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:	Dunavon
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	05 June 2018
Centre ID:	OSV-0001707
Fieldwork ID:	MON-0021600

About the designated centre

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

Dunavon is a service providing residential services to eight adults with disabilities (both male and female) over the age of 18 years. It is located in County Wicklow and in close proximity to a large town. Residents are supported by staff to access local amenities such as shops, restaurants and cafes. Their healthcare is provided for and access to a General Practitioner (GP) and a range of other allied healthcare professionals is on-going as required. The centre comprises of a large two story building. Each resident has their own bedroom, decorated to their individual choice and there is a number of other communal rooms/sitting rooms for residents to avail of. The centre is staffed on a 24/7 basis with both nursing staff and social care professionals. The provider has made arrangements for five staff to be available during the day to support the residents and two waking night staff to cover nights.

The following information outlines some additional data on this centre.

Current registration end date:	06/09/2018
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
05 June 2018	09:00hrs to 20:00hrs	Raymond Lynch	Lead

Views of people who use the service

Some residents expressed satisfaction with aspects of the service they received such as the choice of food options made available to them, some of the activities they were supported to engage in to include social outings and they way in which they were supported to maintain positive family relationships.

However, a number of residents reported that the house was too large, too noisy and not always accessible (to include the back garden). Those spoken with said they would like to avail of day activation services and would like to have more staff on duty so as they could engage in more social activities. The inspector met briefly with all eight of the residents and saw that the ground floor of this centre was a noisy and busy environment. It did not lend itself to a homely environment, the back garden was not easily accessible for residents with mobility issues and the kitchen was not accessible to residents at times during the day.

Staff interactions with residents appeared positive and residents seemed comfortable and at ease in the presence of staff.

Capacity and capability

This inspection found that the provider's oversight, governance and management arrangements required urgent review so as to ensure that the assessed needs of the residents were provided for at all times in an effective and timely manner. As a result of the provider's failure to address these areas there was evidence of direct negative impacts on aspects of care provided for example, some social care activities and healthcare appointments had to be cancelled and/or rearranged. Additionally there were areas of risk which were not being managed. As a result of this, HIQA took the unusual step of issuing the provider with an urgent compliance document directly after the inspection. This document required the provider to give written assurances to HIQA within seven days of the inspection that there were adequate fire safety procedures and staffing arrangements in place in the centre at all times.

The provider had not ensured that key management positions were filled. At the time of this inspection the role of person in charge was vacant. There was a deputy manager in place who facilitated the inspection process. He was found to have appropriate skills and experience and was responsive to the regulatory and inspection process. He knew the needs of the residents in detail and was providing leadership and on-going support to the staff team in the absence of the person in

charge.

The staffing arrangements in place required urgent review as at times staffing arrangements, to meet the assessed needs of the residents, were not adequate. For example, it was documented in the centre that due to staff shortages some social care activities had to be cancelled and/or rearranged and a medical appointment for one resident was cancelled. In turn, this resulted in some of the assessed needs of the residents as detailed in their individual plans not being met in a timely or effective manner. Feedback from some residents also informed that they would like more staff to be made available so as they could engage in more social activities.

Documentation retrieved by the inspector also informed that the person in charge had identified in May 2018 that the staffing levels required to manage the day to day operations of this centre in an effective manner were below what was required. While this information was made available to the provider it had not been acted upon prior to inspection.

There was no annual review of the quality and safety of care undertaken for 2017. This concerned the inspector, as this review was a mechanism to inform the provider of the quality and safety of care provided in the centre, to identify any deficits and provide an opportunity to put a plan of action in place to address any challenges and/or concerns identified.

The inspector found that there were six monthly audits undertaken. On review of a sample of these it was found that they were (at times) highlighting non compliance with the Regulations, with explicit plans of action to address those areas of non compliance. For example, a recent audit identified that some positive behavioural support plans required updating and they had been updated by the time of this inspection.

However, some important actions arising from the provider's audits had not been implemented in a timely or effective manner. For example, a health and safety audit undertaken in April 2017 identified issues with the upkeep of the premises to include the need to replace some loose wall panelling. These items were not addressed until February 2018. This showed that the provider was not responding in a timely way to identified issues and areas for improvement.

It was also observed that the most recent audit undertaken in April 2018 (which was a very in depth and informative assessment of the service being provided) highlighted areas of the service that required review. However, there was no action plan identified, time frame agreed or person identified as being responsible to address these matters.

Overall this inspection found that the systems of oversight, governance and management in place required urgent review so as to ensure the centre was meeting the assessed needs of the residents in a timely, appropriate and effective manner.

Regulation 15: Staffing

The staffing arrangements in place were not adequate to ensure the assessed needs of the residents were met in a timely or effective manner.

Judgment: Not compliant

Regulation 16: Training and staff development

From speaking with some staff members and reviewing a sample of the training files the inspector saw that staff had the appropriate mandatory required to work in the service

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in place required review so as to ensure there was adequate oversight, review and management of the centre. There was no review of the quality and safety of care available for 2017, actions arising from audits were not being implemented in a timely manner and the staffing arrangements were not adequate in meeting some of the assessed needs of the residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The service being provided was not in line with the Centres Statement of Purpose.

