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:	Appleview
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	13 November 2019
Centre ID:	OSV-0001702
Fieldwork ID:	MON-0024835

About the designated centre

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

Appleview is a designated centre operated by Sunbeam House Services CLG, located in an urban area in County Wicklow. The designated centre offers residential services to five adults, male and female, with intellectual disabilities. The designated centre consists of a detached house and an apartment. The house is located in a housing estate and consists of a sitting room, dining room, kitchen, utility room, four individual bedrooms, a staff sleepover room, an office and a number of shared bathrooms. The apartment located on a main street in an urban area consists of kitchen, sitting/dining room, bathroom, staff sleepover room and an individual bedroom. Both the house and the apartment provide residents with a garden space to the rear of the properties. The centre is staffed by a person in charge and social care workers. The person in charge works in a full time capacity and they are also responsible for a separate designated centre. Staff lone work in this centre and the provider has risk management systems to support this arrangement.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
13 November 2019	09:30hrs to 18:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the five residents living in the centre. Overall, the residents spoke positively about living in the centre and the supports they received. The inspector also observed that residents appeared content and comfortable in the centre.

Residents spoke with the inspector about the things that interested them and things they liked to do including their family, sports, hobbies and gaming. One resident spoke about a number of sports they enjoyed and followed, their family and the staff supporting them. Another resident spoke with the inspector about a writing class they attend and the arts and crafts they enjoyed which included making key rings and Christmas cards. Other residents spoke with the inspector about their hobbies such as gardening, TV shows and video games. The inspector observed that residents participated in the running of the house through regular resident meetings.

The inspector spent time in the dining room of the house and observed residents as they prepared to engage with their daily activities which included accessing the community, attending appointments and day services. In addition, the inspector observed residents engaging in various activities in their home such as watching tv, playing video games, accessing the local community independently and preparing meals. Throughout the day of inspection, the inspector observed positive interactions between staff and residents in both locations which included staff discussing plans for the day and talking about the role of the Health Information and Quality Authority and the inspection.

Overall, the inspector observed that the designated centre was decorated in a homely manner. However, some areas of the centre were not kept in a good state of repair. The house comprised of a homely sitting room decorated with pictures of current residents, four individual bedrooms, a kitchen, utility room, dining room and a number of shared bathrooms and toilets. A number of residents showed the inspector their bedrooms which were decorated in line with their tastes and preferences. There was a garden to the rear of the house which included a small shed for storing gardening equipment and another shed which a resident uses as a space to engage in their personal pastimes and hobbies.

The apartment consisted of a kitchen, sitting/dining room which was bright and decorated in a homely manner, bathroom, staff sleepover room and an individual bedroom. There was a large garden and decking area to the rear of the property which was shared with another apartment.

Capacity and capability

While residents appeared content and comfortable in this centre on the day of the inspection, the provider's governance and management arrangements in place required improvement. The governance and management systems did not ensure that the service provided was, at all times, effectively and consistently monitored or adequately resourced to ensure the effective delivery of care and support in line with the assessed needs of residents. This impacted on a number of areas of the quality and safety of the service provided to residents. In addition, the staffing arrangements required review and some improvements were required with notification of incidents.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time person in charge who was appropriately qualified and experienced and demonstrated good knowledge of the residents and their assessed needs. The person in charge was also responsible for the management of another designated centre.

There were quality assurance audits in place including six monthly unannounced provider visits and an annual review for 2018 in line with the regulations. However, some improvement was required in the annual review. For example, it was not evident that the residents and/or their representatives were consulted in the development of the Annual Review 2018. In addition, the provider had failed to make resources available to address areas of the premises which required repair for a prolonged period of time - this is further discussed under Regulation 17. This issue was ongoing at the time of the inspection.

The person in charge maintained a planned and actual roster. The inspector reviewed a sample of rosters which demonstrated that staff lone work in this centre at key times during the day in the morning and evening and on certain days there is a second staff on location. The rosters also demonstrated that 1:1 staffing support was provided in the apartment. It was evident that continuity of care was ensured as any gaps were covered by the use of regular relief staff.

However, the staffing arrangements required review as the provider could not demonstrate, at the time of the inspection, that there was sufficient staffing available to meet some of the assessed needs of residents at all times in the designated centre. For example, some residents were assessed by an allied health professional as requiring additional staff supports at specific times throughout the day. At the time of the inspection, this was not in place at all times.

There were systems in place for the training and development of the staff team. From a sample of files reviewed, the staff team had up-to-date mandatory training which included the safe administration of mediation, people handling and de-escalation and intervention techniques. The person in charge maintained a training schedule which ensured that the staff team had up-to-date knowledge and skills to meet the needs of residents.

