

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



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| Centre name: | Hansfield Group - Community Residential Service |
| Centre ID: | OSV-0004040 |
| Centre county: | Dublin 15 |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | Daughters of Charity Disability Support Services Company Limited by Guarantee |
| Provider Nominee: | Mary Lucey-Pender |
| Lead inspector: | Thomas Hogan |
| Support inspector(s): | Conan O'Hara |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 6 |
| Number of vacancies on the date of inspection: | 1 |

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:

17 August 2017 09:10

To:

17 August 2017 11:45

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 08: Safeguarding and Safety

Summary of findings from this inspection

Background to inspection

This was an unannounced inspection of the Hansfield Group designated centre after the Health Information and Quality Authority (HIQA) received information of concern regarding the temporary absence of a resident due to safeguarding incidents which had occurred.

The notifications related to incidents of resident peer to peer physical abuse which resulted in one resident being removed from the designated centre by their family. While ongoing supports and day services are made available to this resident, the transition of another resident from the designated centre - to facilitate a return to residential services for the resident who is temporarily absent - had not progressed in the intervening timeframe.

How we gathered our evidence

The inspection took place over 2 hours and 30 minutes, and due to the unannounced nature of the inspection, a refocused approach was taken due to residents and staff going on a planned holiday. Inspectors respected these plans and carried out a single issue inspection focusing on Outcome 8 - Safeguarding and Safety Management.

Inspectors met and spoke with residents, staff, the person in charge, and persons participating in management. In addition inspectors reviewed documents such as risk assessments, safeguarding plans, multidisciplinary team notes and meeting minutes, complaints records, incident and accident reports, statement of purpose and contracts of care.

Interactions between staff and residents were observed by inspectors throughout the

inspection and were found to be respectful.

Description of the service

Hansfield Group designated centre is operated by the Daughters of Charity Disability Support Services Company Ltd and provides full time residential services to individuals with intellectual disabilities across two separate units. The designated centre is located in Dublin 15 and provides services to both males and female residents.

Overall judgment of our findings

Overall, inspectors found Outcome 8 - Safeguarding and Safety Management to be in moderate non-compliance with the Regulations. A full breakdown of this can be found in the report and in the action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Overall, inspectors were satisfied that measures to protect residents being harmed or suffering abuse were in place and appropriate actions were taken in response to safeguarding incidents.

There was a policy in place in the designated centre for the protection and welfare of vulnerable adults and the management of allegations of abuse which was dated January 2016. This document outlined the types of abuse, considerations in recognising abuse, procedures for responding to concerns, the actions required for any staff member or volunteer, preliminary screening of concerns, safeguarding plans, and roles and responsibilities of frontline personnel and management.

Staff spoken with demonstrated sufficient knowledge of the types of abuse and the actions which are required having witnessed or suspected abuse. The person in charge was familiar with the policy document for the protection and welfare of vulnerable adults and the management of allegations of abuse and outlined how an allegation or suspicion of abuse would be managed.

The person in charge and persons participating in management outlined the systems that were in place in the designated centre to monitor and protect residents from abuse. The response to incidents of resident peer to peer abuse was discussed at length and multidisciplinary team meetings minutes were reviewed by inspectors. While inspectors found that the incidents of resident peer to peer abuse had been addressed through the multidisciplinary team meeting forum, the outcome of same - the transition of one resident to an individualised service - had not been outlined in a formal transition plan at the time of inspection. In addition, inspectors found there were lengthy delays in the

plan being implemented which had a knock-on effect on another resident - which included an unplanned absence from the service since October 2016.

Inspectors were informed by a person participating in management at the conclusion of the inspection that the transition of one resident to an individualised service would be complete within three months of the date of inspection. This information had been confirmed by the person participating in management with the Director of Client Services.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Thomas Hogan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

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|----------------------------|--|
| Centre name: | A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Company Limited by Guarantee |
| Centre ID: | OSV-0004040 |
| Date of Inspection: | 17 August 2017 |
| Date of response: | 13 September 2017 |

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The registered provider has failed to protect all residents from all forms of abuse, and while the risk is currently mitigated through the absence of one resident from the designated centre, a timely resolution to the identified concerns has not been implemented.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

1. An alternative Placement has been secured for one Resident to meet his assessed needs.
2. A Transition Plan is being put in place for this move by the MDT members.
3. Following the Transition Plan and move of the Resident, the return of one Resident who is temporarily absent will be facilitated.

Proposed Timescale: 30/11/2017