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:	Hollybank
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 June 2019
Centre ID:	OSV-0001921
Fieldwork ID:	MON-0023320

About the designated centre

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

Hollybank designated centre is located on a shared campus setting in a rural area of West County Dublin. It provides residential services to persons with intellectual disabilities and increased care support needs, particularly in advanced age and as a step-down support following discharge from hospital. The centre is comprised of one large unit and at the time of inspection was supporting 17 residents and had eight vacancies. Services provided in the centre were structured in a medical model of care and the staff team was made up of a person in charge, clinical nurse managers, staff nurses, health care assistants, catering staff and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
12 June 2019	10:00hrs to 18:00hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with a number of residents who were availing of the services of this centre and spent time observing care and support being delivered by staff members. Overall, residents appeared to be satisfied with the care and support they were receiving; however, the environment in which they were residing was observed to be of a poor standard and not homely in its nature.

Capacity and capability

Overall, the inspector found that this centre had very mixed findings and presented contrasting levels of compliance across a number of areas. While residents were found to be safe while residing in the centre, the care being provided was institutionalised and had not modernised in line with a person centred approach, best practices or national standards. For example, there were several observations of institutionalised practices including staff members wearing nursing uniforms, centralised kitchens preparing all meals off site, and residents being referred to as 'patients'. Despite this, the inspector observed that staff members individually cared for residents in a kind and respectful manner. The most significant finding of this inspection related to the physical environment and premises of the centre which were of a very poor standard in some areas and were not adequately maintained to allow for the provision of high quality services.

The inspector met with the person in charge at the time of the inspection and found that they had good awareness of the needs of residents availing of the services of the centre. The person in charge met the requirements of the regulations through their experience in managing services and the academic qualifications they had achieved. The inspector found; however, that the person in charge had responsibilities for the management of another large designated centre for older persons and given the geographical size of the campus, the number of residents and the number of staff, the person in charge did not have the capacity to be effectively engaged in the governance, operational management and administration of the centre.

A review of staffing arrangements was completed and the inspector found that there were sufficient numbers of staff employed in the centre; however, the skill mix of the staff team did not reflect the need of residents or the aims and objectives of the centre which were set out in the statement of purpose. Observations completed by the inspector found that staff members treated residents with kindness and respect and attended to their needs in a timely manner. A review of a sample of four staff files found there were a number of gaps in the documentation outlined as being

required by the regulations.

The inspector reviewed staff training records and found that there were deficits in six of ten areas of training identified as being mandatory by the person in charge. The person in charge had put in place a training plan to address these deficits prior to the time of inspection. A review of staff supervision arrangements found that staff members were not in receipt of formal one-to-one supervision meetings in line with the frequency detailed in the organisation's policy on this matter.

A review of the governance and management arrangements in place in the centre found that there was a clearly defined management structure and both annual reviews and six monthly unannounced visits to the centre by persons on behalf of the registered provider had been carried out. The person in charge and safeguarding designated officer outlined recent achievements which included improvements in the staff culture and increased awareness of the roles of staff members in safeguarding and protecting residents. The inspector found; however, that little action had been taken in progressing actions which were issued to the provider following the last inspection of this centre relating to premises concerns. While internal action plans in place in the centre listed refurbishment and individualised bedrooms for residents as clear actions, these objectives had not been realised in line with their target dates of August 2018. There was an absence of a formal service plan to address these issues at the time of inspection and at the request of the inspector the registered provider developed a short to medium term plan to put in place measures to address these concerns. Despite these issues having been raised at the time of the previous inspection, the registered provider failed to take appropriate action to resolve the identified failings and resolve the concerns relating to the premises of the centre to a satisfactory standard.

Regulation 14: Persons in charge

The person in charge managed more than one designated centre and as a result the inspector found that effective governance and operational management of the designated centre was not ensured.

Judgment: Not compliant

Regulation 15: Staffing

- The inspector was not assured that there was an appropriate skill mix present amongst the staff team to meet all residents' needs and to meet the aims and objectives of the centre as outlined in the statement of purpose.
- A review of a sample of staff files identified that there were gaps in the required documentation including incomplete full employment histories and

references not being signed.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector identified that there were deficits in an number of training areas which were described as being mandatory by the person in charge. These were as follows:

- one staff member had not completed training or refresher training in manual handling
- five staff members had not completed training or refresher training in practical hand hygiene
- one staff member had not completed training or refresher training in infection control
- three staff members had not completed training or refresher training in basic life support/automated external defibrillation
- six staff member shad not completed training or refresher training in behaviours of concern and
- three staff members had not completed training or refresher training in children first.

