Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Elmville House
Name of provider:	St Joseph's Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	17 April 2019
Centre ID:	OSV-0001821
Fieldwork ID:	MON-0023315

About the designated centre

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

This service is provided in a purpose built, single storey residence located in a housing development in a rural village. A maximum of six residents can be accommodated and the service supports residents with higher needs in the context of their disability. In general five residents live in the centre and a respite service may be provided to a sixth resident is this is suited to and compatible with the needs of all residents. The provider aims to provide an individualised service informed by the needs, choices, interests and preferences of each resident. Residents are encouraged to maintain family and community links. The centre is open on a full-time basis and a staff presence is maintained at all times. The staff team is comprised of care assistants and social care works led by the person in charge who is a registered nurse in intellectual disability nursing.

The following information outlines some additional data on this centre.

Current registration end date:	07/01/2021
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
17 April 2019	09:00hrs to 17:30hrs	Mary Moore	Lead

Views of people who use the service

The inspector met with all of the five residents (there was one vacant bed). Residents communicated by a range of means other than verbal; residents very effectively communicated their wishes and preferences including their preference to observe but not engage with the inspector; this was respected. This choice exercised by some residents was reflective of their assessed needs including the need for familiarity and routine in their daily life. Also observational clinical assessments were taking place on the day of inspection and the inspector ensured that the inspection process did not interfere with these.

Residents exchanged a welcoming smile and gentle handshake; the inspector was given a tour of the house where areas and items of interest were pointed out. The inspector noted that residents presented as at ease and comfortable in the house and with the staff on duty; there was a busy but relaxed atmosphere in the house. A prominently displayed graphic reminded staff that residents did not live in their workplace but that staff worked in the residents home; this principle was reflected in the practice and engagement observed by the inspector.

Capacity and capability

There was scope for improvement but overall the inspector found that the governance structure was clear and the objective of management and staff was to provide each resident with a safe, quality service that was responsive to their needs.

There was evidence that change (in how the service was delivered) was planned and managed so that it succeeded. The provider did have several systems of review but the inspector found that the findings of individual reviews were not collated so as to give a clear overview of the quality and safety of the service. In addition individual reviews did not always identify deficits in that particular area or demonstrate what action was taken in response to bring about improvement as necessary.

The management structure was clear as were individual roles and responsibilities; collaborative and supportive working relationships were described to the inspector. The person in charge was appointed in January 2019 but had solid knowledge of residents, their needs, their required care and support and of the general operation of the centre. The person in charge had responsibility for two designated centres and had developed a rota of attendance in each centre. The person in charge was seen to be accessible to residents and staff and actively engaged in the planning

and monitoring of the care and support provided to residents.

The provider had several systems for reviewing the quality and safety of the service provided to residents. These systems including stand-alone audits completed by responsible persons for example of residents finances, heath and safety and medicines management; monitoring and oversight by the person in charge, team meetings with staff (the staff team was described as positive and proactive), and the provider reviews required by the regulations on an annual and six-monthly basis.

The inspector reviewed the findings of individual audits, the annual review and the most recent unannounced six monthly review. The inspector found that despite the many systems of review, deficits and failings were not always identified and therefore corrective actions were not always taken. Or where failings were found the follow-through on the implementation of corrective actions was not adequately demonstrated. In addition the findings and action plans of individual reviews were not collated so that collectively they provided a clear overview of the quality and safety of the service provided to residents. For example the six-monthly provider review referenced and included data such as accidents and incidents and incidents related to medicines but it did not specify any further or provide a statement of assurance of the quality and safety of practice in these areas following audit and review. Further specific examples of where review did not provide assurance of learning, improvement and a consistently safe and quality service was the review of incidents involving residents and the failure of any of the completed reviews to identify and address the fact that staff did not for sometime have properly functioning and suitable equipment to weigh residents as part of the monitoring of their well-being.

