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:	The Hollow
Name of provider:	Health Service Executive
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	14 December 2021
Centre ID:	OSV-0002478
Fieldwork ID:	MON-0031496

About the designated centre

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

The Hollow is a full-time residential service that can provide care and support for five adults with an intellectual disability. The house is a bungalow that comprises: five bedrooms, two bathrooms, one en-suite, two sitting rooms, a kitchen/dining area, and a large garden to the rear of the house with tarmac and a large lawn at the entrance of the house. The house is located between two nearby towns in Co Westmeath. Residents have access to local amenities such as shops, restaurants, bars, and cafes. Residents receive support on a twenty-four-hour basis from a team of staff nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 (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
Tuesday 14 December 2021	09:15hrs to 15:30hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

This service was providing supports to two residents. Both residents had moved in this year, the first in May and the second in September. The provider had identified that both residents would benefit from a low arousal and personalised service. They both had their own rooms and separate living areas. The staff spoken to during the inspection referenced that the move for both residents had been positive.

On arrival at the service, the inspector was introduced to one of the residents. The resident was relaxing in their sitting room and the staff member supported communication between the resident and the inspector. The resident showed the inspector around their home and the inspector saw that visual aid planners had been developed which were used to support the resident with routines. They appeared comfortable in their surroundings and the staff member supporting them was aware of their needs and spoke of the their plans for the day whereby the resident was due to attend their social farming project.

The inspector was introduced to the second resident later in the day. The resident interacted for a brief period with the inspector. This resident liked to relax in their room listening to music and was observed to take time away in their bedroom. Staff offered them the opportunity to engage in other activities, but the resident chose not to do so and their choice was respected.

The review of records demonstrated that residents were being supported on a one-to-one basis both day and night. Daily activity notes showed that one resident was engaging in regular physical activity per their wishes and was being supported to get to know their new community. The records for the second resident showed that the resident was each day offered opportunities to engage in activities but that the resident would often choose to relax at home.

While daily records had been well maintained, the inspector found that there were a number of issues with other aspects of record keeping. Residents personal plans had not been appropriately updated following their transition to their new homes, nor had their person-centered plans.

The existing governance and management arrangements were also found to be inappropriate. This impacted the provider's ability to ensure that the provided service was appropriate.

Furthermore, the inspector found that the infection prevention and control measures were unsuitable. The existing arrangements were not robust and failed to adopt procedures consistent with the standards for preventing and controlling healthcare-associated infections published by HIQA.

The inspector also found that the provider had not fully responded to actions identified in the previous inspection completed in September 2020. Damage to

flooring had been identified in 2020. The latest inspection found that the damage had yet to be addressed. Some areas also required deep cleaning and some repairs.

The impact of the above findings will be discussed in more detail in the following two sections of the report.

Capacity and capability

The provider had ensured that a person in charge was in place. However, the inspection found that the existing management arrangements were not adequate. The person in charge was responsible for two other services, and this had impacted their ability to ensure that the residents living in this centre were receiving effective delivery of care. The management systems were not ensuring that the service being provided was appropriate, consistent, and effectively monitored.

The inspector sought to review audits that had been completed, but these were not available for review at the time of inspection. Staff training records were also not available for review by the inspector. The provider had also failed to ensure that the directory of residents had been appropriately maintained and contained the information regarding the two residents living in the centre. Throughout the inspection, the existing systems regarding record-keeping were found to require significant attention and improvement. The impact of this on the residents will be discussed in more detail in the Quality and Safety section of the report.

A member of the provider's senior management team submitted information to review during the inspection. The inspector reviewed this information and found that an unannounced visit had been completed in the service on 08/12/21. The review found that wide-ranging improvements were required to the service provided to the residents. Following the audit, the provider had identified that there was a need to review the management systems and were in the process of making adaptations to the person in charge arrangements. It was planned that a person with a reduced remit would take on the person in charge role. This would increase the management presence in the centre.

The staff team supporting the residents was made up of staff nurses and care assistants. The review of rosters demonstrated that the provider was ensuring that safe staffing levels were being maintained. The review also showed that the provider had assured that residents were receiving continuity of care.

Overall, the inspection found that the provider had failed to ensure that the existing management arrangements were appropriate. This had negatively impacted the service provided to each resident and the standard of record-keeping.

Regulation 15: Staffing

The provider had ensured that the number, and skill-mix of staff was appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 21: Records

It was found that there were significant improvements required to record-keeping and ensuring that all relevant information was easily accessible. Furthermore, some information was not available for review by the inspector.

Judgment: Not compliant

Regulation 23: Governance and management

The inspection found that the existing management arrangements were not adequate. The provider had not demonstrated that they had effective oversight of the service provided to the residents. This had negatively impacted the supports provided.

Judgment: Not compliant

Regulation 19: Directory of residents

A directory of residents had been established. However, it did not contain the relevant information as per the regulations.

