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:	Unannounced
Date of inspection:	16 October 2018
Centre ID:	OSV-0001707
Fieldwork ID:	MON-0025317

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. 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 assist residents during the night.

The following information outlines some additional data on this centre.

Current registration end date:	06/09/2021
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
16 October 2018	10:30hrs to 16:00hrs	Raymond Lynch	Lead
16 October 2018	10:30hrs to 16:00hrs	Anna Doyle	Support

Views of people who use the service

The inspectors met and spoke briefly to three of the residents who live in this centre. Residents appeared relaxed and at ease in the company of staff and staff were seen to interact with residents in a caring and warm manner. One resident communicated with the inspectors using photographs and objects of reference. They were happy to show the inspectors pictures of important people in their lives and places they liked to visit. The residents appeared content during this time and it was observed that staff knew and respected their communication style and preference.

Capacity and capability

The provider representative had failed to ensure there was appropriate governance and management arrangements in place so as to provide adequate oversight and monitoring of the centre. In turn, the service provided was not responding to some of the assessed needs of some residents in a timely manner.

This inspection was in response to a notification received by the Health Information and Quality Authority (HIQA) with regard to a resident who had engaged in a prolonged incident of self injurious behaviour on 6 October resulting in significant bruising to their body. Despite these injuries the resident had not been brought to their General Practitioner (GP) for a medical review until 10 October four days after the incident. Given the resident's medical condition, the degree of injury and on-going issues with serious incidents of self injurious behaviour this posed a risk to the health and safety of the resident. A case review was due to take place regarding the resident on the 18 October.

It was also observed that on 30 September an on call doctor reviewed the resident in the designated centre and advised the centre to make arrangements for them to see their GP the next day. This appointment was not facilitated.

The centre had a person in charge and deputy team leader in place at the time of this inspections. Both were qualified social/health care professionals and facilitated the inspection process. However, it was observed that within the last six months the centre has had three different persons in charge and there was no nominated person in charge providing oversight to the centre from the 21 September to 8 October.

The current person in charge (who had only been appointed to the centre on 10 October) had responsibility for three centres overall. Taking into account the issues found on this inspection and the significant complex needs of the residents, the inspectors were not assured that the arrangements in place for person in charge were sufficient to provide adequate oversight of the centre. For example, some important individual risk assessments and a behavioural support plan (related to the issues identified above) requiring urgent review had not been updated at the time of

this inspection. It was also observed that rosters were not adequately maintained as they did not include the times staff started or finished their shifts.

A number of internal audits had been carried out in the centre over 2018. Some of these audits were bringing about positive change in the centre. For example, a six monthly audit highlighted the need for additional training for staff. This training had been facilitated (or dates had been identified to facilitate it) by the time of this inspection.

However, some of the actions arising out of the auditing process were not being addressed appropriately. For example, an audit identified that there was a need for a GP to sign off on the protocols in place for the use of p.r.n. (as required) medicines. While the audit informed that this action had been completed, this was not the case as some protocols had still not been signed off. Another audit in April 2018 identified the need for a review of risk assessments. While this process had commenced, as already identified above, some risk assessments still required review and updating at the time of this inspection.

The inspectors followed up on the actions arising from the last inspection. Some of those actions had been addressed or were in the process of being addressed. For example, an issue with regard to fire safety had been addressed and another issue pertaining to a use of a significant restrictive practice was under review and it was observed at the time of this inspection to be less restrictive. However, the most up-to-date statement of purpose was not compliant with the regulations as it was not reflective of the governance and management arrangements in place in the centre. For example, the details related to the organisational structure were obsolete as the named provider and person in charge on the organisational chart were no longer working in the centre.

It was also observed that some of the records on file to guide safe practice were not being updated and/or reviewed in a timely manner in order to deliver a person centred, safe effective service. For example, medication protocols were not dated, reviewed or signed and some records related to residents health and social care were not included in their personal plan.

Regulation 14: Persons in charge

The current person in charge (who had only been appointed to the centre on 10.10.18) had responsibility for three centres overall. Taking into account the issues found on this inspection and the significant complex needs of the residents, the inspectors were not assured that the arrangements in place for person in charge were sufficient to provide adequate oversight of the centre.

Judgment: Not compliant

Regulation 15: Staffing

The roster in the centre was not adequately maintained as it did not indicate the hours staff worked, For example, the rosters did not identify the time staff commenced their shift at and the times they finished. The inspectors had to seek clarification on this with the deputy services manager on the day of inspection.

