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:	Helensburgh
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	04 December 2019
Centre ID:	OSV-0001703
Fieldwork ID:	MON-0024964

About the designated centre

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

Helensburgh is a designated centre operated by Sunbeam House Services CLG located in a small town in Co. Wicklow. It provides a full-time community residential service for up to six adults (male or female) with a disability. The centre is a two storey house which consists of seven individual bedrooms, office, sleepover room, a sitting room, dining room/kitchen, a number of shared bathrooms and utility room. The centre is managed by a full-time person in charge who also has responsibility for a day service. The centre is staffed by social care workers.

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
04 December 2019	10:00hrs 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 on the day of the inspection.

Overall, the residents spoke positively about living in the centre and the supports they received. Some residents chose to sit with the inspector and others chose not engage with the inspector. The inspector observed all residents appearing content and comfortable in the centre.

The inspector spent some time in the kitchen/dining room and in the sitting room and observed residents as they prepared to engage with their daily activities which included accessing the community, attending appointments and day services. The inspector also observed residents engaging in activities of daily living such as enjoying their dinner, watching TV, listening to the radio and spending time in their bedroom. Residents who spoke with the inspector told them about the things they liked including recent holidays, their family, movies and music. Throughout the day of inspection, the inspector observed positive interactions between staff and residents.

Overall, it was observed that the designated centre was decorated in a homely manner. However, some areas of the centre required some upkeep. For example, there were areas of plaster and paint in the kitchen which required attention. The inspector completed a walk through of the house guided by a resident and staff. The house consisted of seven individual bedrooms which were decorated in line with residents' tastes and preferences, office, sleepover room, sitting room, dining room/kitchen, a number of shared bathrooms and utility room. There was a well maintained garden to the rear of the house.

Capacity and capability

Overall, there were governance and management arrangements in place to ensure that the service provided was of a good quality. However, the management systems in place to ensure the service was safe and effectively monitored required improvement.

There was a defined management structure in place. The centre was managed by a full-time person in charge who reported to the Senior Client Service Manager, who in turn reported to the interim Chief Executive Officer. The person in charge was suitably qualified and experienced and demonstrated good knowledge of the residents and their needs. There were quality assurance audits in place which included an annual review for 2018 and the six-monthly unannounced provider visits

as required by the regulations. These audits identified areas for improvement and there was evidence of action plans being implemented to bring about improvement to the service. However, improvement was required to ensure the six-monthly unannounced provider visits were completed in a timely manner in order to be in compliance with regulation 23. For example, the last two six-monthly provider visits available on the day of the inspection were dated June 2019 and October 2018. The provider informed the inspector that a recent unannounced visit had been conducted and a report was drafted.

The management systems in place to ensure the service was effectively monitored also required improvement. For example, while it was evident that adverse events were reviewed by the person in charge, the oversight of all incidents required improvement to ensure that all potential safeguarding issues were identified in a timely manner, and managed in line with the provider's and national policy. The inspector was informed that the provider had recently engaged with the community safeguarding team to discuss safeguarding concerns and this was a positive action. However, there was an absence of the formal reporting mechanisms being used along with screening tools to determine if cause for concern existed at an earlier stage.

The person in charge maintained a planned and actual staffing roster. A review of the roster demonstrated that there was sufficient staffing levels in place to meet the assessed needs of the residents. In addition, continuity of care was maintained by covering shifts with a small number of familiar staff. Staff spoken with demonstrated a good knowledge of the residents and their needs and preferences.

There were systems in place for training and development of the staff team. From a review of a sample of training records, the inspector found that the staff team were up-to-date in mandatory training which included fire safety, safe administration of medicine and safeguarding. In addition, there was evidence that refresher training was scheduled to ensure that the staff team had up-to-date skills and knowledge to meet the assessed needs of residents.

Regulation 15: Staffing

The person in charge maintained a planned and actual staffing roster. There was sufficient staffing levels in place to meet the assessed needs of the residents and there was evidence that continuity of care was maintained.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for training and development of the staff team. The

staff team were up-to-date in mandatory training.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not ensure the care and support available was effectively monitored at all times.

