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**Woodview, OSV-0003731, 28 March 2019**

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## Office of the Chief Inspector

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

Name of designated centre:	Woodview
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	28 and 29 March 2019
Centre ID:	OSV-0003731
Fieldwork ID:	MON-0023369

## About the designated centre

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

Woodview is a residential setting providing care and support for up to 24 residents over the age of 18 with an intellectual disability. The centre is located within a campus based service located in North Dublin. The centre comprises of a single occupancy apartment which is home to one resident. The other area of the centre contains a number of large dormitory style bedrooms, a number of single bedrooms, two large bathrooms with six toilets, two shower rooms, two bathrooms with a bath, a number of offices and storage rooms, two large open plan dayrooms, two large kitchen come dining rooms, two laundry rooms and laundry storage areas and two small sitting rooms which are used for visitors and as relaxation rooms also. Residents are supported 24 hours a day, 7 days a week by a staff team comprising of a person in charge, clinical nurse manager, staff nurses, care staff and household staff.

**The following information outlines some additional data on this centre.**

Current registration end date:	08/12/2020
Number of residents on the date of inspection:	15

## 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
28 March 2019	09:15hrs to 17:00hrs	Marie Byrne	Lead
29 March 2019	09:25hrs to 13:30hrs	Marie Byrne	Lead

## Views of people who use the service

The inspector had the opportunity to meet and briefly engage with nine residents living in the centre on the day of the inspection. In addition they had the opportunity to briefly speak with one residents' family member who was complimentary towards the care and support for their relative in the centre.

Residents did not express their opinions verbally to the inspector but they appeared content and comfortable throughout the inspection. In addition, throughout the inspection they appeared comfortable in the presence of, and with the levels of support offered by staff.

Residents were being supported to make choices in relation to their day-to-day lives and to engage in meaningful home and community based activities in line with their wishes and preferences. Residents' meetings were held regularly and residents were supported to make choices through the use of pictures of reference. Accessible information was available and on display throughout the centre including the complaints process. A number of residents were part of an advocacy group and residents could access advocacy services if they so wish.

## Capacity and capability

Overall, the inspector found that the registered provider and person in charge were striving to ensure a good quality and safe service for residents. There was evidence that the person in charge, person participating in the management of the designated centre and the service manager were monitoring the quality and safety of care in the centre. However, the provider was not ensuring full oversight of the centre due to the fact that they had not completed the annual review of care and support in the centre since 2016.

The centre was well managed and residents were being supported to make choices in their daily lives. There were clear management systems and structures in place and staff had clearly defined roles and responsibilities. The staff team reported to the person in charge who in turn reported to the person participating in the management of the designated centre (PPIM). The person in charge and a clinical nurse manager facilitated the inspection. In addition, the inspector had the opportunity to meet and briefly engage with six staff members and a student nurse on placement.

The person in charge had the necessary qualifications, skills and experience to fulfill the role. They were knowledgeable in relation to residents' care and support needs

and were fully engaged in the governance, operational management and administration of the centre. They had systems in place to monitor the quality and safety of care in the centre, and were supporting staff to carry out their roles and responsibilities.

Staff meetings were occurring regularly and there was evidence that the actions developed following the meetings were leading to positive outcomes for residents. In addition, the person in charge, PPIM and service manager were meeting regularly and completing audits which were leading to improvements for residents in relation to their care, support and their home. The six monthly reviews by the provider were also identifying areas for improvement in line with the findings of this inspection. They had developed an action plan following this review and were tracking progress in relation to these actions.

Throughout the inspection, residents appeared comfortable with the level of support offered by staff. Staff who spoke with the inspector were knowledgeable in relation to residents' specific care and support needs. Planned and actual rosters were available and well maintained. There were a number of staff vacancies in the centre and the provider was in the process of recruiting to fill these. In the interim, they were providing continuity for residents through staff completing extra hours and the use of regular relief staff. There was a robust induction process in place for new, relief and agency staff. The inspector reviewed a number of staff files and found that they contained all the information required by schedule 2 of the regulations.