In addition, the arrangements in place for the formal supervision of staff were not satisfactory as staff members were not in receipt of one-to-one supervision in line with organisational policy.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider was found to have failed in ensuring that actions relating to premises highlighted in the previous inspection and those identified through internal written reports on the quality and safety of care and support provided in the centre were addressed in an appropriate manner.

Judgment: Not compliant

Quality and safety

As previously mentioned, the inspector reviewed the premises of the centre and completed a full walk through in the company of a clinical nurse manager and person in charge. The centre's premises was comprised of a large old single storey building and includes an entrance hallway, a sitting room, a kitchen area, a small dining room, two lounge areas, a number of bathrooms, a number of storage rooms, a medication and clinical room, a sensory and relaxation room, 10 resident bedrooms, store rooms, staff bathroom and shower room, a staff office, a staff break room, and a manager's office. Overall, the inspector found that the premises of the centre was in a poor state of repair and was not designed or laid out to meet the needs of residents. The inspector observed paint and plaster work damaged throughout the building, extensive areas requiring repainting and decoration, and staining on flooring areas in a number of areas. In some areas of the centre it was noted that bedrooms and bathrooms were not clean.

The inspector observed that the privacy and dignity of residents was not promoted in some areas of the centre. Three residents were sharing one bedroom at the time of the inspection and there were plans to admit a fourth individual to a vacant bed there. In a separate area of the centre the inspector observed that a renovated bedroom had been empty for a prolonged period of time and when questioned, the person in charge outlined that residents could not be transferred to this area as inbuilt oxygen and suction facilities had not been installed. When investigated further, the person in charge confirmed that no resident had been allocated this room and as a result it could not be determined whether there was an actual need for these facilities to be installed. The inspector considered this to be another example of an institutionalised approach to the provision of care in the centre.

In another area of the centre a bathroom had been determined to be out of commission and a sign had been placed on its door stating "out of order - do not use". When asked, the clinical nurse manager stated that the bathroom had been in this state for a lengthy period of time and there were no plans to renovate it. While two other bathrooms in another part of the centre had been renovated since the time of the last inspection, the inspector found that overall, the condition of the premises of the centre did not promote the dignity or well being of residents. It was identified that there had been an issue with rodents in the centre. The inspector found that appropriate follow up action had been taken in response to this issue. However, the physical state of repair of certain areas of the centre continued to pose a risk of reoccurrence as many external doors were poorly fitted.

The inspector reviewed the arrangements in place for the management of risk in the centre. There was a risk register in place and it was found to have assessed all presenting risks in the centre. There was appropriate oversight of all incidents and accidents which had occurred and satisfactory responses and follow up actions were recorded in all documentation which was sampled. Quarterly analysis of all incidents, accidents and near misses were taking place and there centre specific recommendations for learning and safety and quality improvement were created.

There was a fire alarm and detection system in place in the centre and emergency lighting had been fitted to required areas. All staff had completed fire safety training and fire drills were completed on a regular basis and included the participation of

residents. The fire alarm and detection system and the emergency lighting were found to have been serviced by appropriate personnel on a regular basis. There were fire doors fitted throughout the centre and self-closing mechanisms had been fitted to doors which required them; however, a number of self-closing mechanisms were observed not to be in full working order. Personal emergency evacuation plans (PEEPs) were in place for each resident and the inspector reviewed a sample of 10 of these documents. There were considerable differences in the information presented in the PEEPs and in some cases it was found that the supports required by residents were not clearly outlined.

The inspector spoke to a number of staff members and managers about safeguarding and the protection of residents. All persons spoken with demonstrated satisfactory knowledge of the types of abuse and the actions to take in response to witnessing or suspecting abuse involving a resident. A safeguarding register was maintained for the centre by a designated officer who was met with by the inspector. A review of incident and accident records found that appropriate follow up actions had taken place in response to matters of a safeguarding concern.

