of these residents also have complex medical conditions. The centre consists of one house which appears as two semi-detached houses from the outside, however the provider had redesigned the house internally to be operated as one designated centre. The centre consists of two sitting rooms, three bathroom/toilets, two kitchens and a dining room, a utility and there are five bedrooms in the centre. The centre has a garden to the front and rear of the premises. The centre is managed by a person in charge and the residents are supported by three separate staff teams.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 3 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Friday 14 May 2021 | 09:00hrs to 17:00hrs | Thelma O'Neill | Lead |

## What residents told us and what inspectors observed

On the day of the inspection, there were three residents living at the centre. Two residents lived full-time in the centre and a third resident was availing of day respite and was currently visiting the centre five days a week and was transitioning to live in the centre on a full-time basis. The inspector met one resident, the person in charge, two staff members, and the person participating in the management (PPIM) of the centre. In addition, the inspector spoke to one family representative who gave an account of the family's experience of using the service and the inspector gave feedback on the inspection findings to the person representing the provider on the day of the inspection.

The premises consisted of one house that looked like two semi-detached houses from the outside, prior to the registration of this centre, the provider had redesigned the premises internally to allow access to both houses. However, on the day of inspection, the inspector found the provider had changed the service provision to operate as two services, which resulted in restricted access for the residents to separate sides of the house. This was a result of new admissions to the centre, and one resident lived in one half of the house and two residents shared the other side of the house. Access around the building was restricted by locked internal doors upstairs and downstairs. The inspector was told these restrictions were put in place as a means of managing behaviours of concern relating to risks associated with residents' health and the need to monitor their daily food intake.

Residents accessed day services with the support of day staff five days a week and had individualised programmes in place to meet their individual care and support needs. However, there was not a consistent staff team working in Sonas Services, as one of the residents was continuing to be supported with 1:1 staffing from their previous designated centre. A second resident was supported by 2:1 staffing by day service staff and the third resident was directly supported by Sonas staff. The inspector was told that there was a recruitment process in place, as there was only one permanent staff working in the centre and the remaining staff were relief staff due to ongoing staffing retention issues in the centre. The inspector also found the management arrangements in the centre were not sufficient to ensure effective oversight of the designated centre; for example, the management of staffing, staff training and development, notifications of incidents, management of complaints, risk management, medication management and positive behaviours of concern. Some of these were actions from the last inspection that had not been addressed.

The changes in service provision since the new residents were admitted to the centre had impacted on the rights of the existing resident, as it restricted their access around their home to half since the new admissions to the service. There was also very limited communal space for the two new residents that were sharing one side of the centre together, as they were very active individuals and liked to moved about a lot. These residents were also supported by three staff members, which further impacted on the accessible space in the house available to them. Prior

to the inspection, the provider had advised the Health Information and Quality Authority that a plan was being put in place for alternative arrangements for the individual on respite and this would take place by the 12 March 2021, however, on the day of inspection, no alternative arrangements had taken place.

The inspector found the provider had implemented environmental restrictive practices in the centre, such as physical and environmental restraints. Residents were restricted from having free access around the centre to communal areas, such as the kitchens which were locked and could only be opened with the use of a key code. The inspector found these restrictive measures were not assessed as the least restrictive options, such as only locking the kitchen presses, which would allow the residents' access to the kitchen, while also ensuring the residents' safety was maintained. While these restrictive measures were in place since February, they had not been reviewed by the organisation's restrictive practice oversight committee.

The provider had also sanctioned additional restrictive practices in the centre to be used (if required) due to a resident being assessed as high risk of displaying aggression and violence in the centre. This included the use of physical and environmental restraint, such as; the use of physical holds by two staff, and the use of a secure room suitable for the use of ''environmental restraint'' and had installed an observation panel in the resident's bedroom door, so staff could observe the resident while they were secured in their bedroom. Although the resident's assessment of need was updated on the 30/03/21 and identified that the resident required a secure environment, these risks were not recorded in the centre risk management register, or the control measures staff should follow should these measures be used in the centre. In addition, these measures were not approved by an external party, such as the provider's restrictive practice committee.