The previous inspection identified that that the centre's Statement of Purpose did not include all of the information as required by Schedule 1 of the regulations. This

had been addressed by the provider.

The inspector reviewed a sample of adverse incidents and accidents and found that not all incidents were notified to the Office of the Chief Inspector of Social Services in line with Regulation 31.

Regulation 15: Staffing

On the day of the inspection, the provider could not demonstrate that there was adequate staffing levels in this centre at times to meet the assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for staff training and development. All of the staff team were up-to-date mandatory training. The person in charge maintained a training schedule which ensured that the staff team had up-to-date knowledge and skills to meet the needs of residents.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in place did not ensure that the service provided was effectively and consistently monitored. For example, it was not evident that the residents and/or their representatives were consulted in the development of the Annual Review 2018. In addition, the provider had not ensured that the centre was adequately resourced to ensure for the effective delivery of care and support - for example some areas of the premises required repair for a prolonged period of time.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose included all of the information as required by Schedule 1

of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents were notified to the Office of the Chief Inspector of Social Services in line with Regulation 31.

Judgment: Substantially compliant

Quality and safety

Staff were observed to support residents in a person centred manner at all times over the course of this inspection and residents appeared content and comfortable in their home. However, the governance and management oversight arrangements in place required review as improvements were required in regards fire safety management, risk management, safeguarding and premises. In addition, some minor improvements were required in positive behaviour support and the review of restrictive practices.

The inspector completed a walk though of the designated centre. Overall, the designated centre was decorated in a homely manner. However, some areas of the centre were not kept in a good state of repair. For example, a shower area was identified as requiring urgent repair by an allied health professional in February 2019. While this issue was on the risk register and was identified in the health and safety audit carried out in September 2019, this issue remained ongoing at the time of the inspection.

The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. However, the systems in place for the containment of fire and evacuating all persons, in the event of a fire, required review.

The inspector observed a number of fire doors being held open by door wedges, flower pots and furniture. This practice impacted on the effectiveness of the doors to contain fire and smoke. The inspector verbally instructed the person in charge to immediately remove the door wedges and other items, this immediate action was addressed by the person in charge and provider on the day of the inspection, as observed by the inspector. The provider was required to ensure fire compliant measures were in place which would allow fire doors to remain open without impacting on their containment effectiveness.

In addition while, there was evidence of fire drills and regular discussions with residents regarding fire safety, improvements were required to ensure the safe and timely evacuation of all persons in the designated centre in the event of a fire.

There were systems in place to identify, assess and review risk and the provider maintained a risk register which outlined general risks. In addition, individual personal risk assessments were in place in relation to management and prevention of slips, trips and falls and management of behaviours that challenge. In the most part, the inspector found that risk was well managed in the designated centre. However, the inspector found that some risk assessments did not accurately reflect the controls in place to manage identified risks. For example, as noted above under Regulation 15: Staffing, some residents were assessed by an allied health professional as requiring additional staff support to mitigate a risk at specific times. These supports were not in place at the time of the inspection.

The inspector reviewed a sample of residents' personal files and found that an up-to-date assessment of need had been completed for each resident. The assessment of need comprised of personal plan assessment and a heath and well being assessment. The assessments identified residents' health and social care needs and informed the residents personal plan. The personal plans reviewed were up-to-date and guided the staff team in supporting residents with their assessed needs. However, as outlined under Regulation 15: Staffing and Regulation 26: Risk Management, it was not evident that the provider had adequate arrangements in place at times to meet some of the assessed needs of each resident.

There were positive behaviour supports in place for residents where required. The inspector reviewed a sample of the positive behaviour support plans and found that they were up-to-date and guided the staff team in supporting residents to manage their behaviour. However, some minor improvement was required in a positive behaviour support plan reviewed. While there was a PRN (as required) medication protocol in place to guide staff, it was not suitably linked to a behaviour support plan. Residents were supported to enjoy their best possible mental health and, where required, had access to psychiatry and psychology. There was a small number of restrictive practices in use in the designated centre. While the restrictions had been identified and reviewed by the person in charge, the restrictions were not reviewed by the provider's Human Rights Committee in a timely manner.

Residents told the inspector that they were happy in the centre and were observed to appeared comfortable in their home. However, the systems in place for safeguarding residents required review. For example, the inspector reviewed a sample of adverse incidents occurring in the centre and while they were responded at a local level, they were not reviewed/investigated in line with the National Policy for Safeguarding Vulnerable Adults.

