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:	A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	31 August 2021
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0031292

About the designated centre

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

The designated centre is comprised of three individual units and is located on a shared campus setting in West County Dublin. It provides 24-hour residential support services to persons with intellectual disabilities and at the time of inspection was supporting 13 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a person in charge, a social care leader, staff nurses, carers, an activity coordinator and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 31 August 2021	10:00hrs to 18:45hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

From speaking with residents and from what the inspector observed, it was clear that the basic care and support needs of residents were being met in this centre and they were experiencing a reasonably good quality of life. The inspector found, however, that the centre was not adequately resourced which impacted on the registered provider's ability to meet the social care needs of the resident group and allowed them to live active and meaningful lives.

The inspector met with 10 residents during the course of the inspection and spent time speaking with them and listening to their stories and experiences of living in the centre. The residents were glad to meet the inspector and stated that they felt happy and safe living in the centre. One resident told the inspector how they planted flowers and shrubs in the garden area and were really pleased to see them bloom over the summer period. Another resident told the inspector that while they were happy with their living arrangements, they found that it was "too noisy" at times and would like to have another living room to create a more relaxed environment. Some of the residents told the inspector that their favourite thing about the centre was their "friends and staff". In one of the units there was a birthday party for one of the residents and the group were setting a table and arranging candles on a birthday cake to mark the occasion.

The inspector completed a full walk-through of all three units of the centre in the company of the person in charge. All interior spaces were found to be clean and well maintained. Residents had individual bedrooms and there were sufficient numbers of toilets and showering facilities to meet their needs. There were outdoor spaces where residents could relax and enjoy the good weather. All three units were found to be decorated in a homely manner and provided for a comfortable living environment for residents. The inspector found, however, that the exterior of some of the units required painting and upkeep.

While residents told the inspector that they were happy living in the centre, it was found that there was minimal off-campus activity opportunities for them to engage in. The activities which were available were primarily centre and campus based. When a sample of "meaningful activity" records were reviewed by the inspector, there were entries such as "leisure at home", "home activities", "listening to music" and "watching television" recorded as the main activities for the majority of the resident group. When staff members were asked about the activity options available for residents they told the inspector that residents would like greater opportunities for off campus and community-based activities, however, they cited staffing resources as a barrier to the facilitation of these types of activities. During the course of the inspection, the inspector found that residents were largely unoccupied and there was an absence of any plans for meaningful activities for the day.

The inspector found that the centre was not appropriately resourced and this was evident through the number of staff deployed in the centre. There was an absence

of a consistent staff team with the appropriate numbers to meet the needs of the resident group living in the centre. There was evidence to demonstrate that the number of staff deployed in the centre did not meet the numbers committed to by the registered provider in the centre's statement of purpose. In addition, there was a significant reliance on agency and relief staff to supplement the staff team.

Overall, the findings of this inspection were mixed and it was clear that the registered provider was required to make significant improvements across a number of key regulations to bring about the required changes. Key findings included the need to provide a stable and resourced staff team, the requirement to enhance the governance and management arrangements, the need to review and improve the manner in which residents are supported with their social care needs, and improve the supports and oversights in place for the management of resident finances.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The inspector found that given the level of non-compliances identified during the course of this inspection, there was a clear need for significant improvements in the development and implementation of robust and effective management arrangements to ensure improved governance and oversight of services being provided in this centre. The inspector found that the registered provider had not ensured that the centre was appropriately resourced to meet the social care needs of the residents availing of its services.

There was a strong person in charge in place along with social care leader who were found to have good knowledge of the regulations, legislation and policy. They had a clear understanding and vision for the services to be provided in the centre and had the required competence, qualifications and skills to manage the centre and bring about the required changes.

The inspector found that the centre was not adequately resourced. A sample of staff duty rosters reviewed by the inspector found that the registered provider had not ensured that the number of staff deployed to work in the centre matched those outlined in the centre's statement of purpose. For example, in one unit of the centre, where there were six residents living, the inspector found that there was one staff rostered to work with occasional supports from a 'floating staff member' when it was available. The resident group in this unit presented with evolving care and support needs and were of an aging profile. The inspector also found that there was the significant reliance on agency and relief staff to supplement the staff team. In a one month period reviewed, the inspector found that there 17 different agency staff and 14 different relief staff members employed in the centre. The total hours

worked by these individuals was over 29 per cent of the total hours rostered in this period. This, the inspector found, demonstrated that there was a poor continuity of care and support for residents.

While the registered provider had self-identified some of the findings of this inspection through annual reviews and six-monthly unannounced visits to the centre, the inspector found that there was an overall absence of remedial actions to resolve these matters. The inspector found that there had been some improvement in the development of management systems, however, these were not yet contributing to effective oversight of the care and support being delivered to residents. Some examples of this included the absence of a complaints register or a safeguarding log and the reliance on third parties to obtain information of relevance to the local management team.