During the inspection, the inspector met the resident who lived alone on the other side of the house, and they were getting ready to go to their day services with their support staff. They had limited speech, but appeared to understand everything spoken to them and smiled when asked about going to work and the social activities they liked to do. Staff told the inspector that the resident had recently recommenced horse riding and that they were delighted to be back seeing the horses and getting the opportunity to ride again. Staff also told the inspector, the resident also helped out at a local office doing some chores with their support staff. They also attended another day service and enjoyed meeting their friends there daily.

There was documentary evidence that there was a good improvement in the resident attending their daily activities recently. They had a structured day and night routine which included, the resident having access to a relaxing room to watch their DVD player in the evenings. This was a concern raised on the last inspection that was now addressed. However, the inspector saw two incidents reported by staff where this resident was banging doors and throwing things into the hall at night. The PPIM told the inspector that these incidents occurred, as the resident was trying to wake the sleepover staff to get their attention during the night when they wanted support. On review the provider had changed the night staffing arrangements from a waking night staff to a sleepover staff, but there was no documentary evidence of

a review of the suitability of the changes in the night staffing arrangement in the centre.

As part of the inspection, the inspector reviewed the complaints management processes for the centre. There were a number of complaints under investigation at the time of the inspection.

Overall, the inspector found that this service did not always meet the individual care and support needs of the residents and did not promote a rights based service that delivered a safe and consistent service and promoted the residents' wishes and health care needs. In particular, the inspector found significant improvements were required in the oversight and governance and management of the centre. These issues will be further discussed in the next two sections of the report.

## Capacity and capability

The inspector found the provider Ability West, did not have effective governance and management arrangements in place to effectively manage this service as required by the regulations. This inspection was completed to follow-up on the actions of the last inspection and to review several concerns received by HIQA as unsolicited information.

On receipt of the unsolicited information, the provider was issued two provider assurances report to seek assurances on the care and welfare issues identified by the concerned persons and to ensure the concerns were investigated and addressed by the provider. The provider submitted written assurances to HIQA including a quality improvement plan outlining the actions they were taking to address these concerns and these actions were reviewed on this inspection. Some notified actions were addressed, while others were still in progress, or had not been completed on the day of inspection.

In addition, the inspector reviewed the provider's compliance plan response following the last inspection of this centre in November 2020. The compliance plan identified three non-compliance's in the areas of risk management, the management of positive behaviour support, and governance and management. Improvements were also identified as being required in staffing, management of records, complaints procedures, general welfare and development, fire safety, individual assessments and personal plans, and residents rights. The inspector found that while some improvements had occurred in some of these areas since the last inspection, overall the quality and safety, and the governance and management of the centre had significantly deteriorated, and as a result many of the previous judgments that were identified as substantially compliant were now identified as non-compliant.

The inspector found that the provider had not demonstrated that they had put in place an effective oversight arrangements in the centre to ensure that practices at

the centre were in line with residents' care and support needs, the statutory regulations under the Health Act 2007, as well as the organisation's own policies and procedures. The inspector found the absence of these processes and procedures negatively impacted on the safety and quality of life of all residents. The inspector found non-compliance's in staffing, risk management, managing behaviours of concern, staff training, medication management, the management of complaints, notifications, and governance and management of the centre. Improvements were also identified in six other regulations and these are discussed throughout the report.

Since the last inspection on the 8th of November 2020 there has been several changes in the governance and management of the centre, including two changes in the person in charge. The current person in charge had commenced their post in February 2021 and was responsible for the management of three designated centres, with the other two centres being located sixty kilometres away from Sonas service. The person in charge told the inspector they visited the centre two days a week, however, the findings of the inspection indicated that this was not adequate to ensure the delivery of a safe and effective service and to ensure compliance with the regulations.

