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## Damien House Services, OSV-0002442, 25 February 2021

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

## Issued by the Chief Inspector

Name of designated centre:	Damien House Services
Name of provider:	Health Service Executive
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	25 February 2021
Centre ID:	OSV-0002442
Fieldwork ID:	MON-0031202

## About the designated centre

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

Damien House is a designated centre operated by the Health Service Executive (HSE). The designated centre provides a residential service for up to twelve adults with a disability. The designated centre is located in a town in County Tipperary and comprises four houses and an apartment. One of the houses is based in a rural setting outside a main town and the additional four units are located on health service executive grounds. The centre is staffed by the person in charge, clinical nurse managers, staff nurses and health care assistants.

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

Number of residents on the date of inspection:	11
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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
Thursday 25 February 2021	10:15hrs to 17:10hrs	Conan O'Hara	Lead
Thursday 25 February 2021	10:15hrs to 17:10hrs	Deirdre Duggan	Support

## What residents told us and what inspectors observed

From what residents communicated with the inspectors and what was observed, it was evident that the residents received a good quality of care and enjoyed a good quality of life.

In line with infection prevention and control guidelines, the inspectors carried out the inspection mostly from an office located close to the units of the designated centre. The inspectors also ensured physical distancing measures and use of personal protective equipment (PPE) was implemented during interactions with residents and staff during the course of the inspection.

The inspectors had the opportunity to meet with three of the residents in one of the units of the designated centre during the inspection. Residents were observed to appear relaxed and comfortable in their home and engaging in activities of daily living including watching TV and painting their nails. Five residents completed questionnaires, with the assistance of staff members, describing their views of the centre they lived in. Overall, these questionnaires contained positive views regarding the centre and indicated a high level of satisfaction with many aspects of life in the centre such as activities, bedrooms, meals and the staff who supported them.

Resident's rights were found to be respected. The staff team were observed treating and speaking with residents in a dignified and caring manner. The residents were supported to develop and maintain their relationships with family and friends. While there were restrictions on visiting in place, in line with Public Health guidance, video calls had been utilised to support residents to maintain contact with people important in their lives.

The inspectors completed a walk through of two of the units of the designated centre and found that it was decorated in a homely manner. While the units were observed to be, in the most part, well maintained, there were areas of the premises which required upkeep.

In summary, based on what residents communicated with the inspectors and what was observed, the inspectors found that, while there were some areas for improvement, residents received a good quality of care and support in their home.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

## Capacity and capability

Overall, the inspectors found that there were management systems in place to ensure good quality care was being delivered to the residents. There were systems in place to effectively monitor the quality and safety of the care and support. On the day of inspection, there were sufficient numbers of suitably qualified staff on duty to support residents' assessed needs. However, some improvement was required in the centre's annual review and the oversight of training completed by agency staff.

There was a defined management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was supported in their role by two clinical nurse managers 2 (CNM2) and two clinical nurse managers 1 (CNM1). There was evidence of regular quality assurance audits taking place to ensure the service provide was safe, effectively monitored and appropriate to residents' needs. These audits included the annual report 2020 and the provider unannounced six monthly visits as required by the regulations. The quality assurance audits identified areas for improvement and action plans were developed in response. However, improvement was required to ensure the annual review consulted with the residents and their representatives. This had been identified by the provider and questionnaires had been sent out to representatives to be included in the annual review.

The person in charge maintained a planned and actual roster. From a review of the roster, it was demonstrated that there was sufficient staffing levels in place to meet the needs of the residents. The centre was operating with 1.5 whole time equivalent vacancies and the inspectors were informed that the provider was currently recruiting to fill these vacancies. At the time of the inspection, there was an established staff team in place and the use of a limited number of agency staff. This ensured continuity of care and support to residents. Throughout the course of the inspection, positive interactions were observed between residents and the staff team.

There were systems in place for the training and development of the staff team. From a review of the training records, it was evident that the staff team were up-to-date in mandatory training including de escalation techniques, safeguarding and fire safety. The previous inspection identified that improvement was required in the oversight of the training completed by agency staff. On the day of inspection, there was evidence of training completed by agency staff from one agency used by the provider. However, information on the agency staff from the second agency used by the provider was not available to inspectors.

The inspectors reviewed a sample of incidents and accidents occurring in the centre and found that they were appropriately notified to the Chief Inspector as required by Regulation 31.

## Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. The person in charge worked in a full time role and demonstrated a good understanding of residents and their needs.

Judgment: Compliant

### Regulation 15: Staffing

The person in charge maintained a planned and actual roster. There was sufficient staffing levels in place to meet the needs of the residents.

Judgment: Compliant

### Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. However, the oversight of agency staff training required improvement to provide assurance that agency staff had completed training as appropriate to meet the needs of the residents.

Judgment: Substantially compliant

### Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of regular quality assurance audits taking place which identified areas that required improvement and actions plans were developed in response. However, the annual review 2020 required improvement as it did not include evidence of consultation with the residents and their representatives.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

All incidents and accidents occurring in the centre and found that they were appropriately notified to the Chief Inspector as required by Regulation 31.

Judgment: Compliant

## Quality and safety

The management systems in place ensured the service was effectively monitored and provided safe, appropriate care and support to the residents. However, improvements were required in the living arrangements, fire safety, premises and oversight of restrictive practices.

The inspectors visited two of the units of the centre and found that the centre was decorated in a homely manner. However, it was observed that some areas of the units required some general upkeep in areas including painting and peeling laminate on kitchen presses. Some works were also due to be completed on the exterior paths of one unit following identification of external trip hazards. Following concerns raised about the heating in one of the units, the provider had put in place additional heating and undertaken regular temperature checks. The temperatures recorded were seen to be within recommended limits. A bathroom was found to be cooler on occasion and the person in charge told inspectors about plumbing works that had been completed to rectify this.

The resident's needs were assessed through personal planning and an annual health care assessment. The inspectors reviewed a sample of resident's plans and found that they were up-to-date, identified resident's health and social care needs and informed the resident's personal support plans. The personal plans were up-to-date and guided the staff team in supporting the resident with their assessed needs. In November 2019, the provider reviewed the compatibility and suitability of living arrangements for each resident and identified two placements as not suitable. While, the provider had developed plans to transition these residents to an suitable placement, the inspectors were informed that these transitions remained outstanding due to the impact of COVID-19. There was evidence of interim changes to the living arrangements within the units to ensure residents were safe and enjoyed a good quality of life until the transitions took place.

There were positive behaviour supports in place to support the residents. The inspector reviewed a sample of positive behaviour support plans and found that it was up to date and guided the staff team in supporting the residents to manage their behaviour. On the day of the inspection, the inspectors observed that a number of the staff team were attending individualised positive behaviour support training. There were a number of restrictive practices in use in the designated centre. The provider had systems in place to identify and review the restrictive practices to ensure they were appropriate and the least restrictive intervention. However, some improvement was required in the identification of all restrictive practices. For example, the inspectors identified two restrictive practices in place which were appropriately monitored but not identified as restrictive in nature.

There were systems in place for safeguarding residents. Residents appeared

comfortable and content in their home. Safeguarding plans were in place for identified safeguarding concerns and there was evidence of changes made to the living arrangements to safeguarding residents.

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. The centre maintained an up-to-date risk register which detailed centre-specific and individual risks and the measures in place to mitigate the identified risks.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting the residents to evacuate and there was evidence of regular fire evacuation drills. However, improvements were required in the containment measures in place. For example, the inspectors observed a fire door wedged open in one unit of the centre. This negated the function and purpose of the door. In addition, the centre had been reviewed by a fire officer in January 2021 who identified areas for improvement including two fire doors which could not be closed due to broken locking mechanisms. These works had not yet been completed.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre including regular cleaning schedules and cleaning products readily available if required. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection. The centre had access to support from Public Health. In addition, an recent audit completed by the Health & Safety Authority had identified some improvements such as updating of the risk assessment that dealt with COVID-19. This had been completed.

### Regulation 17: Premises

There were areas for some improvement in the maintenance of the premises. This included painting in areas of the centre, peeling laminate on kitchen presses and upkeep of exterior paths of one unit.

Judgment: Substantially compliant

### Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review

of risks in the designated centre. The risk register was up to date and outlined identified risks and the measures in place to mitigate the risk.

Judgment: Compliant

### Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for staffing and self isolation of residents. There was infection control guidance and protocols in place in the centre.

