eDeposit Ireland

No.1 Seaholly, OSV-0004574, 17 June 2020

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'No.1 Seaholly, OSV-0004574, 17 June 2020', [report], Health Information and Quality Authority, 2020-09-11, Designated Centre for Disabilities
Publisher	Health Information and Quality Authority
Download date	2026-03-11 03:38:41
Link to Item	https://hdl.handle.net/20.500.14765/99708

Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	No.1 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Short Notice Announced
Date of inspection:	17 June 2020
Centre ID:	OSV-0004574
Fieldwork ID:	MON-0029492

About the designated centre

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

This centre is located on a campus in close proximity to a major city. It is within access to shops, public transport and public amenities. This designated centre was set up to provide a specialist service for people with an intellectual disability, including autism. The designated centre has been adapted to meet residents' assessed needs and is a four-bedroom, single storey premises. The designated centre has a kitchen and separate dining room, a large day room / television room, a relaxation room, a sensory room, two bathrooms and a shower room. There is also a staff office and utility room. Three young male adults reside in the designated centre. Each resident has their own bedroom. One bedroom is used for staff to sleep over at night in addition to a waking night staff. There was an integrated day service for residents - two residents attending on site and one resident attending off site. Residents are encouraged to live an active, meaningful, everyday life by participating in household tasks, social and leisure activities. There is an outside garden area to the rear and side of the designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Wednesday 17 June 2020	10:00hrs to 17:00hrs	Michael O'Sullivan	Lead

What residents told us and what inspectors observed

The inspector met with all three residents during the course of the inspection. Two residents were non verbal communicators and one resident used some LAMH signs. This resident was able to indicate to the inspector that they were happy for the inspector to view their personal living space as well as their bedroom area. All residents appeared happy and content in the company of staff who had very good knowledge of each residents assessed needs and how best to support them communicate. All residents and staff appeared relaxed and apart from residents playing music, there was little background noise. Residents did not appear to be impacted by having a stranger present. Residents knew what activities were planned and they had been consulted with in advance. Residents were aware of and demonstrated adherence to good hygiene practices with the support of staff.

Capacity and capability

There was evidence that there was an effective governance and management structure in place within this designated centre, ensuring a good quality of care and support to resident's as well as the provision of a safe service. The designated centre was well organised and resourced to meet the needs of residents with complex needs. The inspector observed a service that was bespoke in nature and addressed residents assessed needs and wishes, supported the residents choice in matters concerning their day to day activities and encouraged residents to self determine as much as possibly. Residents assessed needs were observed to be similar and compatible.

The person in charge was an experienced, full-time staff member who had responsibility for five other designated centres. Authority was delegated to an experienced social care leader who was employed within the designated centre. The person in charge had a good knowledge of the residents and their needs and supported the designated centre through regular visits and staff meetings. Governance arrangements had been revised since the last inspection and the person in charge had additional oversight of all staff employed across the 24 hour day. The managers employed at night time reported directly to the person in charge and formal meetings were held quarterly. Two six monthly unannounced audits and an annual review had been conducted within the last 12 months. Residents families had been included in the annual review process.

The person in charge had in place sufficient and suitably qualified staff to deliver person centred care. Two residents had attended a day service based on the providers campus, while one resident had a day service off campus. Due to COVID-19 restrictions, these day services were not operational at the time of inspection.The

staff roster by day ensured continuity of care and facilitated resident's preferred activities. It was evident that the registered provider and the person in charge had applied additional staff resources to the designated centre to support residents continue with daily activities, community outings and assist residents to be more involved in their own activities of daily living. The skill mix of social care workers and trained care assistants provided a good standard of care. There was evidence that the residents received care in an environment that fostered inclusion. Residents were observed to be comfortable in accessing all areas of the designated centre and in assisting with minor food preparation. New staff recruited had an induction programme specific to the designated centre they were allocated to.

The inspector reviewed training records and a training matrix maintained by the person in charge. Staff had undertaken current mandatory prescribed training and training relating to the specific healthcare needs of residents. 47% of staff required refresher fire safety training, 33% required safeguarding training and 53% required managing behaviours that challenge. Some training delivery had been impacted by COVID-19 restrictions. In the absence of formal training, the registered provider had in place a recorded system of self declaration by staff to document online training and knowledge.