There had also been several changes in the operation of the centre since the last inspection, including a change in the use of the premises, the service provision, staffing arrangements, governance arrangements and new admissions to the centre. Consequently, the provider had not ensured that the services and facilities as described in the centre's statement of purpose were appropriate to the residents' needs and had not undertaken appropriate assessments, including the suitability and compatibility of new admissions to the centre.The absence of these actions had lead to negative impacts on residents' rights and freedoms living at the centre.

The statement of purpose was updated on the 13/5/2021, however, on review, the inspector found the revised statement of purpose did not accurately provide information as required under regulation 3 schedule one of the regulations. For example, the specific care and support needs of the residents living in the centre and the facilities and services provided to support residents needs.

Staffing arrangements in the centre required improvement. There were two staff rosters in place illustrating the staff available support the needs of two of the residents at the centre. However, no roster was available for the third resident who was currently transitioning into the centre. As this centre was registered as one designated centre, a full roster of all staff working both planned and actual is required under the regulations. In addition, records and staff discussions showed that there had been a consistent issue with staffing in this centre which were identified on the last two inspections relating to staffing arrangements at the centre, and these issues were still not addressed on the day of inspection.

The provider had also previously given HIQA written assurances that they had completed an individual needs assessment for the initial resident who moved into the centre, which included a staff training needs analysis and assurances that any outstanding or further training would be completed by the 31/03/2021. However,

records showed that the person in charge and staff team had not been provided with the required training in relation to individual complex health conditions.

Furthermore, the inspector found on review of residents' medical and daily care records, that documents maintained did not clearly identify residents' assessed needs and the individual supports required. For example, daily records did not clearly document how staff should or had made health care decisions. Furthermore, another resident with a chronic medical condition who was prescribed herbal medication did not have an agreed protocol in place to manage same. There was poor oversight of resident's medical conditions and medication management, as there was no clinically trained staff working in the centre and the person in charge told the inspector that she did not have knowledge of, or training in the medications prescribed for these two residents. This was a concern, as she was the person responsible for the day-to-day medication management and there was no alternative arrangements for clinical oversight in the centre.

As part of the inspection, the inspector reviewed the complaints management process. There were a number of complaints being investigated at the time of the inspection. The inspector found that while the person in charge was able to give an account of the investigations, the provider was not adhering to their own processes in relation to recording the complaint and the process of investigation

## Regulation 14: Persons in charge

The person in charge was responsible for three designated centres, and was responsible for governance and operational management of this designated centre. However, the inspector found the person in charge did not demonstrate effective operational management of the centre having regard to the risks identified and the changes in service provision in the centre.

Judgment: Substantially compliant

## Regulation 15: Staffing

There was an absence of a regular and consistent staff team in this centre, and the staff did not have the appropriate training and skill mix to ensure the health needs of all residents were met. Furthermore, there was not an effective staff roster showing all the staff on duty in the centre daily. This was an action from the last inspection that was not addressed.

Judgment: Not compliant

## Regulation 16: Training and staff development

Arrangements were in place to provide training and development for staff. However, staff working in the centre did not have the appropriate training and skills to effectively manage all healthcare needs of the residents.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The provider had not ensured the quality and safety of care and the operational management of this service was robust and in line with the aims and objectives of the statement of purpose for this centre. The inspector found the provider was non-compliant in seven regulations namely, staffing, risk management, managing behaviours of concern, medication management, the management of complaints, notifications, and governance and management of the centre, six other regulations also required improvement. Some of these were actioned on the last inspection and were not appropriately addressed.

Furthermore, the provider had not actioned quality assurance plans submitted to HIQA as part of their provider led assurances following receipt of concerns in the centre.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The SOP dated the 13/5/2021 did not accurately reflect the service and facilities on the day of inspection, and required further review.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The provider failed to report to HIQA restrictive practices being used in the centre, such as locked doors and windows, and viewing panels and the impact these restrictions had on the residents' rights and freedom in the centre.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The provider did not demonstrate an effective management system was in place for the recording, monitoring and review of complaints in the centre.