Judgment: Not compliant

Quality and safety

As mentioned earlier, this service was inspected in September 2020. During that inspection, issues were found regarding the premises. and The provider committed

to having the required work completed by the 30 November 2020 however, this had not been achieved. There was evidence that the provider had completed some painting works in one of the sitting rooms but further painting works were required in a number of areas, including hallways and the other sitting room. Flooring in a number of areas also required repair. The issues with the premises detracted from attempts to provide the residents with a homely environment. While there were documents to show efforts made to ensure that the house was suitably clean, the inspector found that some areas required enhanced cleaning. One bathroom, in particular, required deep cleaning.

As previously mentioned, a recent audit completed by the provider found that existing infection prevention and control practices were not effective, the inspector and the recent audit completed by the provider found significant improvements were required to ensure that infection prevention and control measures were appropriate.The audit listed measures to be taken to improve the practices.

While the inspector acknowledges that there had not been sufficient time for all steps to be introduced, the poor practices should have been previously addressed. Isolation plans had been devised for residents if they were suspected or confirmed of contracting the virus. The inspector reviewed these and found some improvements required to ensure that they contained all relevant information.The inspector requested to review the services COVID-19 contingency plan, when the person in charge provided the plan, it was found that it did not contain the most up-to-date or correct information. This was brought to the attention of the person in charge, who began to address the issues.

Improvements were also required to ensure that the staff team had access to the most up-to-date and relevant information regarding the COVID-19 virus.The inspector also found damage to the surfaces of some furniture in both sitting rooms. This damage impacted the staff team's ability to clean the furniture effectively. Furthermore, handrails in a bathroom were observed to have been damaged with rust forming on them. This again impacted the staff team's ability to clean the area effectively.

The inspector reviewed the resident's records and found that there was limited evidence to suggest that their care plans and person-centered plans had been updated since their transition to the service. This did not demonstrate that the residents' health and social care needs were being appropriately monitored. One resident's personal plan had not been updated since their transition to the service. Their care and support plans reflected their previous placement and did not capture the resident's changing needs. Some work had been completed for the other resident. There were improvements required to ensure that each resident had received comprehensive assessments of their health and social care needs as per the regulations. In order to be assured that residents were receiving appropriate care, the inspector reviewed daily recording notes. As mentioned in the first part of the report, residents were being supported to engage in activities in their community, but this was the only area where supports being provided to residents were being documented.

The review of residents daily notes demonstrated that if required residents had access to allied healthcare professionals and were supported to attend medical appointments.The inspector did find that some health and health and medication protocols required improvement.

The inspector noted that the transition to the service had been positive for both residents. Both residents behaviour of concerns had significantly decreased and they also had access to therapeutic supports when required. This was leading to positive outcomes for both residents. However, both residents were prescribed medication to manage these behaviours and the review of one resident's information found contradictions between how often they could receive the medication and the minimum time between the administration of the medication. This meant that there was the potential for a staff member to administer medication inappropriately.

While positive behaviour support plans had been developed, some improvements were required to ensure that they contained the most up to date information. This again demonstrated that there were issues regarding record keeping and maintaining the most up to date information to guide staff in the appropriate care to be delivered to the residents.

There were systems in place to safeguard residents. The inspector found that the provider had initiated investigations into any concerns raised and had implemented interim safeguarding plans when required. At the time of inspection, there were no compatibility concerns between the two residents living in the service.

There were improvements required to ensure that all risk management procedures were appropriate. There was a risk register in place that had not been reviewed following the admission of the two residents. The review of the residents' individual risk assessments demonstrated that in some cases that they had not been updated since their transition and reflected the identified risks from their previous placements. Therefore, the provider had failed to demonstrate that there were appropriate systems for the ongoing review of risk.

The inspection found that improvements were required across many areas. The provider had not demonstrated that the existing practices were appropriate or that the residents were in receipt of a quality service.

Regulation 17: Premises

The provider had not ensured that the residents' home was kept in a good state of repair. There were also parts of the building that required enhanced cleaning.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had not ensured that appropriate systems were in place for the assessment, management, and ongoing review of risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had not adopted procedures consistent with the standards for preventing and controlling healthcare-associated infections published by HIQA.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The review of residents' information demonstrated that improvements were required to ensure that each resident had received a comprehensive assessment of their health and social care needs. The available records did not capture the changing needs of the residents, and the personal plans had not been appropriately updated as per the regulations.

Judgment: Not compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had not ensured that medication protocols and support plans contained the correct information for one resident. The inspector found that some plans

contradicted one another regarding the use of chemical restraint for the resident.

Judgment: Substantially compliant

Regulation 8: Protection

The review of information demonstrated that the provider had developed appropriate systems to safeguard residents.