The provider had a clear and easy to read format on display in relation to its complaints policy. Residents were advised on how to make a complaint and how to avail of advocacy and the confidential recipient service. All complaints were logged in a complaints and compliments log.

The statement of purpose provided to the inspector on the day of inspection reflected the services and facilities provided at the designated centre and the current floor plans and drawings were correct. The statement of purpose had recently been updated. The certificate of registration for the centre was clearly displayed in the designated centres office. All notifications had been made to the Chief Inspector, of any adverse incidents that had occurred in the designated centre.

The registered provider and person in charge had records maintained and available for inspection in the designated centre. While there was documentary evidence to support residents annual attendance for a medical check up with their general practitioner, there was no record of the findings in the resident's healthcare files.

Regulation 14: Persons in charge

The registered provider had appointed a person in charge in a full-time capacity who had the necessary and appropriate experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the number, skill mix and qualifications of staff were appropriate to the assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had access to and completed appropriate training.

Judgment: Substantially compliant

Regulation 21: Records

Records available for inspection did not include Schedule 3 documentation pertaining to medical treatment and care relating to residents annual medical check ups.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider ensured that there was a clearly defined management structure in place to provide a safe service, appropriate to residents assessed needs.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider ensured that each resident had in place a contract clearly showing the terms and conditions of residency.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had in place a written statement of purpose that reflected the services provided.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that the Chief Inspector was informed of all adverse incidents.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a comprehensive and effective complaints procedure in place.

Judgment: Compliant

Quality and safety

The evidence available on the day of inspection, demonstrated a service of good quality where residents appeared to be happy. Residents enjoyed activities they did within their home, on campus and in the community. The focus of care was person centred. On the day of inspection, the inspector observed all staff interaction with residents to be respectful and gentle. Residents appeared unhurried and able to determine the pace and time they took to participate in activities.

The inspector found the designated centre to be clean, homely and welcoming. Residents art work was visible throughout the premises.There were both individual and communal spaces that afforded residents privacy. Some elements were specifically designed to meet the assessed needs of residents where rooms were furnished particular to residents needs and preferences.

There was evidence of the promotion and protection of residents' rights. Staff were

seen to treat residents with respect and afforded residents time to communicate. Communication was through a picture exchange communication system (PECS) and ensured residents were consulted on matters pertaining to their care and activities within the designated centre. Pictures, photographs and visual prompts were displayed throughout the designated centre. One resident communicated their needs to staff through the use of LAMH. There was evidence that each resident was supported to communicate in line with very clear communication passports, aids and maps. Residents had access to phones, the use of televisions and music systems. Staff actively assisted residents engage with the wider community and attend their families and homes for visits. All residents went on bus outings and social trips, including purchasing food for the designated centre.

Each resident had a positive behaviour support plan in place. Where a behaviour support assessment had been in place for a number of years, there was clear evidence of reassessment within the last 12 months. It was noted that there was a significant reduction in the use of seclusion relating to one resident, over the course of recent months. Goals were clearly documented in relation to staff support, interactions and interventions. There was also evidence of time structuring, daily planning and advance planning to support the resident. Staff communicated an intent to support the resident to a point of self independence and control over their own behaviour support plan. Accurate records were kept of all seclusion events. Restrictive practices were for the least period of time and the least restrictive measure used. While the registered provider had a policy committing to a monthly periodic service review of positive behaviour support plans, some plans had not been subject to review for six months. The use of seclusion had ceased to be recorded by the registered provider on their restrictive practices log. The classification of some medicines as not being a chemical restraint was inconsistent with the providers own policy. The person in charge undertook to address these issues.

Residents' individual care plans demonstrated a good standard of review. The detail recorded was easily understood and information was easily retrievable. Detailed risk assessments supported the care planning process. All community based activities undertaken by residents were recorded. Each residents had a daily record of their day, well-being and general welfare. Resident's had a current healthcare plan that was directly linked to their personal plan. A current OK health check was on file for each resident. Residents physical health and observations were regularly monitored and recorded. Each resident was subject to an annual medical check up with a general practitioner. There was no evidence of the outcome or findings on file for these annual check ups which was addressed under regulation 21. Medicines were well managed within the designated centre.