Judgment: Not compliant

## Quality and safety

The inspector found the quality of care provided to residents required improvement following the changes in service being provided in the centre. On this inspection, individual assessments, behaviour support plans and safeguarding plans were not updated to reflect the risks in the centre. For example, the management of health care needs, risk management, medication management, safeguarding procedures, managing behaviours of concern, all required updating.

The health and well-being of each resident was promoted and supported in a variety of ways, including through diet, nutrition, recreation, exercise and physical activities. Residents had access to a medical practitioner, such as a general practitioner (GP) of their choice. Residents were supported to live healthily, the person in charge said one resident's health care needs were being managed by their family and they supported the resident with all of his medical appointments and health care needs. However, the inspector found the management of medication management in the centre required improvement, particularly arrangements around the receipt of telephone orders for insulin dose adjustments, as they were not managed in line with the organisations policy or procedures or best practice. In addition the administration of herbal medication and the procedures in place for managing same were not robust, as the medication protocol was not agreed between the provider, the general practitioner, herbalist and family and this had led to a dispute in the dosages to be administered and an inconsistent approach between the family and the service in the administration of the medication. Furthermore, the provider had not ensured that all staff were trained in the use of medications being prescribed to residents and this posed a risk to the residents.

The inspector also found one resident's behaviour support plan dated September 2020 had not been updated since their admission into the centre. An up to date behaviour support plan was required to identify any current risks or potential behaviours of concern that could be displayed since their transition commenced to the centre. In addition, one resident had their access and freedom restricted in the

centre, and there was no rights assessment completed or evidence that all residents were consulted with in relation to the environmental restrictions in use in the centre.

There were not effective systems in place for the assessment, management and ongoing review of risk. For example, known safeguarding risks were not appropriately assessed in this centre and appropriate plans put in place to manage same in the event of their occurrence. In addition, one resident's crisis intervention protocol recommended the use of a secure bedroom, but this was located upstairs and the risks associated with two staff having to escort the resident upstairs while possibly displaying aggressive behaviour. This had not been adequately risk assessed in the individual's risk assessment or the centre's risk register. In addition, one resident's personal fire evacuation plan was not updated since 25/3/2020, despite their evacuation plan and escape route being changed since the reconfiguration of the centre.

The provider also failed to risk assess and put appropriate measures in place to identify the lack of safe medication management practices and a lack of suitable staff training in safe administration of medication in the centre. These risks were not included in the centre's risk register and the provider had not identified these hazards/ risks and put appropriate control measures in place to manage same.

## Regulation 26: Risk management procedures

There were not effective risk management procedures in place to ensure that the residents were protected from potential safeguarding risks posed by others' behaviours of concern. In addition, the management of risks such as staff turnover, safe administration of medication, the suitability of the premises and governance and management arrangements all required improvement. Some of these issues had been highlighted in previous inspections and had not been adequately addressed.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

The person in charge did not ensure that the designated centre had appropriate and suitable practices in place for the administration of diabetic medication, especially in relation to the oversight and management of telephone prescriptions. The provider had also not ensured that they adhered to their own medication policy in relation to diabetic medication. Furthermore, there was no clear agreement on the use of herbal medication between the doctor, herbalist , provider and family which could have a negative impact on the resident's health

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Residents did not have an up to-date comprehensive assessments of need or care plans to reflect the residents current health and behaviour support needs, and living arrangements. The plans also did not guide staff on their individual support needs.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

The provider had implemented restrictive procedures including the use of physical and environmental restraint, and it was not clear that such restrictions were appropriately implemented with the informed consent of each resident, or their representative and were reviewed as part of their personal planning process.

The inspector found one resident's behaviour support plan was dated 15/9/2020, but it was not updated to reflect the resident's recent admission and transition to the centre. For example, the associated risks of the restrictive practices to be used if required, and the management of same. Furthermore, the restrictive practice committee had not reviewed restrictions or interviewed staff to review if these restrictions were appropriate and not in breach of the resident's human rights. This was an action on the last inspection and was not addressed.