Judgment: Substantially compliant

Regulation 21: Records

Some of the information on file in the registered centre was not being updated and had conflicting information in relation to records kept pertaining to some residents as specified in Schedule 3 of the Regulations

Judgment: Not compliant

Regulation 23: Governance and management

The centre did not have adequate systems in place to ensure that the service provided was responsive to the needs of the residents or effectively monitored. An intervention for a resident recommended by an allied health care professional was not followed up on and some actions as identified in the auditing process last April had not been addressed or were incomplete.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose did not accurately reflect the service being provided to the residents. For example, the details related to the organisational structure were obsolete as the named provider and person in charge on the organisational chart were no longer working in the centre.

Judgment: Not compliant

Quality and safety

On the day of this inspection residents appeared relaxed and at ease in the presence of staff. For example, communications between staff and residents appeared warm and friendly and of the staff spoken with, it appeared they knew the residents individual likes and preferences. However, as outlined earlier in this report the centre was not responding to some adverse incidents and assessed needs of the residents in a timely or responsive manner.

From a small sample of files viewed, residents had access to a range of allied health care professionals to include GP services, dietitian, physiotherapy and dental services. It was also observed that in respect of the actions arising from the last inspection additional staffing hours had been secured and a number of activity schedules had been implemented for the residents.

However, the inspectors found that one resident was not satisfactorily supported to achieve and maintain best possible health outcomes. For example, a behavioural support plan noted that pain could be a precursor to this resident engaging in serious self injurious behaviour. However, there was insufficient information on the residents medical file to guide staff with the administration of some p.r.n. medicines prescribed for the management of pain and no comprehensive pain management assessment had been completed to guide practice in this area.

It was also noted an allied health care professional had advised the centre on 30 September to take one resident to see their GP on 01 October however, this appointment had not been facilitated.

On the 06 October the resident in question presented in crisis for an 11 hour period, engaging in significant self injurious behaviour causing extensive bruising to their body and injury to the temple area of their head. On review of the residents records on the day in question, inspectors found that staff had responded as outlined in the residents behavioural support plan.

However, having reviewed the resident's behavioural interventions it was observed that there were contradicting strategies included in their support plans. Guidance for staff members was found to be unclear and did not clearly outline the supports to be provided to the resident. For example, the resident's behavioural support plan outlined that proactive strategies included the resident being "pain free". Inspectors were not assured that the least restrictive intervention was being used in response to this behaviour as p.r.n. protocols informed that staff were to administer a benzodiazepine medication as a first response as opposed to considering pain relief. One of the p.r.n. plans in place did not include all of the prescribed medication in order to guide practice and some p.r.n. protocols has not been signed off by a prescribing doctor. This issue had been identified and actioned in a previous audit of the centre, but had not been addressed at the time of this inspection.

There was no evidence available in the centre that a comprehensive review of the serious adverse incident (detailed above) had taken place prior to this inspection

however, a case review had been organised for the resident on 18 October. HIQA requested a copy of the recommendations arising from this case review so as to be assured the centre had a comprehensive up-to-date plan and strategy in place to adequately respond to the residents needs.

There were adequate fire precautions systems in place to include a fire alarm and a range of fire fighting equipment such as fire extinguishers, fire blankets and emergency lighting. Documentation viewed by the inspector informed that regular fire drills took place and each resident had a personal emergency evacuation plan in place and the issues pertaining to fire safety as found in the last inspection has also been addressed. However, it was observed that one personal evacuation emergency plan required updating after the most recent fire drill to reflect that one resident was reluctant to leave the premises when the fire alarm was activated.

Overall residents appeared happy in this centre and staff were seen to tend to their needs in a caring and respectful manner. However, the quality and safety of care provided to the residents required review. The process of how some aspects of risk were managed required review, as did a positive behavioural support plan and some health care interventions.

Regulation 26: Risk management procedures

The process of managing risk required required review. One resident who presented with a serious prolonged incident of self injurious behaviour had not had their individual risk assessment updated or reviewed since June 2018. An audit in April 2018 also identified that risk management processes required review as did some p.r.n. protocols. These actions arising from this audit has not been appropriately addressed.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector saw that there were adequate fire precautions systems in place to include a fire alarm and a range of fire fighting equipment such as fire extinguishers, fire blankets and emergency lighting.

