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:	Hayden's Park Way
Name of provider:	Peter Bradley Foundation CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	17 January 2024
Centre ID:	OSV-0005602
Fieldwork ID:	MON-0034728

About the designated centre

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

Hayden's Park Way is a designated centre operated by Peter Bradley Foundation Company Limited by Guarantee. The centre is a four bed residential neuro-rehabilitation service located in Co. Dublin. All residents are over the age of 18 years of age and the maximum number of people that can be accommodated is four. Hayden's Park Way is in a location with access to local shops, transport and amenities. The centre provides single occupancy bedrooms, bathrooms, sitting room, kitchen and garden space is provided for the residents. The service is managed by a person in charge and a team leader. There is a team of Neuro Rehabilitation Assistants to support residents according to their individual needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 January 2024	10:00hrs to 12:45hrs	Jennifer Deasy	Lead
Thursday 18 January 2024	10:45hrs to 16:45hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection, scheduled to inform decision-making in respect of the provider's application to renew the centre's certificate of registration. The inspection took place over two days. On the first day, the inspector attended the designated centre, met with residents and staff and completed a walk-around of the premises. On the second day, the inspector attended the provider's head office and reviewed paperwork relating to the centre. Overall, the inspector found that residents were comfortable in their home and were happy with the supports that they received from the staff team. However, enhancements were required to the oversight of the centre at the provider level. In particular, a review was required of the management of risk and of residents' care plans to ensure that they were comprehensive and clearly guided staff in how to best meet residents' assessed needs.

On arrival to the centre, the inspector noted that it was clean, warm and homely. Residents had their own individual bedrooms which were decorated in line with their preferences. They also had access to a communal kitchen, utility, living room and two bathrooms. These were seen to be clean and well-maintained. A large back garden was welcoming and provided additional facilities for recreation through the use of a garden room.

It was evident that the provider had addressed previously identified risks in respect of infection prevention and control. The inspector saw that there were adequate hand hygiene facilities throughout the house and appropriate systems in place for the safe management of linen and laundry.

The inspector had the opportunity to meet with two of the residents who lived in this house. Residents told the inspector that they were very happy with the care and support that they received. One resident said that the staff had supported them to build their confidence and develop their daily living skills after they acquired their brain injury.

This resident told the inspector about an alarm system they had in their bedroom. This alarm was used to alert staff in the event of the resident requiring assistance by night due to an assessed health care need. The resident was well-informed regarding this system and spoke about how it was used. They said that the staff respected their privacy by knocking before entering the room even if the alarm had activated. This resident spoke about their goals including getting back to work and described how the staff were supporting them to work towards that goal.

Another resident showed the inspector the menu board that was displayed in the kitchen. They told the inspector about the meals that were planned for the week and the household jobs that each of the residents were responsible for. The resident said that they had plans for the weekend and that there were lots of community

facilities that they could access in their free time.

All four of the residents had completed resident questionnaires for the inspector to review. These questionnaires detailed that the residents were happy with the facilities in the centre, the staff support, the meals and how their rights were upheld.

While the inspector was told by residents that they were satisfied with the quality and safety of care, an issue was identified on this inspection in relation to access to health care services and the management of risk. One resident was temporarily absent from the centre on the day of inspection. This was due to a serious incident that had occurred the week previously. The inspector discussed this incident with the staff and reviewed related documentation. The inspector was not assured that the risk factors for this incident had been appropriately documented and controlled for. This will be discussed further in the next two sections of the report.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspector was not assured that the management systems were effective in ensuring that the service provided was safe and appropriate to meet the entirety of residents' assessed needs. In particular, enhancement was required at provider level to ensure that there were clear structures in place to escalate risk to senior management and to define responsibilities for responding to different levels and types of risk.

Residents in this centre were supported by a familiar staff team who reported to a local team lead and a person in charge. The staff team were in receipt of regular support and supervision through both formal, individual supervision meetings and group staff meetings. The inspector saw that the staff team used staff meetings to highlight concerns regarding the quality and safety of care in the designated centre.

However, when concerns were expressed by staff, there was a failure to escalate serious risk to the provider level and to respond comprehensively to control for the risk. For example, the inspector saw that staff raised concerns at staff meetings from October to December 2023 regarding the changing health needs of one resident. The response from local management was to remind staff of the contact details for the on-call manager should an emergency occur. Staff concerns did not prompt a review of the resident's associated care plans and risk assessments or the introduction of additional controls. The result of this was a serious incident which occurred in January 2024 which had a negative impact on the resident and on the staff and other residents who were in the house at that time.

The inspector also found that the person in charge had not received formal supervision in over 12 months. This was in not in line with the provider's policy time lines for staff supervision. The result of this was that the person in charge did not have a forum through which to discuss the quality of care in the designated centre, to drive service improvement or to seek support and guidance regarding their professional responsibilities.