Judgment: Not compliant

## Regulation 9: Residents' rights

One resident's had their access and freedom restricted in the centre, and there was no rights assessment completed or evidence that all residents were consulted with in relation to the environmental restrictions in use in the centre.

Judgment: Substantially compliant

## Regulation 6: Health care

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| The provider did not have clear arrangements in place to support residents with their identified healthcare needs, which could have a potential negative outcome on their quality of life. |
| Judgment: Substantially compliant |

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Substantially compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 9: Residents' rights | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |

# Compliance Plan for Sonas Services OSV-0004073

## Inspection ID: MON-0031394

## Date of inspection: 14/05/2021

**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 14: Persons in charge | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

Assessment of needs were completed for all residents and updated regularly between March and May 2021. The most recent Assessment of Need was completed due to a new admission to the service, with contributions from resident, family, front line staff, and relevant multidisciplinary team members and details areas of needs and individual supports, such as health care needs, behaviours of concern, medication management, staffing and environmental considerations. The Person in Charge will continue to review assessment of needs on a scheduled basis, at least annually, or more frequently if there is a change in needs or circumstances. The Person in Charge (PIC) is responsible for three designated centres, one of which has a Team Leader and opens for 15 nights per month. The second service is in the process of being transferred to another service provider with an expected completion date of August 2021. Following completion of this transfer the PIC will be responsible for two centres, Sonas Service and a second centre that is open half time and also has a Team Leader in place to support governance there. The PIC is supernumerary across all services under her management and has allocated protected time for oversight and management in each service, with flexibility to respond when needed in each centre. This flexibility in hours and support from Team Leader and a Person Participating in Management (PPIM) will remain in place indefinitely. The PIC receives ongoing support and supervision from the PPIM who also currently maintains close contact with the team in Sonas Services and family members of residents there. Support meetings currently take place at a minimum of once per week; this frequency is to be reviewed on 01/09/2021 based on the needs and effectiveness of same particularly in relation to Sonas Services.

| Regulation 15: Staffing | Not Compliant |
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Outline how you are going to come into compliance with Regulation 15: Staffing:
All front line staff are medication trained and refreshers completed as required. All front line staff who support resident with diabetes are trained in diabetes and the administration of insulin.
There is a consistent staff team for each resident who have been identified as requiring individualised support and this is also evident in the centre assessment of needs. In the Statement of Purpose, version 19, dated 13/05/2021, centre assessment of needs, and the completed individual assessment of needs, the requirement for nursing care has not been identified in Sonas Services.
There is a planned and actual roster in place to support the individualised services and this is now maintained in one location within Sonas Services.
There is currently a consistent staff team in place, and this will be reviewed on a monthly basis at meetings between the Person in Charge and the Person Participating in Management, should vacancies arise they will be addressed through the Human Resources processes. In addition it is acknowledged that there has been a high rate of staff turnover, and in that regard we are committed to an analysis to identify reasons for same, and identify targeted actions to address this.

| Regulation 16: Training and staff development | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A centre assessment of needs was completed on the 30/03/2021 identifying the training needs for staff related to resident's needs. All frontline staff, i.e. Social Care Workers and Care Assistants have completed the required training, from commencement of their employment to May 2021, which includes Studio III and medication management. One resident requires diabetes supports, and so all frontline staff who support that resident received the requisite Diabetes training by qualified trainers (e.g. Diabetic Nurse) between 2019 and 2021. This will be refreshed within the three year timeframe. The Person in Charge, who is supernumerary to the staffing rota, has yet to complete Diabetes training, and is seeking to complete this with a qualified trainer. This is currently not available because it is typically provided by hospital-based nurses who are currently unavailable due to the COVID-19 pandemic. Alternatively, qualified supervision of medication practice and care is provided by the PPIM, who is a qualified and registered nurse. This alternative clinical oversight will continue until the PIC has been successful in completing Diabetes management training.

