Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Beechview House
Name of provider:	Autism Spectrum Disorder Initiatives Limited
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	24 April 2018
Centre ID:	OSV-0002060
Fieldwork ID:	MON-0021042

About the designated centre

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

Beechview apartments is a residential centre which accommodates up to nine adult residents with autism and other associated conditions. There are currently eight residents living in the centre, six gentlemen and two ladies. There are three apartments in the centre and staff support is offered across the three apartments. Staff support and encourage residents to take part in meaningful activities in their local community. Each resident has their own bedroom with an en-suite. Residents are supported with their positive behaviour support needs, augmentative communication needs, emotional support needs, and physical and intimate care support needs. The centre is situated in a suburban area of County Dublin with access to a variety of local amenities such as shops, train stations, bus routes and the city centre. There is transport available in the centre for residents to enable them to access day services and local amenities. Residents are supported by staff 24 hours a day, seven days a week. The staff team comprises of a person in charge, team leaders, senior social care workers, social care workers and support workers. Staffing in the centre is adjusted in line with residents' assessed needs.

The following information outlines some additional data on this centre.

Current registration end date:	26/11/2018
Number of residents on the date of inspection:	8

How we inspect

To prepare for this inspection the inspector or 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
24 April 2018	09:20hrs to 19:00hrs	Marie Byrne	Lead

Views of people who use the service

The inspector met and spent some time with three of the eight residents residing in the centre on the day of the inspection. The inspector also spoke on the phone with one family member. All residents and the family member indicated their satisfaction with the care and support in the centre. Residents who spoke with the inspector said they were happy and were engaged in activities of their choosing. The inspector observed positive interactions between residents and staff in the centre throughout the inspection.

Five residents completed questionnaires prior to the inspection, some of whom were supported to complete these. They were complimentary towards the care and support in the centre and indicated that if they had a complaint they knew the process and who to make their complaint to.

The inspector observed that residents in the centre were being supported to communicate their needs and wishes, and to receive the support they required to make decisions in relation to their day-to-day lives. This was facilitated through the use of pictures and easy read information for some residents.

Capacity and capability

Overall, the inspector found that there were leadership and management systems in place which were ensuring residents were in receipt of good quality care and support in the centre. However, improvements were required in relation to fire containment and staff training and development. The provider had put measures in place to address all of the actions from the previous inspection.

There were clearly defined management structures which identified the lines of authority and accountability in the centre. The staff team reported to team leaders and senior social care workers who in turn reported to the person in charge. The inspectors met and spoke with the person in charge and a number of staff in the centre who displayed a good knowledge of residents' care and support needs.

There was evidence of regular staff meetings in the centre with evidence of good attendance and resident focused agenda items. There was evidence of follow up on actions from these meetings which were resulting in positive changes and outcomes for residents.

There was an annual review of the quality and safety of care in the centre which provided for consultation with residents and their representatives. The provider or

provider representative had also visited the centre at least once every six months and produced a report on the quality of care and support provided in the centre. The inspector reviewed a number of audits in the centre which contributed to the annual review. There was evidence of follow up and completion of actions from these audits which were resulting in improved outcomes for residents in relation to the service and facilities in the centre.

The majority of policies and procedures required by schedule 5 policies and procedures were available in soft copy in the centre on the day of inspection. The communication with residents policy was not available in but this was forwarded to the inspector after the inspection. One of the schedule 5 policies in the centre had not been reviewed in line with the timeframe identified in the regulations.

The inspector found that the skill mix and qualifications of staff in the centre were appropriate to meet residents' needs. There were two staffing vacancies in the centre and the recruitment process had commenced to fill these vacancies. The inspector found these staffing vacancies were not negatively impacting residents as the provider was using regular relief staff to fill the necessary shifts.

The inspector found that in general staff in the centre had access to training and refreshers in line with residents' needs. There was a live traffic light system in the centre which highlighted mandatory staff training requirements and a training plan was in place for the year ahead. A number of staff required positive behaviour support training. Staff were in receipt of formal supervision to support them to perform their duties and best support residents with their care and support needs.

