Peamount Healthcare Neurological Disability Service, OSV-0003505, 08 April 2019

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Peamount Healthcare Neurological Disability Service
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	08 April 2019
Centre ID:	OSV-0003505
Fieldwork ID:	MON-0026612

About the designated centre

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

The aim of Peamount Healthcare's Neurological Disability service is to promote the long term physical and psychological wellbeing of all service users through consultation, co-operation, collaboration and communication with them, their families or advocate and healthcare staff. The centre provides continuing care services for 19 service users that are male and female under the age of 65 on admission, who have prolonged disorders of consciousness; complex medical needs associated with a neurological disability and require 24 hour nursing support. The centre has 19 beds; currently 17 single rooms and one twin room. This unit is single storey with ramp access to the front door. Service users can dine in a large dining room or at their bedside if they prefer. There are two sitting room areas, and an open plan large area with access to the garden. The centre is based in a large campus, situated in a rural location in county Dublin.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	18

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 - 2015 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
08 April 2019	09:20hrs to 20:00hrs	Andrew Mooney	Lead
08 April 2019	09:20hrs to 20:00hrs	Thomas Hogan	Lead

Views of people who use the service

The inspectors judgements in relation to the views of the people who use the service, relied upon observing residents throughout the day, reviewing documentation and discussions with some residents. Throughout the inspection, inspectors met with ten residents. Inspectors engaged with these residents in line with their assessed needs. Residents appeared very comfortable in the company of staff and this was observed throughout the day. Residents expressed their satisfaction with the care they received within the centre.

Some residents told inspectors they had limited access to activities outside the centre. They felt that there was a need for the centre to have transport so outings could be facilitated.

Capacity and capability

The capacity and capability of the centre was adversely impacted as a result of the centres staffing levels and skill mix not being adequately assessed.

There were adequate numbers of staff available to meet the essential day to day healthcare needs of residents within the designated centre. This included the availability of nursing staff as required. However, staffing arrangements required review. The provider had not implement systems to assess and ensure that appropriate staffing levels and skill mix were in place, so that each resident's needs could be met. It was unclear if the current staffing ratios could support residents to live their lives the way they wished. Inspectors observed staff engaging in a caring and respectful manner with residents. However, the majority of staff interactions with residents were limited to times when residents healthcare or personal care needs were being met. This led to a very structured work schedule and limited the availability of staff to be flexible and engage residents with meaningful activities throughout the day. Furthermore, the maintenance of the staff roster required improvement as the full names of staff wasn't always recorded.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. There was a suitably qualified and experienced person in charge, who demonstrated that they could lead a quality service and develop a motivated and committed team. Staff could clearly identify how they would report any concerns about the quality of care and support in the centre. There were arrangements in place to monitor the quality of care and support in the centre, however these required improvement. For instance the provider had failed to prepare a written report on the safety and quality of care and support

provided in the centre every 6 months.

Staff were provided with suitable training and refresher training in areas such as fire safety, manual handling and adult protection. There were some gaps within the refresher training but the provider was aware of these gaps and had made arrangements to address them and ensure all refresher training was provided.

There was an effective complaints procedure that was in a accessible and appropriate format, which included information on how to access advocacy when making a complaint. Inspectors observed a log of complaints and these were documented and managed in a timely manner. Learning from complaints was taken and this brought about positive change within the centre.

Regulation 14: Persons in charge

The centre was managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels and skill mix was not sufficient to meet the needs of residents. Furthermore, the maintenance of the planned and actual roster required improvement, as staff names were not always fully documented.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training available to staff reflected the statement of purpose.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clearly defined and identified the lines of authority and accountability, specified roles and detailed responsibilities for all areas of service

provision. However, the register provider had not produced a report on the safety and quality at least every six months.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints were resolved in a proactive and timely manner.

Judgment: Compliant

Quality and safety

Overall there were good healthcare systems in place and adequate arrangements in place to ensure residents were safe. However, the lived experience of residents was negatively impacted by the lack of opportunity to engage in meaningful activities. Furthermore, there was evidence of institutional practices that required review. These practices included staff wearing uniforms and the reliance on a off site centralised kitchen for meal preparation.

Throughout the day of inspection, inspectors observed high levels of inactivity within the centre. This included residents spending time in their bedrooms alone, sitting in the communal and areas or watching television in the T.V room. There appeared to be limited opportunity for social interaction between residents and staff. This was mainly due to the staffing arrangements within the centre, as staff were required to focus on supporting residents with their healthcare and personal care needs. A communal music session was organised during the day but this was for a limited part of the afternoon, and involved a musician coming into the centre to engage residents as a group rather than there being individualised arrangements. Inspectors completed a review of documentation relating to residents' meaningful activities. This documentation recorded activities such as "quite time," "personal care" and "watching tv" as meaningful activities. Another residents' activities tracker noted "social chat" for fifteen minutes as a meaningful activity. Residents told inspectors that there was a lack of activities facilitated outside the centre. They also felt there was a need for the centre to have its own transport and that staff should be able to drive so social outings could be facilitated. The person in charge outlined that while the centre did not have its own exclusive transport, they could book transport from other parts of the organisation if it was required.