The provider and person in charge ensured fire precautions were in place to safeguard all residents. Each resident had a current personal emergency evacuation plan. Fire drill evacuation times for residents conducted in June 2020 were within acceptable limits. All fire equipment, fire doors and emergency lighting was checked by staff on a weekly basis. Fire extinguishers and fire blankets were checked and certified annually by a registered contractor in 2019. The person in charge had a

planned fire evacuation drill to simulate minimum staffing levels.

The provider had a current safety statement and risk register in place for the designated centre. Risks were identified and assessed specific to the designated centre, the residents and staff. Each resident had an individual risk assessment. The risk assessments and risk register had been recently updated to include COVID-19. Actions in response to this risk included additional staff training on site and through electronic learning platforms, enhanced daily cleaning rota's specific to the designated centre, additional recording of temperature checks, the provision of hand hygiene stations and personal protective equipment (PPE). All staff working in the designated centre had completed recent training in hand washing techniques, breaking the chain of infection and the donning and doffing of PPE. There were a number of bins located in the designated centre for the safe disposal of PPE. Staff employed the use of appropriate PPE gear where social distancing could not be employed and residents were actively encouraged and reminded to attend to hand hygiene. Staff hygiene practices were observed to be of a good standard.

Residents were observed to have open access to the kitchen and to the foods within the kitchen in the presence of staff. There was a choice of nutritious food available to residents and residents could choose food stuffs they liked. Staff were observed to wash their hands and use protective gloves when dealing with individual residents dietary needs.

Each resident had a contract of care in place that clearly recorded the terms and conditions of residency. Two contracts of care had yet to be returned by residents families to the provider. This matter was subject to ongoing follow up by the person participating in management.

Regulation 13: General welfare and development

The registered provider ensured that each resident was provided with appropriate care and support in relation to their wishes and to facilitate activities and recreation to make each day meaningful.

Judgment: Compliant

Regulation 17: Premises

The registered provider ensured that the designated centre was laid out and designed to meet the needs of the residents.

Judgment: Compliant

Regulation 18: Food and nutrition

The person in charge ensured that all residents had access to and a choice of nutritious and wholesome food.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had in place a risk management policy and risk register that was up to date.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider ensured that residents that may be at risk of healthcare infections were protected by adopting procedures and standards that reduced the risk, especially in relation to COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had good practices and procedures in place to reduce the risk of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had in place a suitable system and practices for the safe administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that each resident had a comprehensive care plan in place that was subject to regular review.

Judgment: Compliant

Regulation 6: Health care

The registered provider had in place appropriate health care for each resident having regard to the resident's personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The registered provider needed to ensure that seclusion as well as medicines used for chemical restraint were recorded as a restricive practice in line with the providers own policy.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to develop the knowledge, self awareness, understanding and skills for self care and protection.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that each resident participated and consented to

decisions about their care and support.
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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for No.1 Seaholly OSV-0004574

Inspection ID: MON-0029492

Date of inspection: 17/06/2020

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge has ensured that delays in mandatory trainings due to COVID 19 restrictions were notified to the Training Department and the Provider for resolution.

On-line Training on fire safety and safeguarding training to the standards set out by the Safety Officer and Designated Officer have been put in place. Staff requiring training have been given access to these on-line training courses. This will be completed by 17/07/2020.
Local fire evacuation training completed by all staff.

MAPA training is recommencing in line with COVID-19 restriction guidance and staff have been booked in to attend this training. This will be completed by 27/11/2020.</td></tr>
<tr><td>Regulation 21: Records</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
A system is in place for annual medical review of residents using an Ok Health Check format. This is reviewed by a nurse and General Practitioner.

The Provider will ensure that the system ensures that a record of the outcome and findings of these medical reviews is maintained in the resident's records as required under the Regulations.</td></tr>
</table>

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Seclusion was discontinued on 04/09/2019. The emergency use of environmental restraint has been re-referred to the Behaviour Standards Committee in line with Seclusion Policy and Procedure, 15/07/2020.

The infrequent use of a chemical restraint will be reviewed in line with Services Policy and referred to the Behaviour Standards Committee for a sanctioning meeting, 30/09/2020.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	27/11/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/09/2020
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each	Substantially Compliant	Yellow	30/09/2020

	resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/09/2020