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:	The Hollow
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	25 April 2022
Centre ID:	OSV-0002478
Fieldwork ID:	MON-0036803

About the designated centre

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

The Hollow is a full-time residential service that can provide care and support for five adults with an intellectual disability. The house is a bungalow that comprises: five bedrooms, two bathrooms, one en-suite, two sitting rooms, a kitchen/dining area, and a large garden to the rear of the house with tarmac and a large lawn at the entrance of the house. The house is located between two nearby towns in Co Westmeath. Residents have access to local amenities such as shops, restaurants, bars, and cafes. Residents receive support on a twenty-four-hour basis from a team of staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 25 April 2022	10:15hrs to 17:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspector was introduced to the two residents, while interactions were brief they appeared happy. Both were receiving one-to-one support from staff members. Residents were interacted with in a caring and considerate manner. There was also evidence of, where possible, residents being supported to maintain links with family.

The residents throughout the day engaged in activities outside of their home, going for walks, to the barbers, and attending medical appointments.

The living arrangements were organised so that each resident had their own living space and kitchen. The inspector observed that the residents' home was suitably clean and that improvements to the premises had been completed since the previous inspection in December 2021.

Residents moved freely throughout their home. One resident was observed to relax in their sitting room, while the other resident was listening to music in their bedroom, which was their preferred activity. Residents were being supported in a manner that respected their views and wishes. There were pictures of recent outings, such as visiting religious sites and other landmarks displayed in the centre. The inspector also observed positive interactions between the residents and those supporting them.

As mentioned earlier, this service was previously inspected in December 2021. That inspection found that the service being provided to the two residents was not appropriate. There was a need for significant enhancements to the management and monitoring of the service provided.

Overall, this inspection found that improvements had been made since the December inspection, but the provider failed to address all of the required improvements fully. The inspector found that enhancements were required across nine of the fourteen regulations that were reviewed.

For example, the provider had failed to address issues with the premises that had been first identified in a 2020 inspection. Furthermore, the provider failed to fully respond to actions regarding infection prevention and control practices identified in the December 2021 inspection. As mentioned earlier, the provider had begun to make improvements, but these had yet to have the necessary impact to ensure that all areas were compliant with the regulations.

The following two sections of the report present the findings of this inspection about the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection found that the provider had changed the management arrangements as per the December 2021 compliance plan. A new person in charge was recently appointed to the role. This person in charge, unlike their predecessor, was solely responsible for the running of this service and was based on-site. This change to the management arrangements was introduced to ensure that the service being provided to the residents was being appropriately monitored. The new person in charge had only recently begun their role. While there was evidence that the provider had taken steps to address the areas of concern, they had yet to implement a management system that consistently focused on ensuring the best possible service was provided to each resident. There was evidence of completed audits that identified areas that required improvement. However, the reviews of information found that some actions had not been completed, such as updating both residents' personal plans.

An appraisal of residents' information found that residents had not been provided with updated contracts of care following their move to their current home in 2021. There were contracts of care on file, but these reflected the residents' previous living arrangements. The regulatory requirement is that a resident is furnished with a contract of care on admission to a service. One of the residents had lived in the service for twelve months without being provided with an updated contract.

This inspection found that there continued to be an issue with the maintenance of residents and the provider's records. Throughout the inspection, the inspector found that large volumes of information in residents' files were not relevant to their current living arrangements and required archiving. Furthermore, an appraisal of the provider's written policies and procedures found that the provider failed to review some of the policies and procedures in line with the three year review period as per the regulations.

The person in charge had ensured a planned and actual roster was available for review. An appraisal of the roster showed that the provider relied heavily upon the usage of agency staff nurses to ensure that the skill mix of the staff team was appropriate. The staff team comprised staff nurses and care assistants. The current and previous rosters review demonstrated that the residents were receiving continuity of care as there was a consistent staff team in place despite the reliance on agency staff.

The inspector also found that improvements were required to staff training and development for full-time and agency staff members. In regard to full-time staff it was found that basic life support training was outstanding for two staff and fire safety training for another staff member. The provider had not identified this prior to the day of the inspection. The inspector notes that a member of the provider's senior management team and the person in charge informed the inspector before the end of the inspection that the training had been arranged for the three staff

members.

The person in charge did not have access to the agency staff members training records during the inspection. Agency staff training records were submitted in the days following the inspection. An appraisal of these found that one agency staff nurse required basic life support training, positive behavioural support training, and fire training. Positive behavioural support training was also required for one agency health care assistant. The provider supplied confirmation that training had been booked for the two staff members. However, prior to the inspector's requests, the provider and person and charge were unaware that these staff members required the training. There were, therefore, improvements required to ensure that staff training and development were prioritised.

Regulation 15: Staffing

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

Judgment: Compliant

Regulation 16: Training and staff development

The review of staff training records found that there was outstanding training for members of the staff team.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had established and maintained a directory of residents. The directory contained the information as per the regulations.