A review was required by the provider to ensure that there were clearly defined management systems which allowed for the escalation of risk and a comprehensive response to mitigate against these risks.

Registration Regulation 5: Application for registration or renewal of registration

The provider had made an application to renew the centre's certificate of registration in line with the time-frame prescribed by the Regulations. The required fee had been paid. However, some of the prescribed information including the statement of purpose submitted required review in order to ensure that it met the requirements as set out by the Chief Inspector.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The provider had appointed a suitably qualified and experienced person in charge. They had oversight of two designated centres including this one. The person in charge was employed in a full-time capacity.

There were systems in place to support them in having oversight of both designated centres, including the appointment of a local team leader who could act up when the person in charge was not in the centre.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained for the centre. This was reviewed on the day of inspection. There were found to be sufficient staff to meet the needs of the residents and the staffing levels were in line with the centre's statement of purpose.

There was one whole time equivalent vacancy. A small panel of regular relief staff

was used to fill gaps in the roster. This was effective in supporting continuity of care for the residents. Residents spoken with were familiar with both regular and relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was maintained which demonstrated that there was generally a high level of staff compliance with mandatory and refresher training.

Staff were in receipt of regular support and supervision through monthly staff meetings and individualised supervision sessions. Records of these were maintained and were reviewed by the inspector. The content of these was seen to be appropriate to meet the needs of the staff. The inspector saw that staff used team meetings in order to highlight concerns regarding the quality and safety of care.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted a copy of their certificate of insurance along with the application to renew the centre's certificate of registration. The inspector saw that the provider had effected a contract of insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The management structures in this centre required enhancement to ensure that the provider was informed of service-specific risks and could take timely action to address these.

Staff in this centre were supported by a local team leader who reported to the person in charge. The person in charge reported to a national manager who had a large remit, including oversight of all of the provider's designated centres at national level. It was found that the person in charge did not have regular, direct support or supervision from this manager. The impact of this was that there was not a clearly defined system in order to escalate risk to the provider level or a forum through which the person in charge could drive service improvement.

The roles and responsibilities of all managers were not clearly defined and it was not set out how risk should be managed and escalated.

For example, the inspector saw that staff had raised concerns at staff meetings in late 2023 regarding the changing needs of one resident. There was a failure to escalate this risk to the provider level, and to comprehensively update care plans and risk assessments.

The impact of this was that a serious incident occurred in early 2024 which, in spite of identified risk factors, had not been controlled for.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider submitted a statement of purpose along with their application to renew the centre's certificate of registration. The statement of purpose was reviewed in advance of the inspection and was found to require further amendments and clarity regarding the services provided. These amendments were completed by the provider by the time of the inspection.

Judgment: Compliant

Quality and safety

This section of the reports details the quality of the service and how safe it was for the residents who lived there. Overall, the inspector found that improvements were required to residents' care plans and to the management of risk to ensure that the centre was safe and that residents' needs were being met.

Residents spoken with told the inspector that they liked living in the centre and that they felt well supported. The premises was generally clean and comfortable. There was some minor upkeep required to certain aspects of the premises. For example, painting was required in communal areas. The provider had ensured that there were adequate facilities to detect, contain and extinguish fires and had ensured that all residents and staff were familiar with the fire evacuation procedure and could be evacuated in a timely manner.

Staff had received training in positive behaviour support and the inspector saw that there was an up-to-date positive behaviour support assessment on residents' files. These assessments were written by the relevant multi-disciplinary professional and were comprehensive and detailed.

However, on reviewing residents' files, the inspector saw that not all care plans were as comprehensive, detailed or informed by the relevant multi-disciplinary professionals. This resulted in gaps in the quality of care, whereby staff were not fully informed of residents' assessed needs and were unaware of under what circumstances they should refer residents back to multi-disciplinary professionals for a review of their needs and care plans.

Additionally, risk assessments which were implemented in line with residents' assessed needs required review. Some of these risks assessments did not detail comprehensive control measures. One of the risk assessments was seen to be risk rated green or low risk, when in fact, staff had identified that there were changes to residents' needs and that they were presenting with an increased risk. It was not demonstrated that risk assessments were being effectively used to ensure that the service was safe and to control for known risks.

Regulation 17: Premises

The premises was generally clean and homely. The provider had completed upkeep to the kitchen and main bathroom in the last 12 months. These were seen to be well-maintained.

There were adequate storage facilities and all residents had access to their own private bedroom.

There remained painting required to the walls, ceilings and banisters in the centre.

Additionally, a shower chair in a downstairs bathroom was seen to have rusted and required replacement.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk assessments were in place for known risks and were detailed on the centre's risk register. However the inspector saw that some of these risk assessments were not appropriately risk rated. For example, an increase in risk factors for one resident's needs had not prompted a review of the associated risk assessment and an increase in the colour-coding of the risk profile.