The provider had in 2018 changed the nature of the service delivered; residents had previously attended off-site day services. This programme was now delivered by staff in the centre. The provider had updated the statement of purpose accordingly; (a record that the provider is required to keep under review and that contains information that describes the centre and the service provided, for example the staffing levels and the range of needs to be met).

To support these changes the provider had reviewed and altered staffing levels and arrangements so that they had the capacity to support and deliver a meaningful programme of engagement for residents. The inspector was advised that these changes had been discussed with residents, families and staff and had been positively received. The inspector found that staffing levels and arrangements were adequate; there were also daily systems of delegation that supported responsibility and accountability. While it had been necessary to recruit additional staff to meet these changes a team of regular staff was in place; this provided for the consistency and familiarity that residents needed.

Staff attendance at mandatory and additional training was monitored; there was a planned staff training schedule. The inspector was advised that there were no concerning deficits in staff attendance at training; one staff was due refresher training in fire safety and this training was imminent; this concurred with the sample of training records seen by the inspector. Additional training completed by staff

included the safe administration of medicines including medicines required in emergency situations, infection prevention and control and hand hygiene.

Any records requested by the inspector were readily available, complete and well-maintained.

Regulation 14: Persons in charge

The person in charge was employed full-time and had responsibility for two designated centres. The person in charge held suitable qualifications in disability nursing and management and had established experience in a supervisory capacity. The person in charge facilitated the inspection with ease and had sound knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the provider monitored the adequacy of staffing levels and arrangements and made changes as necessary to ensure that the were suited to residents' needs and the service delivered. When preparing the staff rota consideration was given to the familiarity and consistency that residents required.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training within the specified timeframe. Staff had also completed additional training that supported them to safely meet resident's needs.

Judgment: Compliant

Regulation 21: Records

Based on the regulations reviewed on inspection, the inspector found that the records listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. The requested records were retrieved for the inspector with ease; the required information was readily retrieved; the records were well maintained.

Judgment: Compliant

Regulation 23: Governance and management

The provider did have several systems of review but the inspector found that the findings of individual reviews were not collated so as to give a clear overview of the quality and safety of the service. In addition individual reviews did not always identify deficits in that particular area or demonstrate what action was taken in response to bring about improvement as necessary.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider reviewed as necessary, maintained and made available in the centre a current statement of purpose; while minor clarification was needed, overall the record contained all of the required information and was an accurate reflection of the centre as it was now operated.

Judgment: Compliant

Quality and safety

As discussed in the first section of this report it was necessary for the provider to review and improve on the effectiveness of its auditing systems as individually and collectively these systems did not always assure the appropriateness, safety and quality of the service provided to residents.

Notwithstanding this however, the inspector found that staff had a ready knowledge

of residents, their needs, abilities and the care and support needed to ensure resident well-being. This care and support was set out in a personal plan of support and overall the care and practice observed and described to the inspector was what was recorded in the personal plan.

However, the assessment and personal plan was not always updated in response to changing needs as opposed to on an annual basis which is the minimum requirement. There was evidence that the annual review of the plan was multi-disciplinary (MDT) and there was good MDT representation at the review meeting. However, actions, responsible persons and completion timeframes were not specified and based on records seen the inspector was not assured as to the timeliness of the actions taken based on the recommendations of the review.

As discussed in the first section of this report the provider had in 2018 taken the decision to deliver a programme of activity to residents in and from their home rather than residents travelling to the day service. The inspector was advised that residents complex needs, early mornings and the length of the day were factors considered when making this change. The inspector was satisfied that this was a positive decision for residents and that with staff support residents enjoyed good community access and a range of meaningful activities and engagement such as swimming, music programmes, the multi-sensory room in the main facility, walks in the local community and other amenities and dining out.

The importance of maintaining links with family was recognised with staff going to great lengths at times to facilitate this.