Judgment: Compliant

Regulation 21: Records

The inspection found that the arrangements for maintaining and updating records

were not appropriate.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the existing management arrangements had not been effective in addressing actions that had been identified via audits and reports. There were also improvements required to ensure that there were appropriate oversight arrangements in place that ensured that the best possible service was provided to each resident.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The provider had not furnished either resident with an appropriate contract of care as per the regulations.

Judgment: Not compliant

Regulation 4: Written policies and procedures

While there were written policies and procedures, the inspector found that the provider had not ensured that all policies and procedures had been reviewed within three years as per the regulations.

Judgment: Substantially compliant

Quality and safety

The inspection found that the centre was operated in a manner that promoted and respected residents' rights. Residents were, when possible, engaging in activities of their choosing and were being supported to develop and maintain links with the broader community. However, as mentioned earlier, there were a number of areas that required attention and improvement.

The provider had begun to address the issues with the premises. A new kitchen had been installed since the 2021 inspection, painting had been completed in some areas, and there was a more homely feel to the centre following the improvements. However, the provider had yet to address issues with the flooring. As discussed earlier, this had been identified as an area that required improvement in the 2020 and 2021 inspections. There was damage to the flooring surface in hallways and one of the resident's sitting rooms. This further demonstrated that improvements were required to ensure that identified actions were being appropriately addressed.

The inspector found that improvements had been made regarding the cleanliness of the residents' home. The cleaning recording systems had been improved, and the person in charge intended to make further enhancements. There was a contingency plan to guide the staff team on how to react and respond to residents in the event of a suspect, confirmed or outbreak scenario. While this was in place, all aspects of the plan did not reflect current guidance. There was information available to staff members regarding infection prevention and control, but again there was a need to ensure that the information reflected current guidance.

The review of staff training records demonstrated that the staff team had completed relevant infection prevention and control training. There were also arrangements for the provider's Infection prevention and control lead to meet with the staff team regarding their roles and responsibilities.

The inspector found three handrails in residents' bathrooms that required replacing. The surfaces of the handrails had been damaged and, in some areas, were rusting. This meant that the surfaces could not be appropriately cleaned. The provider had given assurances that these handrails had been replaced following the 2021 inspection, but this had not been completed. The inspector notes that two handrails were sourced and replaced during the inspection and that the third was removed. However, the provider had not responded to the identified actions within their own timeframes.

The provider and person in charge had, for the most part, assured that appropriate fire precautions had been implemented. Regular fire drills were taking place, and these demonstrated that the residents and those supporting them could safely evacuate the premises under day and night scenarios. The inspector found that fire containment measures were appropriate and that the fire detection system was reviewed quarterly. Weekly checks were being completed, but it was found that these required improvements as they did not identify that two fire extinguishers had not been serviced within an appropriate timeframe. They were last serviced in September 2020. The inspector notes that all other extinguishers and fire blankets had been serviced in October 2021.

The provider had ensured an appropriate risk management policy was in place as per the regulations. The review of risk management information specific to this service demonstrated that there had been a period where there was not an ongoing review of potential and actual risk. The inspector notes that there had been changes to this practice in recent weeks and that there had been a significant review of existing risk assessments and the establishment of new risk assessments to guide

those supporting residents. The inspector found that there were inconsistencies regarding the review and updating of residents' individual risk assessments but that overall improvements had been made.

The inspector reviewed the resident's individual assessments and personal plans. It was again found that there were inconsistencies between the two residents' information. For example, one resident had been supported to identify and achieve personal goals, whereas there was no documentation to demonstrate that the other resident had been supported. As mentioned earlier, there were pictures of residents engaging in some trips, but enhancements were required to capture the activities and progress residents were making effectively.

The same resident's personal and person-centred plans referred to their previous placement. There were aspects of the personal plan that had been updated since their transition, but there had yet to be a complete overhaul of the document. This issue was identified in the 2021 inspection. The provider stated that the matter would be addressed by 25.01.22, but this was not achieved. Therefore, the provider had failed to ensure that comprehensive assessments of residents' needs had been completed.

In contrast to the above, the inspection found that appropriate positive behavioural supports had been developed for both residents. The residents' behaviours of concern were reviewed regularly, and there were plans to guide the staff team in supporting each resident. These plans focused on identifying and alleviating the cause of the residents challenging behaviours.

The inspection found that the governance arrangements had been changed in recent weeks. There was evidence to show that some positive steps had been taken. However, there had been delays in responding to identified actions. Further enhancements were required across many regulations to ensure that the residents were receiving the best quality service.