Regulation 15: Staffing

The inspector found that there were insufficient numbers of staff members employed in the centre to meet the assessed needs fo the resident group availing of its services. In addition, the inspector found that was poor continuity of care and support for residents given the registered provider's reliance on agency and relief staff members to supplement the centre's staff duty rosters. Despite this, the inspector observed that the staff team in place in the centre were highly motivated and were observed to interact with residents in a kind, patient and respectful manner.

Judgment: Not compliant

Regulation 16: Training and staff development

There were a number of deficits noted in training described to the inspector as being mandatory. These included 'fire online training', 'fire equipment training', 'practical hand hygiene' and 'basic life support/automatic external defibrillator'. The person in charge had a plan in place to address these deficits within a number of weeks of the completion of the inspection. The inspector found that there were good arrangements in place for the supervision of the staff team.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the centre was not appropriately resourced to meet the

assessed needs of the resident group. While there were clear management structures in place, the inspector found that there was a need for the development and implementation of enhanced management systems to facilitate improved oversight of the care and support provided to residents. The registered provider had demonstrated the ability to self-identify some of the areas of non-compliance identified during the course of the inspection, however, they had not completed follow-up actions as required in many of these areas.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications of incidents were reported to the Chief Inspector in line with the requirements of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that there were satisfactory arrangements in place for the management of complaints. A number of complaints had been made in the time since the last inspection and the inspector found that these had been appropriately followed up on and investigated.There were easy-to-read procedures on display in the centre to support residents when making a complaint and the inspector observed a culture of promoting and welcoming complaints from residents and their representatives.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were supported and encouraged to have a reasonably good quality of life while residing in this centre. There was evidence to demonstrate that residents were consulted with and had been informed and supported to exercise their rights where possible. There were, however, limited opportunities for residents to live active and meaningful lives as part of their local community and to have the opportunity to develop and maintain valued social roles. This, the inspector found, resulted in barriers for residents to live active and rewarding lives which reflected their wishes, choices and individual abilities.

Residents were appropriately protected from experiencing incidents of a safeguarding nature in the centre through the practices of the staff team and local policies. While there had been a number of incidents of a minor nature in the time since the last inspection, the inspector found that these had been appropriately followed up on and investigated in line with local and national policies.

While there were some improvements noted in the quality of the service being provided in this centre, the inspector found that significant improvements were required to ensure that a person-centred culture was created and promoted. For example, the staff teams had recently begun preparing some meals within each of the three units of the centre and were gradually reducing their reliance on the campus based centralised kitchens. According to the staff members met with at the time of the inspection, this resulted in increased choice and ability to meet specific needs of residents in the centre. The inspector found, however, that there remained some institutionalised practices in place which included the manner in which residents were supported to manage their personal finances.

Regulation 12: Personal possessions

The inspector found that appropriate arrangements were not in place to support residents to manage their personal finances. The arrangements in place at the time of the inspection did not provide appropriate levels of protection for resident monies. From a review of a sample of residents' financial records, the inspector found that some residents' finances were used on a regular basis to pay for items, such as a television for a shared sitting room, light fittings, wall paint, bulbs and washing detergent despite the organisation's policy clearly stating that such costs were the responsibility of the registered provider and not residents. The inspector found that the organisation's policy 'Supporting Residents' in the Management of their Monies and Property in the Intellectual Disability Service' (dated 18 August 2021) was not implemented in practice in this centre. The inspector found that there was significant use of shared receipts for residents and an absence of receipts for a considerable number of transactions in the accounts of residents which were reviewed by the inspector. In the case of one resident, the inspector found that there were no receipts available for some expenditures of their personal money.

Judgment: Not compliant

Regulation 13: General welfare and development

While the resident group were provided with some opportunities to recreate and partake in activities, the inspector found that these were primarily centre and campus-based and did not provide for sufficient opportunities for residents to engage in community-based activities in accordance with their interests, capacities

and abilities. For example, there was limited supports in place for residents to develop and maintain personal relationships and links with the wider community in accordance with their wishes. The inspector reviewed a sample of three residents' 'activity records' and found that in total these residents had left the campus on 10 occasions in a one month period (one resident on three occasions, a second resident on three occasions and a third resident on four occasions). Three of these off campus activities involved the resident being brought for a "drive".