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Comprehensive auditing processes and oversight arrangements currently in place are detailed hereunder. Provider Led Audits are completed at least once every six months; the most recent 03/02/2021. Comprehensive actions and review of same are currently in progress. The second Provider Led Audit will be completed by the Quality and Compliance Team within the six month period. Overall review of care and support needs of individual residents takes place as part of ongoing review processes such as case reviews, assessment of needs, health care reviews. This is completed on an annual basis or more frequently if circumstances change. Any actions identified from such reviews are documented and kept under regular review by the PIC. In addition, the following audits are completed by the PIC on a regular basis, e.g. medication, finance, training, rosters, review of incidents, risk assessments, health and safety checks. Reviews are also carried out on health related areas (e.g. bowel charts), at least monthly. All audits and checks are carried on a scheduled basis, e.g. monthly and this will continue. Results form part of support meetings with PPIM. In addition, staff support and development schedules are currently in place and managed by the PIC. The PIC and PPIM currently meet weekly for support meetings; agenda items include oversight of these areas of governance and management, encompassing staffing, risk management, responding to behaviours that challenge, management of complaints, notifications, and statement of purpose.

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| Regulation 3: Statement of purpose | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
At the time of inspection, the most recent Statement of Purpose was dated 13/05/2021 (V. 19, pg. 5-6), which states that 'Sonas services currently provides full time residential placement to two young adults in separate living accommodation within the same building. Residents have their own living space within the centre.' However, it is recognised that the floor plans require additional clarity to clearly identify separate living accommodation for residents. Statement of Purpose, V.19 was submitted to registration, HIQA on 15/06/2021 by the PIC. A further updated Statement of Purpose with clarity of floor plans was submitted to HIQA by our Quality and Compliance Dept. on 25/06/2021. A further version of the Statement of Purpose will be submitted by PIC to HIQA on receipt of the updated floor plans from the architect, this will be completed by 31/08/2021.

This review will include a specific cross check through use of a checklist with Schedule 1 of S.I. 367 to ensure that it meets all requirements of the Schedule, including the current

services and facilities of the centre. The checklist will be signed off by the Person in Charge, Person Participating in Management and the Registered Provider Representative.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Person in charge submitted NF39A on HIQA portal on 15/06/2021 in relation to one restrictive practice which had not been identified previously, and resubmitted with further clarity on 25/06/2021. All other restrictive practices which had been utilised were submitted at the end of Q1 2021 and any restrictions which have not been utilised to date will be submitted on NF40 at the end of Q2 2021.
Environmental Review will be carried out on a quarterly basis to coincide with the quarterly returns, co-ordinated by the Person in Charge. The environmental review involves a tour of each of the rooms, reviewing each area in terms of restrictions and restrictive access. If any restrictive practices are identified they will be addressed through the restrictive practices committee and included in the quarterly returns for submission to HIQA and as required by the regulations.

| Regulation 34: Complaints procedure | Not Compliant |
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
At the time of inspection the complaint (consisting of a number of complaints) was at the formal investigation stage, by the Chief Executive, as per the organisation's complaints policy and procedure, and this was relayed to the inspector. The complaint was at the stage of draft report being with the complainant at the time of inspection, and this was relayed to the inspector. As the complaint was in process, it was not at the stage of obtaining the satisfaction level from the complainant in terms of the outcome. The provider will ascertain the satisfaction level with the complainant on the outcome of the investigation. The investigation report can be provided to the Inspector if still required.
Complaints training on the effective management of complaints has been undertaken by the staff team on 08/03/2021.
Completed complaints records are available in the service, complaints in progress are retained by the person the complaint is assigned to until such time as the complaint is closed. Details of status and progress on individual complaints is recorded on the individual complaints record on the Quality Management Information System. In some circumstances, for example, the complaint may be directed towards the Person in Charge or Person Participating in Management, or complaints received may warrant a more

organisational response at a senior level. In such situations it may be deemed more appropriate and proportionate to assign same to a more senior role, for example, Senior Management Team member. The reason for not assigning the complaint directly to the Person in Charge or Persons Participating in Management is that in the event that they are the subject of the complaint, it is assigned to a more senior role, this is reflected in the Quality Management Information System. This is to ensure that due process is followed for the complainant and the person(s) whom the compliant is made against.