Quality assurance audits were in place which identified areas for improvement and developed action plans to address these areas. However, improvement was required to ensure the unannounced provider visits were done on a six-monthly basis in order to be in compliance with Regulation 23.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all adverse incidents were notified to the Chief Inspector of Social Services as appropriate.

Judgment: Not compliant

Quality and safety

While on the day of the inspection the residents appeared relaxed and comfortable in their home, the oversight of safeguarding issues required improvement. In addition, some improvements were required in personal plans, risk management and premises.

Residents told the inspector that they were happy in the centre and were observed to appear comfortable in their home. However, the systems in place for safeguarding residents required improvement. The inspector reviewed a sample of adverse incidents which showed the behaviour of some residents causing upset and anxiety for others. These adverse incidents had resulted in some safeguarding concerns which were impacting negatively on the residents' quality of life. There was evidence that these incidents were reviewed and responded to at a local level by reviewing of residents' daily routines and environment, staff promoting residents' safety, referrals to allied health professionals and discussions at staff meetings. The provider informed the inspector that they had recently engaged with the community

safeguarding team to discuss safeguarding concerns. However, there was an absence of any formal safeguarding plans in line with the provider's safeguarding policy and the national policy, to guide staff and the oversight of safeguarding issues required improvement.

The inspector reviewed a sample of personal plans and found that each resident had an up-to-date assessment of need in place which consisted of a personal plan assessment and a heath and well being assessment. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. From a sample of plans reviewed, the inspector found that the plans in place were up-to-date and guided staff to support residents with identified needs. However, it was not evident that a plan was in place to support residents with each identified need. For example, supporting a resident to manage their cholesterol and hypertension.

Residents health care needs were managed to an adequate standard. All residents had received an annual health check by their General Practitioner (GP). Residents were supported to manage their health care conditions and had regular access to appropriate allied health professionals. Residents were also supported to avail of community health services and attend hospital appointments as required.

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The inspector reviewed a sample of behaviour support plans and found that they were up-to-date and contained appropriate information to guide the staff team. Residents had access to allied professionals such as psychiatry and psychology as required. On the day of inspection, there were no restrictive practices in use in the centre. In addition, there was evidence of previous restrictive practices being reviewed and removed were appropriate.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre specific risks including medication, behaviour and slips, trips and falls. In addition, individual risk assessments were in place for risks including choking, behaviour and fire safety. Overall the inspector found that risks were being identified in the centre. However, it was not evident that all identified risks had an up-to-date risk assessment in place.

The designated centre was decorated in a homely manner. However, some areas of the centre were observed to require attention. For example, areas of paint and plaster in the kitchen required upkeep. The previous inspection identified areas for improvement in relation to infection control. The inspector found that this had been addressed by the provider. On the day of the inspection, staff demonstrated knowledge of the infection control procedures, appropriate equipment was available and the infection control policy was updated in August 2018.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a Personal

Emergency Evacuation Plan (PEEP) in place which outlined the supports for each resident to evacuate the designated centre. There was evidence of regular fire drills and regular discussions with residents regarding fire safety.

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines. Medication was found to be stored in a secure locked press. A sample of prescription and administration sheets were viewed and found to contain appropriate. information. There was evidence that the provider consulted residents in relation to self administering medication and they expressed the preference for the staff team to continue to provide support in the administration of medication.

Overall, residents appeared comfortable and relaxed in their home and staff were observed to support residents in a person-centred manner over the course of this inspection. However, the management systems in place to ensure that the service is safe and residents are safeguarded in line with the provider's policy required improvement. In addition, improvements were required in notification of incidents, personal plans, risk management and premises.

Regulation 17: Premises

The designated centre was decorated in a homely manner. However, some areas of the centre were observed not kept in a good state of repair.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Overall the inspector found that risks were being identified in the centre. However, it was not evident that all identified risks had an up-to-date risk assessment in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The infection control policy was updated in August 2018. Staff demonstrated knowledge of the infection control procedures and appropriate equipment was available.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place. There was evidence of regular fire drills and adequate arrangements in place for the evacuation of residents in the event of a fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable practices in place in relation to the ordering, storage, administration and disposal of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need in place which consisted of a personal plan assessment and a heath and well being assessment. The personal plans in place were up-to-date and guided staff to support residents with identified needs. However, it was not evident that a plan was in place to support residents with each identified need.