Regulation 17: Premises

- The premises of the centre were not maintained or cleaned to a satisfactory standard.
- The designated centre was not designed or laid out to meet the needs of residents.
- Paint and plaster work was observed to have been damaged throughout the building and extensive areas requiring repainting and decoration.
- There was staining observed to flooring in a number of areas.
- Three residents were sharing one bedroom at the time of the inspection which did not promote the dignity and privacy of individuals.
- A bathroom area was out of use for a prolonged period and had not been renovated by the registered provider.
- The inspector was not assured that the condition of the premises of the centre was appropriate for its current use or contributed to a positive outcome for the health and well being of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were appropriate systems in place for the assessment, management and ongoing review of risk in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

- A number of doors with self-closing devices were found not to be fully operational at the time of the inspection.
- Some PEEP documents failed to clearly outline the supports required by residents in the event of a fire or similar emergency.

Judgment: Substantially compliant

Regulation 8: Protection

Appropriate responses and follow up actions were taken in response to incidents of a safeguarding nature and both the staff and management team demonstrated a clear understanding of of their roles in adult protection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hollybank OSV-0001921

Inspection ID: MON-0023320

Date of inspection: 12/06/2019

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The person in charge meets the requirements of the regulations through their experience in managing services and the academic qualifications they have achieved. The Person in charge is also responsible for the Older Persons service on the campus. The person in charge is supported by a CNM2 and a CNM1 who have day to day operational responsibility for the unit. There is an assistant director of nursing as PPIM for the centre. The person in charge has good overall awareness of the needs of the residents and has the experience and qualities to discharge the functions of the person in charge. The Provider representative will arrange to meet with the Chief Inspector to discuss further. This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The person in charge and the assistant director of nursing have undertaken a review of other social care facilities, and will develop a training programme for the staff on Social care to further enhance their person centred practice. Registered nurses are supported to undertake further training, Aging Health and well-being in Intellectual Disability.	

The person in charge will utilise the experience of a variety of stakeholders including Professor McCarron (TCD) who will deliver a presentation for all staff on the 20th August in Peamount.

The HR department have now put in place a system and processes to ensure the gaps in employment history on CVs and references are explained. These will now be checked at interview stage and copies kept on file.
In relation to the gaps identified in 4 staff files on the day of inspection HR will have this addressed by the 31st August 2019.
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Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The person in charge will be supported by the CNM's in the centre to ensure the training tracker is up dated when training is completed by staff. The Clinical Nurse Managers on Hollybank will continue to ensure staff are informed of training required. There is a training tracker and personal planner in place and available to all staff. Staff are also notified of their training by the HR business partner.
Since inspection the following training has been completed:
Manual Handling
1 staff member completed training on the 22nd July 2019
Practical hand hygiene
staff member completed same on 10th July 2019
Hollybank has since trained a HCA to deliver the national training on hand hygiene at unit level
Infection control
1 staff member completed training on the 31st July 2019
Basic life support
1 staff member completed training on 5th July 2019
PETMA training
5 staff members attended the 2-day training on 1st /2nd July 2019
1 Staff member will be facilitated with training on the next available date.
Children's first
3 staff members have completed their training between the 16th – 19th July 2019

Mandatory training compliance is currently between 93-100%
The plan is to be 100% compliant by September 30th 2019.

A supervision tracker and supervision attendance record is now in place to ensure staff

supervision and development is in line with the organizations policy. The one to one supervision and development record has been updated to ensure key areas of discussion can take place and that staff can raise any concerns or issues.

This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider will ensure that annual reviews and six-monthly unannounced visits to the center, are maintained, and, that a plan is put in place to address any concerns regarding the quality and safety of care and support that arise.
A costed plan for renovation works to address the issues identified in the report has been Submitted to the HSE for approval and funding.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Initial remedial works will commence on the 6th August 2019 to include redecoration, repainting, upgrade of lighting.

A costed plan for renovation works to address the issues identified in the report has been Submitted to the HSE for approval and funding

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PEEPS have now all been updated since 18th July 2019 to reflect a more person centered approach and to ensure the supports required by the residents are clearly outlined.

The self-closing mechanisms on the doors identified during the inspection have been reviewed by the facilities manager and the maintenance department. This work is now completed 18th July 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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Not Compliant	Orange	01/01/2020
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	01/03/2020

Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/08/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/09/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/01/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Red	01/01/2020
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	Not Compliant	Red	01/01/2020

	internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Red	01/01/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Red	01/01/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit 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.	Not Compliant	Orange	31/03/2020
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	18/07/2019