Staff had completed a suite of training and refreshers in line with the residents' assessed needs. However, a number of staff required refresher training in safeguarding. The person in charge informed the inspector that dates had been identified for staff to complete this mandatory training. The inspector found that there were some arrangements in place for formal staff supervision. The person in charge had completed supervision training and was formally meeting staff at least twice yearly. In addition, staff were having annual performance reviews. Staff supervision required further time to be put in to ensure it was fully supporting staff to carry out their roles and responsibilities to the best of their ability.

There were policies and procedures in place for the management of complaints which were on display and available in an accessible format. There was a nominated complaints officer and systems in place to record, investigate, respond to and follow up on complaints. There was evidence that complaints were resolved to the satisfaction of the complainant.

The inspector reviewed a number of residents' contracts of care and found that they contained all the information required by the regulations. They outlined the charges and additional charges which residents were responsible for in relation to their day-to-day care and support. There were no new admissions to the centre in line with the organisations' statement of purpose and the conditions of registration.

There were a number of volunteers in the centre who were supporting residents to engage in activities in line with their needs and wishes. These activities included pet

therapy or music sessions. The volunteers had access to the support and supervision of a volunteer coordinator. They had their roles and responsibilities in writing, had signed a confidentiality agreement and had completed Garda vetting prior to commencing in their role as a volunteer.

#### Regulation 14: Persons in charge

The person in charge had the necessary qualifications, skills and experience to fulfill the role. They were working in the centre in a full time capacity.

Judgment: Compliant

#### Regulation 15: Staffing

Staff were suitably qualified and knowledgeable in relation to residents' care and support needs. Residents were observed to receive assistance in a kind, caring and respectful manner throughout the inspection. There were a number of staffing vacancies and the provider was attempting to minimise the impact of this for residents by staff completing extra hours and by using regular relief staff. They were in the process of recruiting staff to fill the current vacancies.

Judgment: Substantially compliant

#### Regulation 16: Training and staff development

Staff had access to training and refreshers in line with residents' needs. However, a number of staff required safeguarding training. Staff were in receipt of formal supervision on average twice per year and had annual performance reviews. Staff who spoke with the inspector stated that they were well supported in their role.

Judgment: Substantially compliant

#### Regulation 19: Directory of residents

There was a directory of residents in place, which contained all the information required by the regulations.

Judgment: Compliant

### Regulation 23: Governance and management

There were clearly defined management structures in place and staff had clearly defined roles and responsibilities. The person in charge, PPIM and service manager were monitoring the quality of care and support in the centre. However, the provider was not ensuring full oversight of the centre as they had not completed the annual review for the centre since 2016.

Judgment: Not compliant

### Regulation 24: Admissions and contract for the provision of services

Residents had a written contract of care which outlined the care, welfare and support and services to be provided. It also contained the fees to be charged including additional fees if required. There were no new admissions to the centre in line with the centres' statement of purpose and the conditions of registration.

Judgment: Compliant

### Regulation 3: Statement of purpose

The statement of purpose contained all the information required by schedule 1 of the regulations and had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

### Regulation 30: Volunteers

There were a number of volunteers in the centre and they were in receipt of regular support and supervision from a volunteer coordinator. They had clearly defined roles and responsibilities in writing and had completed Garda vetting prior to commencing in their roles.

Judgment: Compliant

## Regulation 34: Complaints procedure

There were complaints policies and procedures which were available and on display in the centre. There was a local complaints officer and evidence that complaints were logged, investigated and closed to the satisfaction of the complainant.

Judgment: Compliant

## Quality and safety

Overall, the inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was good. Residents lived in a caring environment and were engaging in meaningful home and community based activities. However, the design and layout of the premises was not meeting the number and needs of residents or the requirements of schedule 6 of the regulations. There was a lack of private space available for the majority of the residents who resided in dormitory-style accommodation.