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| Regulation 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
There is a risk register in place for Sonas Services, with comprehensive individualised risk assessments for all three residents. These were reviewed by the Person in Charge on 24/06/2021. Risk categories include behaviours that challenge, infection prevention and control, safeguarding, staffing, medication management, and unmet needs. There is a review system in place which identifies timelines for review of each centre-based risk assessment and individual risk assessment (i.e. for residents), which are completed by the Person in Charge. If additional risks present themselves outside of the timelines, or if risk ratings should change for any reason outside of standard review timelines the PIC will update the risk register and risk assessments accordingly without delay. The process of risk assessment, management and review is monitored through weekly support meetings with the PPIM.
All Personal Emergency Evacuation Plans will be reviewed by the Person in Charge to reflect any changes in the evacuation procedures by 30/07/2021, and on an ongoing basis in line with risk assessment review processes.

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| Regulation 29: Medicines and pharmaceutical services | Not Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Appropriate medication management procedures are followed. The organisation's policy and procedure (3.4) notes that 'procedures apply to all medications including all prescribed medications, over the counter medication, and nutritional supplements, and (7.1.5) 'special consideration to be given to the use of medication for the management of constipation.' As per organisation policy (7.1) the registered prescriber is usually the person's General Practitioner, but may also be a locum or hospital doctor or a consultant.

At the time of inspection staff were following the signed Kardex from resident's G.P. and in the event of any other alterations required, staff contacted the G.P or on-call doctor as required. A meeting has been held with stakeholders, including the G.P. Pharmacist, family members, and staff with the purpose of ensuring that there are adequate processes in place to support the residents' needs and determine a safe medication system; a collaborative risk assessment is being undertaken in an effort to reach a satisfactory conclusion. In relation to the other resident the Person in Charge has reviewed the management of high alert medication such as insulin and all front line staff are suitably qualified to receive telephone prescription orders. This is included in the organisation's procedures, and all staff administering medication have received the requisite training in this and signed off on the procedures. Currently clinical instructions are emailed to the service from the local HSE Diabetic Clinic giving clear direction of insulin dosage for that period, including reference to changes needed (if required) if any, which are dependent on the blood glucose readings that the staff have furnished to the Diabetic Clinic. This is completed on a twice weekly basis and the instructions are transcribed onto a devised template. Both the email received and the template is signed off on each entry, upon transcription by the trained medication administrator on duty. This eliminates the need for staff to receive telephone prescriptions. This process has commenced from the 01/07/2021, and so far is working satisfactorily.

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| 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:
Assessment of needs are completed with contributions from residents, family, front line staff, and relevant multidisciplinary team members and details areas of needs and individual supports, such as health care needs, behaviours of concern, medication management, staffing and environmental considerations. Review of assessment of needs will form part of the audit schedule of the Person in Charge and has been added to the yearly schedule. The Person in Charge will continue to review Assessments of Need at least once per year, or more frequently if there is a noted change of needs for a resident, new person moving into the service or other relevant criteria for review.

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| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

At the time of inspection, there were six restrictive practices in place in Sonas Services. All of these had been submitted to the Restrictive Practices Committee, and acknowledgment was on record from the Chair of Committee, noting that the applications were wait listing for hearings. Since the date of inspection, the PIC re-referred all restrictions to the Restrictive Practices Committee; five were reviewed and approved by the Committee on the 16/06/2021, the sixth restriction is on the agenda for the next meeting on 28/07/2021. A new referral has been made to the Restrictive Practices Committee for a restriction identified during the inspection, and a notification of same has been submitted to HIQA NF39A by the PIC on 15/06/2021, and resubmitted with further clarity on 25/06/2021.
In relation to one resident's Behaviour Support Plan, a meeting was scheduled for the 01/07/2021 with the PIC and Behaviour Support Therapist, however, following a review of this resident's needs he will no longer be accessing Sonas Services from 02/07/2021.