Judgment: Compliant

Regulation 9: Residents' rights

Through observations and the review of residents' daily records, the inspector established that residents' rights were being promoted and respected by those supporting them.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 19: Directory of residents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Hollow OSV-0002478

Inspection ID: MON-0031496

Date of inspection: 14/12/2021

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The governance arrangements for record keeping have been reviewed to ensure all information is up to date and readily accessible. All audits will be reviewed by the PIC in conjunction with the ADON and be available on site with recommendations available to staff and a plan devised to ensure each recommendation is carried out within a reasonable timeframe. Each Health care plan will be reviewed and updated in full. Person Centered Planning meetings are scheduled for January 2022 with progress of previous goals and new goals identified. Progress notes will be updated thereafter and reviewed weekly by the PIC and keyworkers. Staff training records have been reviewed and a plan is in situ to ensure all training is up to date and will be available in the Centre at all times. The directory of residents has been reviewed and updated. Covid 19 Contingency plan together with associated risk assessments have been updated to reflect current needs with in the Centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

The current management structure within the Centre is under review. There is a plan in place to recruit an additional PIC to work in the Centre due to the workload of the current PIC. An expression of interest in this position has been forwarded to the current CNM2/PIC panel.

In the interim administrative duties of the current PIC such as payroll, rostering and HR have been undertaken by an additional nurse manager to support the PIC fulfill their regulatory responsibilities for operational oversight.

A person participating in management notified to HIQA will conduct monthly inspections to ensure all actions of compliance have been completed within a reasonable timeframe.

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
The Directory of residents has been updated to reflect the current residents within the Centre and all the information required by the regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Painting and flooring replacement throughout the Centre will be tendered in Jan with an expected completion of March 2022.
Hand rails are sourced to be replaced immediately in the bathroom areas. The furniture has been replaced in both sitting room areas.
All Infection Prevention Control risks identified are currently been reviewed and a plan is in place to replace all items identified to be a risk in respect of IPC.
All parts of the centre have undergone an extensive deep cleaning completed by an external professional cleaning company. The cleaning schedule has been reviewed to ensure cleaning methods and frequency are sufficient to maintain a hygiene environment which is comfortable and meets the needs of the residents.

Regulation 26: Risk management	Substantially Compliant

procedures	

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The arrangements and systems for risk escalation will be reviewed and updated with an audit of open risk assessments completed monthly with the PIC and ADON to ensure risks identified have been actioned.
Where a risk has been identified and maintenance cannot attend to in a timely manner external contractors will be engaged by the ADON to complete the works and to ensure actions from audits are completed in a timely manner.

Residents individual risk assessment have been reviewed and updated to reflect their current needs based on their transition to their new home.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
A deep clean of the Centre has been completed by an external professional cleaning company. The cleaning schedule has been reviewed and updated and will be audited weekly by the PIC. Hand rails are sourced to be replaced immediately in the bathroom areas. New furniture has been purchased for the both sitting room areas. Interior painting will be completed throughout the house no later than March 2022. The flooring throughout the house is out to tender for a full replacement. All equipment and facilitates which are not readily cleanable are currently been reviewed and a plan is in place to replace all items identified to be an infection control hazard or with finishes that are not easily cleanable.
The PIC has reviewed the Infection Prevention and Control Checklist for Residential Care Facilities in the Context of Covid 19 along with the self-assessment Tool Preparedness planning and Infection prevention and control assurance framework and will ensure all findings and recommendations are actioned and communicated to the staff team at monthly team meetings.

Resident's isolation plans have been reviewed and updated to ensure they contain all relevant information in the event of a suspected or confirmed case.
The Covid 19 contingency plan is reviewed at regular intervals in line with Public Health Guidance to ensure it contains the most upto date correct information.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Each resident's health care plans will be reviewed and updated to ensure all personal plans contain sufficient detail which is evidenced based to guide care practices and interventions and to take account of their changing needs since transition to the centre
Each person centered goal orientated plan will be reviewed to ensure they are up to date and SMART goals are identified in conjunction with the individual. Where goals have been agreed a named key worker will be identified to support the resident achieve their goals. Actions or required supports where necessary will be identified to help the resident achieve goals in their personal plans. Progress notes will be completed weekly to outline the progress of each plan in place to support the individual achieve their identified goals.

Health and medication protocols will be reviewed to ensure policy is sufficiently detailed to guide care practices.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A full review of the Positive Behaviour Support plans has been completed with particular focus on the review of chemical restraint protocols. Both of the PRN protocols have been reviewed and updated. One of the Positive behavior support plans is updated. The second plan is being progressed however the proactive, reactive strategies, behavioural risk assessment and the approval for restrictive intervention are up to date. The behavior support plan itself needs to be updated in line with his new home and activities.
The behavior support team will conduct an educational interactive meeting with the staff team.

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.	Not Compliant	Orange	25/03/2022
Regulation 19(1)	The registered provider shall establish and maintain a directory of residents in the designated centre.	Not Compliant	Orange	23/12/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that	Not Compliant	Red	01/03/2022

	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.			
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	20/01/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	23/12/2021
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident	Not Compliant	Orange	25/01/2022

	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).			
Regulation 05(4)(b)	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 outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	25/01/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	25/01/2022