The premises was a large building based on a rural campus setting, it was clean and bedrooms had been personalised to some degree. The centre had been renovated in 2016 to upgrade sleeping arrangements for residents. All residents apart from 2 now

had their own bedrooms. The person in charge noted that the 2 residents that shared a bedroom, did so as this was their preference. The centre had a kitchen but this was not used to prepare meals, as meals were made within a centralised kitchen on the campus. The kitchen arrangements required review as they did not have a oven that could be used with or by residents to prepare their own meals.

Residents' healthcare needs were well supported by a skilled and dedicated team and this led to positive healthcare outcomes. There was a clear emphasis on rehabilitation within the centre and there was a dedicated physiotherapy room located within the centre, with access to regular physiotherapy and massage being a consistent feature of residents weekly routine. Residents were supported to access all national screening programs as required.

Medicines were used within the centre for their therapeutic benefits and to support residents with their health and wellbeing. Inspectors observed good medicines management systems in place. There was a clear system in place for the reporting of administration errors and any such errors were suitably investigated and appropriate measures were taken

The centre had appropriate systems in place to prevent or minimise the occurrence of healthcare-associated infections. Inspectors observed good hand hygiene facilities and personal protective equipment was available. Additionally, the centre had access to a infection control clinical nurse specialist and there was evidence of appropriate audits being completed.

The provider had ensured that there were systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centres policy. Staff had received appropriate safeguarding training and were knowledgeable about what to do in the event a concern was identified.

The provider had put systems in place to promote the safety and welfare of the residents. The centre had a risk management policy in place for the assessment, management and on-going review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. Any incidents that did occur were reviewed for learning and where appropriate, additional control measures were put in place to reduce risk.

There were a range of appropriate fire precautions in place, which included fire doors, emergency lighting and fire fighting equipment. The registered provider had ensured that all fire equipment and building services were provided and maintained appropriately. Fire safety checks took place regularly and were also recorded. However, it was unclear if the centre could be evacuated during times of full occupancy and when the lowest number of staff were on duty, as fire evacuation records did not simulate these scenarios. This was raised with the provider and

appropriate assurances were provided post inspection.

Regulation 13: General welfare and development

From a review of documentation, observations throughout the inspection and discussions with residents it was evident that residents had very limited opportunities to engage in meaningful activities.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the centre was in line with the statement of purpose. However, not all matters to be provided for as set out in schedule 6 were sufficiently accounted for. For example; the centre relied upon a centralised kitchen and therefore the designated kitchen area within the centre did not have suitable and sufficient cooking facilities.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified. Arrangements were in place for identifying, recording, investigating and learning from serious incidents.

Judgment: Compliant

Regulation 27: Protection against infection

The prevention and control of healthcare-associated infections was effectively and efficiently governed and managed.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced as required. Staff showed enough knowledge and understanding of what to do in the event of a fire. However, fire drills were not reflective of all possible scenarios.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The practice relating to the ordering;receipt;prescribing;storing;including medicinal refrigeration;disposal;and administration of medicines was appropriate.

Judgment: Compliant

Regulation 6: Health care

Appropriate healthcare was made available to each resident, having regard to residents personal plans.

Judgment: Compliant

Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where any resident was alleged to be harmed.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Peamount Healthcare Neurological Disability Service OSV-0003505

Inspection ID: MON-0026612

Date of inspection: 08/04/2019

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: A review of staffing levels and skill mix will take place, and the roles of staff will be developed to ensure that a more flexible approach is adapted, and residents are supported in a way that promotes community inclusion and active citizenship. This will also involve a review by the Meaningful activities manager to support further engagement according to the residents will and preference. The staff will be rostered to meet the needs of the residents. A planned and actual roster folder in hard and soft copy is now in place since 10/04/2019 and all the staff names are fully documented.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Peamount Healthcare will carry out an unannounced visit every 6 months and an action plan on the safety and quality of care support provided in the centre will be put in place to address any concerns regarding the standard of care and support.	

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Residents will be consulted on their choice of activities. Residents will be encouraged and supported to increase social integration and participation in the community as per resident's wishes and choice. Peamount provides transport on a booking system to facilate all residents. In addition a wheelchair accessible transport is now available exclusively to the unit in the evenings to cater for any unplanned activities. Transport can be pre booked for the day as per planned activities.
An additional driver has been recruited to the transport team which will assist access to activities. Staff will be educated on identifying and recording meaningful activities. The activities plan will be reviewed and additional activities that residents have chosen will be identified and implemented with the support of the meaningful activities manager. Team meeting to be held with meaningful activity manager on a monthly basis to plan for the weeks ahead and ensure that all residents needs are being met.
Practice development will support the team in increasing the focus on social care.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
After discussion with MDT, a table top oven will be purchased to facilitate food appreciation for the residents on the unit. This is also available to the residents in the HUB. Residents will be fully supported to bake/prepare food, if they choose to do same.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drill was done on 10/04/2019 at 06.30 hours and forwarded to HIQA inspector as requested.

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 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	02/12/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Red	02/12/2019
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	Not Compliant	Orange	02/12/2019

	statement of purpose and the size and layout of the designated centre.			
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	10/04/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/06/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Not Compliant	Orange	10/04/2019

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			