Residents did have specific communication needs. Based on this inspector's observations of practice and engagement with residents there were no barriers to effective communication. Residents effectively communicated using their preferred means of communication what it was that they wanted or did not want; this was understood and respected. There were times when objects of reference were used by staff; for example a pair of shoes to indicate going for a walk. Staff were currently exploring the possibility of the use of personal tablets and applications to develop communication options, skills and interests.

The provider had systems to protect residents from harm and abuse; for example staff had completed safeguarding training and there was ready access to the designated safeguarding officer and the social work department for support as needed. The person in charge was present in the centre on a regular basis and had since her appointment commenced formal staff supervisions. The person in charge had full confidence in the staff team that they would report safeguarding concerns. The inspector saw that in the context of delivering personal care and living with other peers there were plans to ensure that resident privacy and dignity was protected.

Generally residents' needs were described as compatible but individually residents did at times present with behaviour that posed a risk to themselves and to lesser degree peers and staff. There were plans in place to guide staff on how to avoid and manage these behaviours; these plans were overdue review due to the absence for

some time of psychology support within the organisation. The inspector was advised that following a successful recruitment campaign this deficit in review was being addressed on an incremental basis in the organisation based on the priority of need.

In this particular service though the plans were overdue review the inspector found that staff were attuned to residents and their needs, responded therapeutically and considered possible causes for behaviour such as pain, thirst, discomfort or illness. These factors were addressed first and generally alleviated the behaviour and prevented escalation. Staff maintained good records of their actions and these records indicated that staff adhered to the plan and the protocols in place for intervening including any requirement for chemical intervention; that is the use of PRN (as required) medicines. The provider review of December 2018 monitored the use of such medicines.

Oversight was maintained of other restrictive practices; measures were taken to reduce their impact on residents quality of life; for example the door to the garden was on a timer so that residents had unrestricted access by day; the safety gate that restricted access to the kitchen was unlocked when staff were present and was seen during this inspection to present no unreasonable restriction to residents.

The provider had arrangements for ensuring that residents had access to a range of health services and the care that they needed to keep well and enjoy good health. The person in charge was a registered nurse and part of her role was to provide clinical oversight and support. On the day of inspection staff supported residents to attend the General Practitioner (GP) for routine medical reviews. There was documentary evidence of a proactive approach to care with evidence of annual influenza vaccination and regular blood-profiling. There were times when residents found some reviews and interventions difficult; this was considered and there were plans to support intervention when it was considered reasonable and necessary.

Staff cooked on a daily basis and the kitchen dining area presented as relaxed as residents watched staff prepare meals. In the context of their disability residents did require specific interventions such as diet and fluids of different textures. This practice was advised by the speech and language therapist (SLT); staff spoken with described each resident's requirements and the specific recommendations were presented at each meal on individualised table mats so as to ensure that the guidelines were adhered to. Residents were also however supported to be as independent as possible at mealtime. There was a good understanding of the role of nutritional supplement in supporting dietary intake. Where a recent concern had been identified in relation to a loss of body weight the appropriate action had been taken such as GP referral, review of nutritional supplements, SLT review and referral for dietetic advice. However, the inspector has made reference in the first section of this report to the failure to provide staff with all of the equipment necessary and this is addressed again in Regulation 17; the provision and maintenance of such equipment that may be required by residents and staff.

There was evidence of good medicines management systems. Staff had completed baseline and refresher training in the safe management of medicines. Medicines

were prescribed and supplied to residents on an individual basis by a community based pharmacist of their choice. Staff completed records to account for the management of medicines including their administration. Medicines practice was the subject of audit with evidence of corrective action taken to ensure the safety of practice. The audit tool did not however include the monitoring of medicines incidents which were addressed through the general accident and incident process; as discussed in the first section of this report this required reviewed as there was no clear link between the two systems.