Additionally, control measures in risk assessments were insufficiently detailed and staff were not informed of these. For example, when staff informed local management of the changes to a resident's presentation, they were not guided to review risk assessments to ensure that they were familiar with the control measures.

It was not evident that there were effective systems in place to assess, manage and review, on an ongoing basis, risk in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

There were adequate arrangements in place for the detection, containment and extinguishing of fires. All fire equipment was serviced regularly.

Regular fire drills were held which showed that all residents could evacuate in a timely manner. Staff had received fire safety training. Residents' files contained up-to-date personal evacuation plans.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The individual assessment and care plans for two residents were reviewed. The inspector found that, while there was an individualised assessment on residents' files that had been updated within the past 12 months, these assessments were not comprehensive and were insufficiently detailed to guide staff in meeting residents' assessed health care needs.

For example, some health promotion plans had identified that residents had availed of particular health screenings. However, there was no information on the outcome of these screenings or any follow up care required. Another care plan for epilepsy had been identified as "not applicable" however the care plan set out that the resident attended a neurologist and was taking prescribed medication to manage seizures. It was not clear what follow up was required or how staff could ensure that this resident's related needs were managed.

Another resident had accessed health care supports for a particular assessed need in the past. The inspector saw that they had been discharged from this service in 2022 however the discharge letter clearly set out their ongoing needs in this area. The inspector found that care plans for this need were not comprehensive and were insufficiently detailed. The inspector was told by the person in charge that staff were aware of additional measures that they should take to support the resident in managing this need however these measures were not set out in the care plan. Additionally, when there was a noted change to this resident's needs in this area, they were not referred back to the appropriate professionals for a review and updated assessment.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had enhanced their oversight of restrictive practices in this designated centre. Restrictive practices were logged on a restrictive practices register. The inspector saw that these were reviewed regularly by a clinical team. Residents were informed of restrictive practices and there was documented consent to these on their files. Residents spoke about some of the restrictions in the centre and explained to the inspector why they were in place.

Staff had received training in positive behaviour support and were familiar with residents behaviour support assessments which were on their files. These assessments were up-to-date and had been written by relevant multi-disciplinary professionals.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Hayden's Park Way OSV-0005602

Inspection ID: MON-0034728

Date of inspection: 17/01/2024

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**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Statement of Purpose to be updated – Action completed 21/2/24	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Lack of Supervision for PIC and direct support from Senior Management – A 6 weekly schedule of recorded formal supervision has been put in place. The supervision agenda includes risk management and incident reviews. Action commenced 21/2/24 Roles of managers not clearly defined -A full time National Service Manager is now in place who has line management responsibility for the LSM (Person in Charge). Action Commenced on the 21/2/24 Job descriptions and roles of the Person in Charge and the National Service Manager have been reviewed by the Provider and clarified to ensure that all relevant information can be escalated. Action Completed 21/2/24 Full review of resident specific risk assessments and care-plans to be discussed with Clinical Psychologist re client in question and further clinical input will be provided for all changing needs of clients in future to update BSPs – To be completed by 1/3/24 Monthly risk review has been scheduled. The Person in Charge, Team Leader and National Service Manager will meet to review the local Risk Register. Action to commence om the 21/2/24. Review of the PIC training requirements will be completed by 30/06/2024 date to ensure sufficient training and education regarding rights-based approach and risk management.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises:	

Painting works will be completed by the 31/12/2024. Shower chair to be removed or replaced from resident's en-suite due to rusting (IPC concern) – To be completed by 1/3/24	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Full review of risk assessments for service will be done – To be completed by 1/3/24 Monthly risk review has been scheduled. The Person in Charge, Team Leader and National Service Manager will meet to review the local Risk Register. Action to commence on the 21/2/24. The full staff team will be retrained in the recognition and management of resident specific risks. To be completed by the 1/5/24. The National Service Manager will visit the centre bi-monthly and will attend a minimum of 2 team meetings to meet with frontline staff and discuss any current risks or concerns. NSM will attend further meetings on a need's basis. Action to commence on the 21/2/24. The monthly National Services meeting will include a review of any changes in risk ratings or risk management plans. Action to commence from April 2024 meeting onwards.	
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: Review of information on iPlanit system (Person Plan) by the Quality Department to be completed by the 30/4/24 Check list to be put in place to ensure all relevant information needed for the individual plan is recorded on iPlanit. To be completed by the 30/4/24. The Person in Charge, Team Leader and staff team will be retrained in completing the personal plan documentation. To be completed by the 30/4/24 Care plans will be discussed at monthly team meetings and reviewed with the National Service Manager and relevant clinicians– To be completed by 30/4/24	

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	07/01/2024
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	31/12/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the	Not Compliant	Orange	01/03/2024

	designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	01/03/2024
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/06/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	03/04/2024

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	30/04/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	30/04/2024
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall	Not Compliant	Orange	30/04/2024

	be multidisciplinary.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/04/2024