Regulation 17: Premises

The inspection found that the provider had failed to ensure that the interior of the premises had been appropriately maintained.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had ensured an appropriate risk management procedure was in place. It was also found that improvements had been made to the review and response to

risk in the service

Judgment: Compliant

Regulation 27: Protection against infection

While the provider had made improvements regarding infection prevention and control measures, they had not responded to all actions identified in the 2021 inspection. The inspector found handrails in residents' bathrooms that had damaged surfaces. This meant that the surfaces could not be appropriately cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

For the most part, fire precautions were appropriate and under review. However, it was found that there were improvements required to ensure that all fire extinguishers were serviced within appropriate timeframes.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspection found that there remained improvements regarding the completion of comprehensive assessments that reflected the current needs of both residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were arrangements in place that ensured that residents had access to positive behavioural; support if required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Hollow OSV-0002478

Inspection ID: MON-0036803

Date of inspection: 25/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A complete review all regular and agency staff training and professional development needs has been completed. All HSE permanent staff have completed all mandatory training as required and these details are recorded and up to date on the training matrix. All agency regular staff have completed all mandatory training and certificates are held in their personnel file in the centre. A quality improvement plan is in place to support each staff member's professional development to support staff in meeting the needs of the profile of residents accommodated. Staff to complete the following HSELAND CPD course: • Person Centered Planning Module 1- 4 • COVID19 Assessment and recognition among people with intellectual disability • Behaviors of Concern and Autism Awareness training • Dysphagia The training matrix will be reviewed on the 1st of each month to ensure oversight of staff training requirements and plan training in advance. Staff training will be reviewed with each staff member during their supervision appraisal meetings in line with the supervision policy of the centre.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All residents care plans and person centered plans have had a full review reflective of their current living arrangements. Behaviour support plans have been updated All contracts of care and Residential agreements have been reviewed and updated accordingly to reflect current contractual obligations for the centre in which resident now	

reside.
The Centre's Covid 19 Contingency plan has been updated and is reflective of current guidelines.
The Centres risk register has been reviewed to ensure it reflects current risks and control measures in place.

A schedule of monitoring reviews has been completed with working timeframes to ensure that all records within the Centre are actively reviewed and updated and maintained to ensure they are available for inspection as required by regulation 21.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The management arrangements have been reviewed to ensure effective governance for the management and oversight of the centre. A new person in charge has been appointed and commenced in post with responsibility only for the centre to ensure there is sufficient time to oversee management practices and effect the required operational changes.

Each resident's file has been reviewed and updated to reflect their current assessed personal, health and social care needs.
Personal plans have been reviewed and updated.
The training matrix is maintained up to date.
Staff supervision appraisal meetings in line with the supervision policy of the centre will take account of training and professional development plans for staff.
Improvement plans with agreed timelines are in place to address all actions from audits.
Contracts of care to define the terms and conditions of occupancy are agreed and in place with each resident.
Policies and procedures are being reviewed and updated to ensure robust arrangements are in place to guide operational, clinical care practice and staff interventions.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
All contracts of care have been updated to outline the terms and conditions of care and support and the fees to be charged. The contracts of care were agreed with the residents with the support of their family members.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Policies and procedures have been reviewed and submitted to the Schedule 5 folder. All staff have read and signed each newly reviewed policy.

A quality improvement plan is in place for the staff team within the Centre to refresh their knowledge of all policies and procedures.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Painting and floor covering throughout the house has a tender in place and will be completed by the 1st July 2022.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: Painting and flooring throughout the center will be complete by the 01/07/2022 Hand rails which were corroded have been removed and new handrails installed where required to support residents. A weekly cleaning audit schedule has been designed specific to the centre to ensure all areas are cleaned according to the frequency and procedures of the centre to mitigate against the risk of infection. New daily cleaning schedules have been designed for the staff team in line with current IPC guidelines. An IPC audit has taken place with the IPC link practitioner with recommendations from the audit completed. The audit has been discussed with the staff team to ensure learning. All equipment and facilitates which are not readily cleanable are currently been reviewed and a plan is in place to replace all items identified to be an infection control hazard or with finishes that are not easily cleanable to be upgraded or replaced. Copies of the current Infection prevention and control guidance from Public Health are available in the centre.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All fire extinguishers have been serviced and are within date of service renewal. All fire practices have been reviewed within the centre to include the weekly fire safety check on extinguishers. The fire safety checks have been discussed with staff to ensure precautionary checks are completed in line with Centre's fire procedures.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: All resident's care plans and person centered plans have been updated.	

Each plan will be reviewed monthly.
Documenting within personal plans has been reviewed and standard templates are available for staff to record progress and outcomes in a consistent manner to evidence progress achieved by residents.

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 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	26/05/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	01/07/2022
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the	Substantially Compliant	Yellow	13/05/2022

	chief inspector.			
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	30/06/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	18/05/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	01/07/2022
Regulation	The registered	Substantially	Yellow	09/05/2022

28(2)(b)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	20/05/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	13/05/2022
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required	Substantially Compliant	Yellow	09/05/2022

	to maximise the resident's personal development in accordance with his or her wishes.			