Judgment: Not compliant

Regulation 31: Notification of incidents

The centre was notifying HIQA in lines with its legislative remit and the Regulations.

Judgment: Compliant

Quality and safety

The provider had not made arrangements to ensure that residents experienced a safe service. The centre was not resourced to meet residents' needs in a timely or effective manner. It was also observed that the arrangements in place to evacuate all residents in a timely manner in the event of a fire required urgent review. Some individual risk assessment required updating and a number of restrictive practices in use also required review.

Overall, the quality and safety of care provided to the residents required review as the staffing arrangements in place were not adequate to meet some of the assessed needs of the residents, the fire evacuations arraignments also urgent review as did the use of some restrictive practices in this centre.

Due to these findings HIQA issued the provider with an urgent action plan seeking assurances that the issues pertaining to the staffing arrangements and fire safety be addressed as a priority and no later than 15.06.18.

The issues pertaining to the staffing arrangements were also impacting negatively across a number of regulations assessed. For example, one resident who had secured their own apartment had identified a goal to live in it, with the support from staff. Because of inadequate staffing levels this goal could not be realised and the resident was only getting to spend two days a week in her preferred home.

The staffing arrangements in place were also impacting on staffs capacity to evacuate residents from the centre in a safe and timely manner during fire drills. There were only two waking staff on duty at night time and it was recorded that it was taking up to eight minutes to evacuate the residents during fire drills. This was because many of the residents had significant support requirements (requiring 2:1 staff support in an evacuation) and some required staff encouragement and prompting during evacuations.

It was also observed that staff had no alternative but to leave some residents unaccompanied at the fire assembly point during fire drills as they both had re-enter the house to support other residents evacuate. This was of concern to the inspector as documentation retrieved during this inspection informed that six of the eight residents required maximum support at all times. This support was not being adequately provided for during fire drills.

One resident, who refused to leave the centre during a recent fire drill did not have their personal emergency evacuation plan updated to reflect this issue. A number of issues were also identified and recorded during a number of previous fire drills, such

as some fire doors not operating correctly and some of these issues had not been addressed by the time of this inspection. That said, there was a range of fire fighting equipment in place in the centre, to include fire extinguishers, blankets and emergency lighting which was being serviced as required.

The residents living in this centre presented with individual and complex needs. Where required, access to allied healthcare professionals was being provided for, to include psychology support and staff had training in positive behavioural support. However, a report by a psychologist retrieved by the inspector informed that there was limited opportunity to provide stimulating activities for a resident due to a lack of items that could captivate their interest and lack of staff availability to interact with them. Again this was of concern to the inspector as some of this resident's assessed needs were not being met in timely or effective manner.

There were a number of restrictive practices in use in the centre, which had been reviewed by the organisations human rights committee. However, some of the restrictions were significantly impacting on residents rights and liberty to move around their home freely. For example, one resident was locked into their bedroom at night time as it was reported they would not settle otherwise. It was also observed that because the kitchen was deemed to be an unsafe environment for one resident, the centre decided to prohibit all residents from entering or using their own kitchen for certain periods of time everyday.

There were a number of individual risk assessments in place in order to promote each residents safety. For example, where it was assessed that a resident may need support to be safe in the centre, that support was provided. However, some risk assessments required review. For example, one risk assessment stated that a resident was unable to identify the risk associate with a fire however, other documentation retrieved by the inspector stated that the same resident understood that when the fire bell sounded they must go outside. This conflicting information posed a safety risk to the resident.

The premises were found to be institutional in appearance and did not lend itself to providing for a homely environment. Because of compatibility and peer to peer issues, parts of the building remained inaccessible at times to some of the residents. Four residents had their own bedroom on the ground floor and one residents' bedroom was on the first floor. (This was the resident who was locked into their room at night as it was stated that they would not settle otherwise). There was a private parking area to the front of the building and a private well maintained garden to the back. However, it was observed that due to the layout of the back garden, it was not accessible to the residents. Feedback directly from residents to the inspector informed that some residents would like to live in a smaller and quieter environment, better access to the back garden and live in a more accessible environment.

The health needs of the residents was being met to a good standard and where required residents had access to a GP and a range of other allied healthcare professionals. Medication practices were also in line with best practice and all medicines were ordered, stored, administered and disposed of as required by the

regulations. PRN (as required)medicines where in use, were kept under review and there were strict protocols in place for their administration.

Regulation 17: Premises

The premises were institutional in appearance and behind a large wall (This was documented in the centre on the day of this inspection). The back garden was not accessible for residents to freely avail of and residents had expressed dissatisfaction with this issue.