Overall there was evidence of procedures to safeguard residents from and in the event of fire. The fire register was available and was well maintained with evidence of the inspection and testing of equipment at the prescribed intervals and most recently in February 2019. The evacuation plan was prominently displayed and there were designated staff fire safety duties allocated on a daily basis. Each resident had a current personal emergency evacuation plan (PEEP) that detailed challenges that may arise to evacuation and the tools to be used in response to promote evacuation such as offering favoured foods. The inspector found all of the assisting tools as specified in the PEEPS in the emergency box. However, while it was evident that the provider had given careful consideration to the actions that may be needed to ensure that staff could evacuate all residents, the effectiveness or not of these had not been tested in a planned and controlled way during simulated drills.

Risk was identified as were the controls necessary to manage and reduce the risk; a review of these risks had recently been completed by the area manager who was a person participating in the management of the centre. There was evidence of these controls in practice such as regular SLT review and the use of restrictions as discussed above. There was a system for recording and reviewing incidents that involved residents such as a fall. However, the process for reviewing these incidents while timely did not always demonstrate how learning was identified and what corrective actions were necessary to promote residents safety. This is addressed in the context of governance and the improvement needed in the providers systems of review.

Regulation 10: Communication

There was evidence of a broad understanding of how residents communicated and respect for comprehension where expressive ability was limited. How each resident communicated had been assessed by staff and in consultation with the SLT; staff had a ready understanding of how and what residents communicated.

Judgment: Compliant

Regulation 13: General welfare and development

While a greater link was needed between practice and agreed goals and objectives, overall the inspector found that resident's personal objectives were delivered. On an individualised basis residents had access to a broad range of meaningful activities and community engagement; this was evident from records seen and from practice on the day of inspection. Residents were supported to maintain and develop personal relationships with peers, family and the wider community.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with a choice of meals that were prepared daily by staff. Residents had specific requirements and practice in this area was informed by regular review by the appropriate healthcare professional and clear guidance for staff that was seen to reflect the most recent recommendations.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. The approach to risk management was individualised.

Judgment: Compliant

Regulation 28: Fire precautions

The effectiveness or not of resident's personal emergency evacuation plans had not been tested in a planned and controlled way during simulated drills.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had appropriate policies and procedures and there was evidence that medicines were managed safely.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The assessment of needs and plan of support were not always updated in response to changing needs as opposed to on an annual basis which is the minimum requirement.

Responsible persons and the timeframe for completion were not always specified for the actions that emanated from the annual review.

Judgment: Substantially compliant

Regulation 6: Health care

Staff assessed and monitored residents healthcare needs. Each resident was provided with the care that they required and had access to healthcare services as necessary some of which were available from within the providers own resources.

Judgment: Compliant

Regulation 7: Positive behavioural support

Plans for guiding the prevention of and response to behaviour of concern or risk were overdue review.

Judgment: Substantially compliant

Regulation 8: Protection

There were policies. supporting procedures and practice for ensuring that residents

were protected from all forms of abuse.
Judgment: Compliant
Regulation 17: Premises
Staff did not have access to equipment suited to monitoring residents' body weight.
Judgment: Substantially 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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially 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	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 17: Premises	Substantially compliant

Compliance Plan for Elmville House OSV-0001821

Inspection ID: MON-0023315

Date of inspection: 17/04/2019

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: All new audits will reflect the outcomes of previous audits and action plans.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Staff will practice the MAPA technique that may need to be used in real fire evacuation at team meetings to ensure staff familiarity with the prescribed technique. Identified prompts held in the emergency box must be used for all fire drills.	
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:	

Following MDT review meetings all recommendations will be clearly assigned to a named staff and all actions carried out in a timely manner.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A referral requesting the update of the Positive Behaviour Support Plan has been forwarded to the psychology department.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: All residents will be weighed on appropriate equipment at least monthly and more frequently if required and all records of same will be available in the centre.

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(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	29/05/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Not Compliant	Orange	29/05/2019

	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 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.	Substantially Compliant	Yellow	29/05/2019
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	29/05/2019
Regulation 05(7)(c)	The recommendations arising out of a review carried out	Substantially Compliant	Yellow	29/05/2019

	pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/06/2019