Judgment: Substantially compliant

Regulation 6: Health care

Residents health-care needs were managed to an adequate standard. Residents were supported to manage their health care conditions and had regular access to appropriate allied health professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The behaviour support plans were up-to-date and contained appropriate information to guide the staff team. Residents had access to allied professionals such as psychiatry and psychology as required.

On the day of inspection, there were no restrictive practices in use in the centre.

Judgment: Compliant

Regulation 8: Protection

The systems in place for safeguarding residents required improvement. It was not evident that adverse incidents were managed in line with the provider's safeguarding policy and the national policy on 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Helensburgh OSV-0001703

Inspection ID: MON-0024964

Date of inspection: 04/12/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Safeguarding Prelims have been submitted to HSE (19/12/19) and notifications will be submitted to HIQA by 14/01/2020. Staff have been reminded to report incidents of suspected abuse into electronic reporting system (CID), to be reviewed and actioned as safeguarding (where appropriate) by the PIC. The importance of reporting safeguarding concerns will be discussed at the next staff meeting on the 12/02/2020. The PIC has invited a Social Worker to the staff meeting to discuss safeguarding with the team on the 12/02/2020. Individual Keyworking sessions are scheduled with residents to discuss safeguarding, being safe and the importance of reporting incidents. The unannounced provider six-monthly visit had started on the 29th of November and was completed on the 02nd of December. The report was not available on the day of the inspection. The report of this unannounced visit will be forwarded with this action plan.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: In compliance with regulation 31 all future adverse incidents will now be reported to the Chief Inspector of Social Services within the appropriate time frame. This includes the notices and the quarterly returns.	

All incidents not reported will be reported by 14/01/20 All quarterly returns not submitted will be in place by 16/01/20.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Filling and painting of the affected areas and the fitting of additional strips to protect the wall will be completed by 31/03/20.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Further risk assessments have been completed and current risk assessments have been reviewed and updated. Where appropriate support Plans have been updated.

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:
The care/support plan templates for the company are being reviewed to include space for an assessment of the effectiveness of the plan. This addition will ensure the focus of the plans are more closely aligned to beneficial outcomes for the individual and not just the maintenance of the plan.

Additional care/support plans have been developed for the items highlighted during the inspection.

A full review of all assessments of need will take place for all residents by the 29/02/20. From this care/support plans will be developed and/or updated as required.

PPIM will review these actions with PIC during Bi-Monthly Supervision and Governance sessions.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Incidents will be reported to HSE Safeguarding in line with Company and national guidelines.

Company and national safeguarding policy to be discussed at the next staff meeting. Appropriate and timely reporting of adverse incidents to HIQA and HSE Safeguarding to happen from now on.

Safeguarding plan.

• Four residents have positive behaviour support plans in place.
• Residents are encouraged and supported to have positive interactions.
• Staff have MAPA training.
• After analysis of the timing of incidents, weekly timetables and daily routines have been adjusted to reduce the likelihood of negative interactions.
• Mealtimes are staggered to reduce the chance of negative interactions.
• A second sitting room is being made available by 31/01/2020.
• Suggestions and recommendations from Psychologist are being implemented
• Supports from the Social Work department are in place.
• Support from Counsellors in place for residents.
• Residents encouraged (successfully) to explore activities they had shown an interest in, but, were initially reluctant to proceed for various reasons.

All the above appear to have had a positive impact upon the individuals in the location and consequently their interactions have improved. The interactions are monitored, and further changes/adjustments will be implemented where possible.

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 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	31/03/2020
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	12/02/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit	Substantially Compliant	Yellow	29/11/2019

	to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	20/12/2019
Regulation 31(1)(f)	The person in 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.	Not Compliant	Orange	14/01/2020
Regulation 31(3)(a)	The person in charge shall	Substantially Compliant	Yellow	16/01/2020

	ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 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).	Substantially Compliant	Yellow	29/02/2020
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/01/2020