The provider had plans in place in relation to the future direction of the service and there were no new admissions to the centre. The inspector found that additional efforts had been made to make the premises more homely since the last inspection. The number of residents living in the centre had reduced from 24 to 15. This had resulted in more bedroom space available to support residents to improve privacy and dignity issues associated with the multiple occupancy bedrooms. A number of residents had been supported to transition from the centre in line with their changing needs, or in line with their wishes and preferences. However, concerns remained in relation to the suitability and fitness for purpose of the building. In addition, improvements were required to the maintenance and upkeep of areas in the centre. The person in charge showed the inspector evidence that maintenance requests had been raised in relation to the areas in need of repair or redecoration. In line with the findings of the last inspection, the provider had plans for one resident to transition from a self-contained apartment in an isolated area of the original institutional type building, to another premises in close proximity to the centre. The provider had submitted plans regarding this to the Office of the Chief Inspector (OCI). The provider was recognising the premises deficits in their six monthly reviews of care and support in the centre, and the impact this was having on residents' privacy and dignity.

Residents' needs were appropriately assessed and personal plans were found to be person-centred. A new personal plan format had been introduced in the centre and there was a clear link between assessments and plans of care. There was evidence of regular review and update of residents' personal plans in line with their changing needs. Their personal plans were detailed and clearly guiding staff to support them

in line with their needs and wishes. There was evidence of annual multidisciplinary review of personal plans. The inspector viewed a number of residents' personal plans in an accessible format. In addition, some residents had their life stories on tablet computers. The person in charge had developed a care plan audit tool for use with the new personal plan format.

Residents were being supported to enjoy best possible health. They had access to allied health professionals in line with their assessed needs and staff were knowledgeable in relation to their care and support needs. Health action plans were developed as required and there was evidence of regular review and update of residents' personal plans in line with their changing needs. Some residents were accessing national health screening programmes and there was evidence that for others these programmes had been considered in line with their wishes and preferences. The provider had recently set up a committee to review health screening programmes and to set up various health promotion initiatives.

Residents were supported and encouraged to connect with their family. Improvements had been made since the last inspection to make sure that residents were engaging in meaningful activities in their local community. There was also an increase in the number of meaningful home based activities enjoyed by residents in the centre. An audit had been completed in relation to residents' activities and levels of enjoyment. Activities were discussed at residents' meetings and the importance of documenting residents' engagement in and levels of enjoyment were discussed at a recent staff meeting. There was a newsletter on display in the centre which outlined upcoming events on the campus which residents may wish to engage in. These events were also discussed at the weekly residents' meeting.

A number of residents had transitioned from the centre since the last inspection. In addition, there were a number of residents in the process of transitioning in line with their needs and preferences. Each resident who had or was in the process of transitioning from the centre, had a individual needs and preference assessment completed. This assessment was detailed in nature and reviewed aspects of residents' care and support needs, their social role, their communication preferences, their activity preferences, their preferences for future accommodation, and other details in relation to their needs and wishes. In addition to this they had a detailed step-by-step transition plans in place. From reviewing documentation and speaking to staff, it was clear that residents were being supported to transition in a planned and safe manner and at a pace that suited them and their peers.

There was a residents' guide in place which clearly outlined the services and facilities provided for residents. It also detailed the terms and conditions relating to living in the centre, the arrangements for residents' involvement in the running of the centre, how to access any inspection reports, the procedure for complaints and the arrangements for visitors.

Residents were protected by appropriate risk management procedures and practices in the centre. The risk management policy dated March 2015, did not contain all the information required by the regulations and had not been reviewed in line with the

timeframe identified in the regulations. The provider was aware of this and was also in the process of reviewing and updating the policy to ensure it contained all the information required by the regulations. There were systems in place for keeping residents safe while responding to emergencies and the person in charge had completed a full review of all incidents in the centre since the last inspection. This audit had resulted in the review and update the risk register and general and individual risk assessments. There was a clear link between residents' assessment of need, care plans and risk assessments. There was evidence of regular review and update of risk assessments in line with residents' changing needs and learning following incidents.

There were policies and procedures in place for residents to raise their concerns including the complaints procedure. These procedures were available in a format which was meeting residents' communication needs. There was accessible information available throughout the centre to support residents to make choices in relation to their day-to-day lives. Residents had access to advocacy support if they so wish and there was an advocacy group meeting regularly in the centre.