Records in the centre were found to be well maintained, up-to-date, and guiding staff practice to support residents. There was a complaints policies and procedure in place and they were available in a format accessible to residents. Residents had access to advocacy services if they so wished. There was a local complaints officer in place and residents and staff who spoke with the inspector could clearly explain the complaints procedure. There was evidence of follow up, resolution and response to complaints.

Regulation 15: Staffing

There were enough staff in the centre with the right skills, qualifications and experience to meet the residents' assessed needs. Residents were receiving continuity of care and support despite the fact there were two staffing vacancies in the centre. This was achieved through the use of regular relief staff who had received core skills training. Information and documents required by schedule 2 of the regulations were in place.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre had access to training and refreshers in line with residents' needs. However, a number of staff required training or a refresher in positive behaviour support to ensure they could best support residents with their behaviour support needs. Staff in the centre were in receipt of good quality supervision to support them to best support residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a directory of residents in place which was kept up to date and contained all the required information. The provider was working on a system to make the directory of residents available and a live document on an electronic system.

Judgment: Compliant

Regulation 21: Records

The relevant records were maintained and available on the day of inspection. They were kept safe and were easily retrievable. There were a number of audits in place to ensure records were up-to-date and accurate and this was found to be supporting the effective and efficient running of the centre.

Judgment: Compliant

Regulation 22: Insurance

Valid insurance certificates and written confirmation of insurance cover was available in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The management structure in place in the centre was clearly defined and there were systems in place to monitor the quality and safety of care and supports for residents in the centre. This included an annual review of quality and safety and six monthly visits by the provider. There was evidence of follow up on actions from these visits which were resulting in positive outcomes for residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Residents admissions were in line with the statement of purpose and residents had a contract of care which outlined the services and facilities in the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reflective of the services and facilities for residents in the centre. It contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and required notifications were provided to the Chief Inspector within the timeframes identified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a user friendly complaints process in the centre and an appeals process which was fair and objective. Staff and the resident who spoke with the inspector could describe the complaints process and could name the complaints officer. Complaints in the centre were fully investigated and measures put in place for

improvement in response to complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

The majority of schedule 5 polices and procedures were available in the centre on the day of inspection and the one which was not, was forwarded by the provider post inspection. The provision of information to residents had not been reviewed and updated in line with the timeframe identified in the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents were in receipt of a good quality of care and support in the centre. However, some improvement was required in relation to fire containment in the centre. The provider had put measures in place to address all of the actions from the previous inspection.

Residents' personal plans were in place and clearly guiding staff in relation to their care and support needs. Their personal plans were found to be person-centred and there was evidence of the involvement of the resident, their representatives and relevant members of the multidisciplinary team in the development and review of these plans. Residents also had a day report book in place which outlined how they were being supported to reach their goals and what activities they were engaging in. There was a keyworker system in place and they were completing monthly reports in relation to residents progress, challenges, and goals.

Residents were being supported to maintain good health. Residents had their healthcare needs appropriately assessed and they had access to allied health professionals in line with their assessed needs. There was accessible information available for residents in relation to health promotion.

The inspector found that the premises was designed and laid out to meet the needs of residents. The services and facilities for residents were found to be in line with the centres' statement of purpose. There was adequate space for residents including large bedrooms with ensuite bathrooms, large communal spaces and adequate storage for personal use. The premises was found to be clean and well maintained.

Appropriate risk management arrangements were in place which protected residents and kept them safe. The inspector found that the provider was responsive to risk in the centre and was balancing the rights of residents to take appropriate risks. There

were risk assessments in place which included risk identification and measures in place to control these risks. Control measures were found to be proportionate to the identified risks and to protect residents' safety. There was a risk register in place which was updated regularly. There were health and safety audits being completed and evidence that these audits were identifying safety concerns and which were being followed up on which was leading to a safe environment for residents to live. There was a system in place for identifying and recording incidents in the centre and a system for reviewing these. There was evidence of learning following these reviews which were resulting in some positive outcomes for residents.