Judgment: Not compliant

Regulation 26: Risk management procedures

Some individual risk assessments required review and updating as the information contained in them was not in line with other documentation in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety procedures required urgent review as it was taking staff up to eight minutes to evacuate residents from the centre during fire drills. Some personal emergency evacuation plans also required review and updating. Some issues arising during fire drills while being reported, were not begin addressed. For example, an issue with some fire doors not closing properly during fire drills had been reported a number of times and had not been addressed in a timely manner.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There was adequate procedures and policies in place for the safe

ordering,storing, administration and disposal of all medicines in use in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

At times, there were insufficient resources available in this centre to meet some of the assessed needs of the residents in a timely or effective manner. Documentation retrieved by the inspector informed that more staff were required in order to promote more social activities for the residents and some goals could not be realised due to insufficient resources.

Judgment: Not compliant

Regulation 6: Health care

While one medical appointment for a resident had to be postponed due to staffing shortages, the inspector found that in general the healthcare needs of the residents was being provided for and they had access to a GP as required an a range of other allied healthcare professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where required, residents a a positive behavioural support plan in place in place however, there were some restrictive practices in operation in this centre including locking a resident in their bedroom at night and due to safety issues pertaining to one resident, there were times when none of the residents had access to their kitchen. Even thought these restrictions had been reviewed by the organisations human rights committee, the inspector was concerned at the level of restrictions in use and deprivation of liberty placed on some residents in their own home.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Dunavon OSV-0001707

Inspection ID: MON-0021600

Date of inspection: 05/06/2018

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Two part time relief staff have been employed to support all leave. This will support the assessed needs of the clients. 3 existing staff members have had their contracted hours increased to meet assessed needs of the residents. Thirty-nine additional hours of support have been re-configured at this center and are available for all residents. Approximately 50% of these hours will be available to residents to support 1:1 activities in line with their assessed needs. One resident that is currently supported by Self Directed Living Services will continue to receive individualized support daily. Reconfiguration of hours enables all residents to avail of 1:1 support for approximately three hours a week. Residents will be accompanied to all appointments by the appropriate number of staff and no appointment will be cancelled due to staffing levels. The Center will utilize the supernumery resources available to it and provide a second staff support in line with the assessed needs of some residents. A review is underway to re-allocate some Day Service Hours to this center. This will provide extra support on the roster for 3 hours a day five days a week and support meeting the resident's goals.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: An Annual Audit has been completed for 2018 and is scheduled to be carried out yearly. The Internal Provider Audit Actions are under review with identified completion dates. Two part time relief staff have been employed to support all leave in the centre and this will support the assessed needs of the residents. 1 WTE staff member will be recruited, interviews are being held on the 20th August. 3 existing staff members have had their contractual hours increased to meet assessed needs of the residents. A full-time deputy has been appointed to support the PIC in terms of providing enhanced oversight of the center.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: An updated Statement of Purpose and Function has been provided to the regulator.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The accessibility of the back garden is under review and works are planned to make this area freely available to all residents.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: All risk assessments are under review in line with new matrix. Risk assessment containing conflicting information has been updated.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: One Ski Pad Evacuation Device has been purchased and training was carried out with staff team on 19th June. Weekly practice is now being implemented. The ski pad was introduced as an alternative way of evacuating and this supports a quicker evacuation process for one resident. Resident's risk assessment (Personal Emergency evacuation Plan) PEEP has been updated. One other residents PEEP has been updated also. Extra staff support has been provided to assist with fire evacuation of this center at night-time, when there is a reduction to 2 staff. A third staff member is available from the nearest center to support evacuation (without impacting the operation of that center). This staff member will support the residents outside at the fire assembly point and the evacuation will continue with the staff allocated to this center. A two-way Tetra radio has been purchased to enhance communication and once the radio is activated the tested response time to the center is 2 mins 45 seconds. Nightly testing of radios functionality is in place. Recommendations from a planned evacuation observed by Internal Health and Safety Officer on the 28/06/2018 have been implemented. This assures the provider that the evacuation time for the support needs of residents, is achievable. An additional planned night time evacuation was carried out 07/08/18, taking into account the Safety Officers recommendations, the evacuation process can now be achieved in 4 minutes and 45 seconds	
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:	

Configuration of 39 staff hours per week within the center will enable all residents to avail of 1:1 support for approximately three hours a week.

Residents will be accompanied to all appointments by the appropriate number of staff and no appointment will be cancelled due to staffing levels. The Center will utilize the supernumery resources available to it and provide a second staff support in line with the assessed needs of some residents.

A review is underway to re-allocate some Day Service Hours to this center. This will provide extra support on the roster for 3 hours a day five days a week and support meeting the resident's goals.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

- The resident is referred to a Clinical Psychologist who will complete his assessment by 30th September 2018.
- A rights restriction is in place and will remain in place until assessment is received from the Clinical Psychologist.

- Once the assessment is received, an MDT meeting will be arranged to discuss the outcome of the assessment and the risks involved.
- To be completed by 30th October 2018.

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 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	Red	15 June 2018
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	Orange	31 October 2018
Regulation 17(6)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	31 October 2018

	adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30 September 2018
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	30 September 2018
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Substantially Compliant	Yellow	30 September 2018

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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.	Not Compliant	Red	15 June 2018
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	31 July 2018
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30 August 2018
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Not Compliant	Orange	30 September 2018

	such procedures are applied in accordance with national policy and evidence based practice.			