There was evidence of consultation with residents in relation to the day-to-day running of the centre. Residents meetings were held regularly and there was a folder on place with photos for reference used during residents' meetings, such as activity options, transportation options and items for shopping. There was information on display in the centre in relation to areas such as residents' rights, complaints, and advocacy. However, some residents' privacy and dignity were still not being upheld due to the design and layout of the centre including dormitory style bedrooms and shared bathrooms. Throughout the inspection it was clear that staff were working hard to ensure that all residents' privacy and dignity was respected at all times. They were attempting to minimise the impact of multiple occupancy bedrooms and shared bathrooms for residents by pulling curtains, closing doors and supporting residents to have their personal care provided at different times in line with their wishes and preferences.

### Regulation 13: General welfare and development

Residents were supported to take part in meaningful activities in line with their wishes and preferences. They were supported to develop and maintain relationships and links in their local community.

Judgment: Compliant

### Regulation 17: Premises

The design and layout of the centre did not meet the number and needs of residents or the requirements of schedule 6 of the regulations. There were areas of the centre in need of repair/refurbishment and the provider had recognised this and had plans in place to complete the required works.

Judgment: Not compliant

### Regulation 20: Information for residents

There was a residents' guide developed which contained all the information required by the regulations. The residents guide was available in the centre for residents and their representatives if they so wish.

Judgment: Compliant

### Regulation 25: Temporary absence, transition and discharge of residents

Residents were in receipt of the necessary supports as they transitioned from the centre. There were individual needs and preference assessments and clear step-by-step transition plans in place to ensure they occurred at a pace suitable to the resident.

Judgment: Compliant

### Regulation 26: Risk management procedures

Residents were protected by appropriate risk management procedures and practices. The risk management policy for the organisation did not contain all the information required by the regulations and had not been reviewed in line with the timeframe identified in the regulations. There were systems in place for responding to emergencies and arrangements were in place for identifying, recording, investigating and learning from serious incidents and adverse events.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

Residents' care and support plans were assessed and they had a personal plan in

place. There was evidence of review to ensure they were effective and that they were updated in line with residents' changing needs.

Judgment: Compliant

### Regulation 6: Health care

Residents were supported to enjoy best possible health. They had access to the support of relevant allied health professionals in line with their needs. Staff were knowledgeable in relation to their care and support needs.

Judgment: Compliant

### Regulation 9: Residents' rights

Residents were consulted with and participating in the planning and running of the designated centre. They had access to advocacy services if required. However, the inspectors found that improvement was required in relation to protecting residents' privacy and dignity due to the design and layout of the premises including dormitory style bedrooms and shared bathrooms.

Judgment: Not 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
<b>Views of people who use the service</b>	
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Woodview OSV-0003731

Inspection ID: MON-0023369

Date of inspection: 28 and 29/03/2019

## 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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Ongoing recruitment campaign in progress to fill vacancies. Interviews carried out on March 13th to recruit care staff, further interviews are due to be scheduled.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training dates for outstanding training scheduled for April 10th and 30th respectively. All staff in the centre will be in receipt of up to date mandatory training by April 30th.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC sent email to Quality and Risk officer on March 31st 2019 highlighting deficits in the quality review, and requesting a review to be scheduled. PIC awaiting response from officer. PIC and Service Manager will continue to monitor quality and risk at local level.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: IPNA process completed for all remaining residents, PIC and Service Manager continue to transition residents to their new home at the preference and pace of residents. Currently awaiting planning permission for one residents new apartment.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk	

management procedures:

PIC sent email to quality and risk officer and Director of Nursing requesting completion date of review of policy. Awaiting a response and confirmation of completion date.

Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: PIC will continue to ensure transitions to more suitable environments continues at the preference and pace of the resident. PIC will continue to ensure that residents are not in the bathroom at the same time and as numbers reduce will reconfigure dormitory style environment to provide more space to each resident.

## Section 2:

### Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2019
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	31/05/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	08/12/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/05/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	08/12/2020
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	31/12/2019

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/12/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/09/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	30/09/2019
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	08/12/2020