Staff carried out regular checks on all fire fighting equipment and from a small sample of documentation viewed, staff had attended fire training as required.

However, it was observed that one personal evacuation emergency plan required updating after the most recent fire drill to reflect that the resident was reluctant to leave the premises when the fire alarm was sounded.

Judgment: Substantially compliant

Regulation 6: Health care

An allied health care professional made a recommendation that a resident should be seen within 24 hours by their GP. This appointment was nor provided for or facilitated as advised. This was of concern to the inspectors as the resident in question had a medical condition requiring the on-going management of pain and could present with significant self injurious behaviours related to that condition.

Some p.r.n. protocols in place for the management of pain required review and signing off by a prescribing doctor.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Some positive behavioural support plans required review and updating with input from appropriate allied health care professionals. Inspectors were not assured that the least restrictive intervention was being used in response to some behaviour of concern caused by pain.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Dunavon OSV-0001707

Inspection ID: MON-0025317

Date of inspection: 16/10/2018

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • **The Provider has advertised and interviewed for a full time PIC and has now made a job offer subject to meeting Providers compliance in line with HIQA Standards 31/01/2018** • **In the meantime, there is a PIC in place that also manages two other Locations but has been given two full time Deputies and one full time administration staff. This is to ensure that there is adequate monitoring of the Location. This is a short-term plan until a full time PIC in post. 31/01 /2019**	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • **The Roster has been updated and now clearly shows the hours staff work. 25/10/2018.**	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • **All Medication PRN Protocols have been reviewed and updated. 31/10/2018** • **Six Residents Records have been reviewed and are now updated. 31/10/2018** • **Two remaining Residents Records are currently been reviewed and updated and will be completed by 19/11/2018 and will be in line with**	

schedule 3 of the Regulations.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • **All Residents Care Plans now state clearly that when any client becomes unwell or following an incident where there has been an injury, the Nurse or CSW in charge of the shift must contact the client's GP or CareDoc Out of Hours to seek their advice. If the injury is deemed serious or life threating an ambulance (999) must be called.** • **If it is recommended that the client should see the doctor in person, then the staff must take the client for further examination the next working day. Should the CareDoc recommend follow up with the GP, this must also be arranged for the next working day. 31/10/18** • **A memo is in place outlining the above guidelines. All Staff will have signed that they have read and understand the guidelines. This is to ensure that all staff are clear and understand the above guidelines. 19/11/2018.** • **The above guidelines are now on the Staff Agenda to be discussed at every staff meeting 05/11/2018**	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • **The Statement of Purpose has been updated, and the organizational structure now has the correct name of the provider nominee and the Person in Charge. Copy sent to HIQA on the 25/10/2018.**	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • **All Risk Assessments for each Resident have been reviewed and updated to the new template and Risk Register (HSE version) has been updated. 28/10/2018.** • **All Medication PRN Protocols have been reviewed and updated. 31/10/2018**	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

- **One Residents Personal Evacuation Plan has been reviewed and updated.**
  17/10/2018.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

- **All Residents Care Plans now state clearly that when any client becomes unwell or following an incident where there has been an injury, the Nurse or CSW in charge of the shift must contact the client's GP or CareDoc Out of Hours to seek their advice. If the injury is deemed serious or life threating an ambulance (999) must be called.**

- **If it is recommended that the client should see the doctor in person, then the staff must take the client for further examination the next working day. Should the CareDoc recommend follow up with the GP, this must also be arranged for the next working day. 31/10/18**

- **A memo is in place outlining the above guidelines. All Staff are currently reading and signing this. This is to ensure that all staff are clear and understand the above guidelines. 30/11/2018**

- **The above guidelines are now on the Staff Agenda to be discuss at every staff meeting 30/11/2018**

- **The PRN Pain Management Protcol has been reviewed and signed by the GP. 15/10/2018**

Regulation 7: Positive behavioural support	Not Compliant

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

- **PBSP has been reviewed and updated and now includes recommendation from the Clinical Psychologist 19/10/2018.**

- **Care Plan for has been reviewed and updated, outlining the least restrictive intervention that must be carried out before any PRN is administrated. 19/10/2018**

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 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	31/01/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	25/10/2018
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	19/11/2018
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	19/11/2018
Regulation	The registered provider shall	Not		31/10/2018

26(2)	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.	Compliant	Orange	
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	17/10/2018
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	25/10/2018
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	30/11/2018
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	19/10/2018
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	19/10/2018