| Regulation 9: Residents' rights | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The current Statement of Purpose dated 25/06/2021 details the layout of Sonas Services, including separate living accommodation, and that 'Sonas Services currently provides full time residential placement to two young adults in separate living accommodation within the same building. Residents have their own living space within the centre. A restrictive practices review was carried out on the 25/03/2021 by the PIC, and no further environmental restrictions were identified. Therefore access and freedom is not restricted for each of the residents individually. In relation to restrictive practices in place specific to each individual, consent is documented; and further consultation and consent will be sought for the restriction identified during inspection, this will be sought from residents by 15/07/2021.

| Regulation 6: Health care | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 6: Health care:
The PIC maintains training records and these were reviewed on 24/06/2021, including the administration of management of high alert medications such as insulin. The outcome of which indicates that all front line staff are suitably qualified to receive telephone prescription orders from registered prescribers for high alert medications. To ensure additional safeguards the PIC is currently collaborating with the HSE diabetic clinic to ensure that all adapted doses under the resident's current regime will be emailed to the service twice weekly. A template has been devised by the PIC to clearly record doses, the detail of this was shared with the staff team at meeting on 28/06/2021.

All frontline staff have the required medication management training, undertaken within the three year timeframe. One resident requires diabetes supports, and so all frontline staff who support that resident received the requisite Diabetes training by qualified trainers (e.g. Diabetic Nurse) between 2019 and 2021. This will be refreshed within the three year timeframe.

In relation to issues with herbal medication related to one resident and how the herbal medication will be managed, a meeting was organised on the 09/06/2021, and chaired by Ability West with stakeholders, including the G.P. Pharmacist, family members, and staff with the purpose of ensuring that there are adequate processes in place to support the residents' needs and determine a safe medication system; a collaborative risk assessment is being undertaken in an effort to reach a satisfactory conclusion. This will include development of a health care plan to guide staff. This is to ensure that the service is in line with the organisation's medication policy and procedure, HIQA Guidance on Medication Management and the HSE National Framework for Medicines Management in Disability Services.

Medication prescribed is reviewed every six months or more frequently if required. Following this review, health care plans are reviewed and any amendments made accordingly. This is part of ongoing review of resident's health care. In addition, medication audits are carried out monthly, results are reviewed by the Person in Charge and any actions identified are discussed at the Person in Charge and Person Participating in Management meetings.

## 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 |
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| Regulation 14(4) | A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned. | Substantially Compliant | Yellow | 01/09/2021 |
| 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 | 30/09/2021 |

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| Regulation 15(2) | The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided. | Not Compliant | Orange | 30/09/2021 |
| Regulation 15(4) | The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained. | Not Compliant | Orange | 21/06/2021 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Not Compliant | Orange | 24/06/2021 |
| 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 | 01/09/2021 |
| Regulation 26(2) | The registered provider shall ensure that there | Not Compliant | Orange | 30/07/2021 |

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| | are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | | | |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. | Not Compliant | Orange | 30/07/2021 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Not Compliant | Orange | 31/08/2021 |
| Regulation 31(3)(a) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in | Not Compliant | Orange | 25/06/2021 |

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| | relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. | | | |
| Regulation 34(2)(b) | The registered provider shall ensure that all complaints are investigated promptly. | Not Compliant | Orange | 30/07/2021 |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis. | Substantially Compliant | Yellow | 09/06/2021 |
| Regulation 05(3) | The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 09/06/2021 |

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| Regulation 06(2)(b) | The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated. | Substantially Compliant | Yellow | 30/07/2021 |
| Regulation 07(3) | The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process. | Not Compliant | Orange | 01/07/2021 |
| Regulation 07(5)(b) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used. | Not Compliant | Orange | 25/06/2021 |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Not Compliant | Orange | 25/06/2021 |

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| Regulation 09(2)(b) | The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life. | Substantially Compliant | Yellow | 15/07/2021 |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Substantially Compliant | Yellow | 15/07/2021 |