The residents who spoke with the inspector reported feeling safe in the centre. There were systems in place for responding to allegations of abuse and the provider was found to be responsive to safeguarding concerns in the centre. Staff who spoke with the inspector were knowledgeable in relation to the types of abuse and their role and responsibilities in allegations or suspicions of abuse including the appropriate actions to take.

Residents' positive behaviour support plans clearly guided staff practice to support residents. There was evidence that they were reviewed and updated in line with residents' changing needs. Staff who spoke with the inspector were knowledgeable in relation to residents' behaviour support needs in line with their positive behaviour support plans.

The inspector found that the provider had put some measures in place against the risk of fire in the centre including equipment for detecting and extinguishing fires. However, suitable arrangements were not in place in relation to fire containment due to fire doors being wedged open thus negating their use in the event of a fire. Fire drills were completed regularly in the centre and residents and staff described how they would safely evacuate the centre in the event of a fire. Fire risk assessments and personal evacuation plans were in place for residents and there was evidence that they were updated following learning from fire drills.

Residents in the centre were protected by policies and practices relating to medicines management in the centre. There were suitable arrangements in place for ordering, receipt, prescribing, storage and disposal of medicines in the centre.

Regulation 10: Communication

Each resident's individual communication requirements were documented in their personal plans and staff who spoke with the inspector demonstrated an awareness of each resident's communication needs and supports. Easy read information was available throughout the centre to support residents to communicate at all times in line with their needs and wishes.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident had access to occupation and opportunities to participate in meaningful activities in line with their interests both home based and in the community.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet residents' needs. The centre was clean and suitably decorated and residents had access to ample private and communal space. Residents had suitable storage for personal items there was suitable heating, lighting, and ventilation in the premises.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transition plans reviewed by the inspector were detailed and planned supports were in place to support residents throughout the transition process.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents in the centre were kept safe through the systems in place for the assessment, management and ongoing review of risk in the centre. Emergency planning was in place, and there were systems to identify, record and learn from incidents in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire equipment was available in the centre and there were adequate means of escape and emergency lighting in place. There was evidence that equipment was serviced in line with the requirement of the regulations. However, a number of fire doors were wedged open during the inspection negating their use in fire containment.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Residents in the centre were protected by safe and suitable medicines management practices. There were systems in place for ordering, receiving, storing, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan outlining their care and support needs. Assessments were in place and care plans developed in line with these assessments. There was evidence that personal plans were reviewed and amended in line with residents' changing needs.

Judgment: Compliant

Regulation 6: Health care

Residents were in receipt of person-centre care and were being supported to live a healthy life through diet and exercise. Residents had access to the relevant allied health professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were appropriate supports in place for residents with behaviours that challenge. Each resident had a behaviour support plan in place with proactive, reactive and where applicable restrictive strategies. Restrictive practices were logged and reviewed regularly in the centre.

Judgment: Compliant

Regulation 8: Protection

Safeguarding plans, risk assessments and extra staffing was in place to keep residents in the centre safe following a number of peer-to-peer safeguarding concerns. Staff in the centre were knowledgeable in relation to these safeguarding plans and could clearly identify their responsibilities in relation to reporting allegations of abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	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	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Beechview House OSV-0002060

Inspection ID: MON-0021042

Date of inspection: 24/04/2018

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff identified, will have been scheduled for and received the PBS refresher training by 6-07-18	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The Provision of Information to Residents policy has been reviewed April 2018 and updated and the subsequent review dates set within the three year timeframe outlined by the regulations	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All items used to prop open internal fire doors have been immediately removed from the service and staff advised that these are no longer to be used. Completed 25-04-18. Consideration is been given to the use of electronic/magnetic door stops – linked to the fire alarm panel, where needed.	

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 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.	Substantially Compliant	Yellow	6-07-18
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	25-04-18
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where	Substantially Compliant	Yellow	30-04-18

	necessary, review and update them in accordance with best practice.			