Judgment: Not compliant

Regulation 17: Premises

The premises of the centre were found to be very clean, spacious and well maintained throughout. There was sufficient provision of private and communal accommodation and the centre provided for a comfortable living environment for residents. Overall, the premises of the centre were found to meet the individual and collective needs of the residents through its design and layout, however, the inspector found that the external areas of some units of the centre required painting and upkeep.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found that there was a risk management policy in place (dated 15 May 2015) which contained the information required by the regulations. There was a risk register in place which outlined all assessed risk and control measures in place to manage these. The inspector found that a risk relating to the use of an evacuation sheet for residents in the event of a fire had not been considered as a risk and as a result was not appropriately assessed or managed.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The inspector found that the staff team were wearing personal protective equipment (PPE) in line with public health guidance and there were sufficient hand sanitising stations in the centre. There were good levels of PPE available in the centre and there was a COVID-19 outbreak management plan in place.

Judgment: Compliant

Regulation 28: Fire precautions

There was a fire alarm and detection system in place in the centre along with appropriate emergency lighting. There were personal emergency evacuation plans in place for each resident which clearly outlined the individual supports required in the event of a fire or similar emergency. There was evidence to demonstrate that residents and staff members could be evacuated from the centre in a timely manner in the event of a fire. The inspector found, however, that one emergency egress route was partially blocked with large bins and a number of fire containment doors were not closing when tested. In addition, the inspector found that specific training had not been provided for the staff team regarding the use of evacuation sheets which formed part of the evacuation plan for at least one resident.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that there were suitable and safe practices in place for the management of medication. A sample of administration and prescription records were reviewed and it was found that all required documentation had been completed. Medication prescribed to residents had been administered and there was appropriate systems in place for the safe disposal of spoiled or out of date medication. PRN (as the need arises) prescriptions stated the circumstances for the administration of PRN medicines and the maximum dosage in 24 hours was stated. There were completed capacity assessments on file for residents regarding the self-administration of medication.

Judgment: Compliant

Regulation 8: Protection

The inspector found that the registered provider and the person in charge demonstrated a high level of understanding of the need to ensure the safety of residents availing of the services of the centre. Residents told the inspector that they felt safe living in the centre. The staff team were aware of the various forms of abuse and the actions required on their part if they ever witnessed, suspected or had allegations of abuse reported to them.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for A2 OSV-0005387

Inspection ID: MON-0031292

Date of inspection: 31/08/2021

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge will conduct a review of the dependency levels of the residents. The staffing will reflect the needs of the residents to include appropriate skill. The provider will continue to recruit to expand the relief panel of familiar staff specific to the centre in order to facilitate Annual Leave for staff that has built up during the pandemic. The Person in Charge will ensure suitable allocation of staff across the centre at the appropriate times.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge will continue to monitor the training tracker to ensure that it is up to date. Staff will be scheduled in advance of mandatory training expiring. Outstanding staff member booked to complete Aed/BLS on the 04.10.2021	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The service provider will ensure that appropriate staffing levels are in place to meet the needs of residents based on dependency levels and assessed needs. The PIC will ensure that a system will be put in place to track safeguarding plans which will be available locally in the centre. The complaints log will be updated to include a full description of the complaint.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: PIC will ensure that staff are familiar with and adhere to the organization's Policy "Supporting residents in the Management of their Monies and Property in Intellectual Disability Service". Shared expenses book has been discontinued; individual financial records are in place. Robust conciliation system is in place with weekly review by PIC.	
Regulation 13: General welfare and development	Not Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The PIC ensures that the residents interests checklist are updated to reflect their assessed needs and their wishes and the supports that they require. According to the residents interests and capability the PIC/SCTL together with the MDT will develop a plan that ensures regular community engagement. This plan will be monitored by the ADONID.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A plan to redecorate the exterior of the Bungalows had already commenced. This plan	

will be completed by 31/10/2021.

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Use of Ski evacuation mat assessed and currently included on the centre's Risk register. All staff have been trained on the use of the ski sheet.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A review of all fire doors has taken place and where required; remedial works have taken place to resolve the issues identified. Daily checks of fire doors will be completed by the PIC. All staff completed training in use of Ski evacuation mat. Bins removed from identified Fire exit. Fire exits daily checks in place by the PIC to ensure that they are free from obstacles.	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/10/2021
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/10/2021
Regulation	The registered	Not Compliant		31/10/2021

13(2)(b)	provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.		Orange	
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/11/2021
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	31/12/2021
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	Not Compliant	Orange	31/12/2021

	than full-time basis.			
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.	Substantially Compliant	Yellow	31/10/2021
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.	Substantially Compliant	Yellow	31/10/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/12/2021
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	Not Compliant	Orange	31/10/2021

	and effectively monitored.			
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.	Substantially Compliant	Yellow	31/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2021
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 and bringing them to safe locations.	Not Compliant	Orange	30/09/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting	Not Compliant	Orange	30/09/2021

	equipment, fire control techniques and arrangements for the evacuation of residents.			