The previous inspection identified that improvements were required in the information included in the residents guide in line with Regulation 20. The inspector reviewed the resident guide and found that this had been addressed.

Overall, residents reported that they were happy with the service provided and

appeared content in their home. However, the governance and management arrangements in place required review as improvements were required in fire safety management, risk management, safeguarding and premises. In addition, some minor improvements were required in positive behaviour support and the review of restrictive practices.

Regulation 17: Premises

The premises were decorated in a homely manner. Some areas of the centre were not in good state of repair.

Judgment: Substantially compliant

Regulation 20: Information for residents

The resident guide contained all of the information as required by Regulation 20.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to identify, assess and review risk. The provider maintained a risk register which outlined general risks and individual risks. However, some risk assessments did not accurately reflect the controls in place to manage identified risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The arrangements in place for the containment of fire required improvement as a number of fire doors were observed being held open. This practice negated the function of the fire door in the event of a fire. In addition, improvements were required in ensuring the evacuation of all persons in the designated centre in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An up-to-date assessment of need had been completed for each resident which comprised of personal plan assessment and a heath and well being assessment. These informed the personal plans which were up-to-date and guided the staff team in supporting residents with their assessed needs. However, it was not evident that the provider had arrangements in place to meet the assessed needs of each resident.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were positive behavioural supports in place for residents where required. Residents were had access to psychiatry and psychology as required. However, some minor improvement was required in a positive behaviour support plan reviewed to suitably guide staff in the use of a PRN (as required) medication in response to behaviour.

There was a small number of restrictive practices in use in the designated centre. While the restrictions had been identified and reviewed by the person in charge, the restrictions were not reviewed by the provider's human rights committee in a timely manner.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place for safeguarding residents. However, while incidents were reviewed and responded at a local level, some adverse incidents were not reviewed/investigated in line the National policy for safeguarding vulnerable adults.

Judgment: Not 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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Appleview OSV-0001702

Inspection ID: MON-0024835

Date of inspection: 13/11/2019

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: Staffing review will be undertaken to provide safe and effective support to residents assessed needs in relation to clients with SALT assessments when in the home/ community, and also in relation to additional supports in the home for safety reasons to ensure client relationships and supports are paired to safeguarding needs. Staffing rota to be adjusted to provide supervision during all meal times and times where client interaction has been assessed as requiring home supervision for safeguarding reasons. To be completed by December 31st 2019.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 6 month internal reviews will be timely and annual reviews will include that the residents and or their representatives be consulted. Maintenance to be completed in relation to work needed in the bathroom and back wall and floor vent to prevent trip hazard. Also painting and décor to be addressed. To be completed by June 30th 2020.	
Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Notification of incident to be submitted into HIQA and preliminary screening submitted to National Safeguarding Committee. To be completed by 23 December 2019

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Areas of the premises that are not in good state of repair to be addressed by maintenance. Minor capital work for costings has been submitted for funding (bathroom) and wall in garden for repair/ vent in hall to be repaired as it is a trip hazard. Painting to improve home décor. To be completed by June 30th 2020	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk assessments and safety plans will be reviewed to check the effectiveness and to accurately reflect identified client needs and control measures required to ensure safety in areas of SALT assessments and safeguarding resident interactions in the home. Staffing rota to be adjusted to provide supervision during all mealtimes and times where client interaction has been assessed as requiring home supervision for safeguarding reasons. To be completed by December 31st 2019.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All fire doors to be kept closed (complete). Monthly fire drills to be carried out monthly to ensure necessary understanding of active participation and evacuation. PEEP for client who requires additional support and involvement in fire evacuation drills to be undertaken. Deep sleep evacuation to be competed. Door guards to be installed in the doors where required (radio controlled for containment). To be completed by January 31st 2020	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Staffing review to be undertaken to effectively assess the needs of each resident in areas of SALT assessments and safeguarding to ensure control measures are in line with accurate risk identification and to monitor current safety plans. To be completed by 31st December 2019.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PBSP has been updated to include information to guide staff in the use of PRN (as required) medication in response to behavior. HRC will review all rights restriction to be completed by January 31st 2020	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Incident of safeguarding to be submitted to HIQA and National Safeguarding Committee . To be completed by 23 December 2019.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	31/12/2019
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	30/06/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the	Not Compliant	Orange	30/06/2020

	effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	30/06/2020
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	31/12/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	13/11/2019
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	31/01/2020
Regulation	The person in	Not Compliant	Orange	23/12/2019

31(1)(f)	charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2019
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	10/12/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of	Not Compliant	Orange	23/12/2019

	abuse and take appropriate action where a resident is harmed or suffers abuse.			