Judgment: Compliant

### Regulation 28: Fire precautions

Improvement was required in the arrangements in place for the containment of fire. For example, the practice of fire doors being wedged open in one unit and addressing two fire doors which could not be closed due to broken locking mechanisms.

Judgment: Not compliant

### Regulation 5: Individual assessment and personal plan

The suitability of the centre to provide care for two of the residents and to address issues of compatibility remains outstanding. While, there was plans developed to transition these residents to a suitable placement, the transitions had yet to take place.

Judgment: Substantially compliant

### Regulation 7: Positive behavioural support

There were positive behaviour supports in place to support the residents as required. There were systems in place to identify and review restrictive practices in use in the designated centre. However, some improvement was required in the identification of restrictive practices as two restrictive practices in use were not

identified as such.

Judgment: Substantially compliant

### Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that incidents were appropriately managed and safeguarding plans were in place to manage identified safeguarding concerns as appropriate.

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
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
<b>Quality and safety</b>	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Damien House Services OSV-0002442

Inspection ID: MON-0031202

Date of inspection: 25/02/2021

## 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 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The issue arising is the refusal of 1 particular nursing agency to share the training records of staff currently deployed to our service.</p> <p>The service will come into compliance by requesting training records and maintaining these records individually for the core pool of agency staff, which currently consists of 3 staff nurses. These staff will then be entered on our service training matrix which is managed and monitored locally.</p> <p>It is proposed this will be completed by 31st May 2021.</p> <p>A recruitment campaign is underway to fill the deficits in WTE's to reduce agency dependency – funding of the identified deficits was approved on 30/3/21 – and expressions of interest from the existing panel has been issued. This process normally takes 3 months to complete – proposed completion date would be 30/6/21</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The issue highlighted in the report will be addressed by the recirculation of consultation documents – satisfaction surveys etc, to residents and their representatives to finalize the 2020 Annual report.</p> <p>To ensure that omissions as above do not reoccur a standard operating procedure (SOP)</p>	

<p>will be devised and implemented prior to next annual report due date. It is proposed that this will be completed by 30/6/21</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: To address the issues raised in the report regarding namely painting and disrepair/damage to kitchen units – a full thematic audit/inspection will occur in each residence to identify matters relating to décor and maintenance and any issues identified will be escalated to the registered provider and relevant departments. The required external issues identified have been escalated and reviewed by estates department and we are currently awaiting report and plan of action from same The proposed timeframe on these works is 15/7/2021</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: The issues identified in the report have been addressed by the staff members who were on duty on date of inspection in the residence where the fire doors were wedged open, this has been addressed with these staff members and a directive to retake fire training on line. All staff in the service have received communications re compliance with fire safety regulations especially relating to the wedging open of fire doors and the associated risks of same. It is proposed this will be completed by 14/4/21</p>	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The issue identified in the report was the compatibility assessment undertaken by the service which had identified compatibility issues of residents in 2 residences. The proposed relocation of residents within the service was postponed due to the</p>	

unavailability of apartment identified.

The proposed transfer of the resident from Avila to Sonas was dependent on the relocation of a resident from Sonas to an identified premises in Cashel. This was progressing in early 2020 and the reason for a halt in the relocations was that the premises in Cashel was temporarily re purposed for emergency accommodation in the Covid 19 senior management response plan. This proposed relocation cannot occur until the premises is made available to Damien House Services. The identified apartment for relocation requires some remedial works and the completion of same and the availability of the apartment is dependent on the national Covid situation and governmental guidance before commencement.

It is proposed this will be completed by 31/3/22

Regulation 7: Positive behavioural support

Substantially Compliant

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

The issues identified in the report pertaining to restrictive practices not previously identified by the service as a restrictive practice – namely a smoking plan/schedule for 1 resident and the secure storage of a resident personal belongings where the resident had no direct independent access to same.

Residents smoking plan will be reviewed and referred to restrictive intervention review committee who next meet in June 2021.

The restriction relating to a residents access to personal belongings was reviewed by local management and was discontinued.

A thematic audit/inspection specifically to identify all restrictions and ensure no unidentified restrictions are in situ. It is proposed this will be completed 30/4/21

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
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	31/05/2021
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.	Substantially Compliant	Yellow	15/07/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their	Substantially Compliant	Yellow	30/06/2021

	representatives.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	14/04/2021
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/03/2022
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	30/04/2021