

# eDeposit Ireland

## Glebe, OSV-0003615, 14 February 2018

Item Type	report
Citation	Ireland. Health Information and Quality Authority, 'Glebe, OSV-0003615, 14 February 2018', [report], Health Information and Quality Authority, 2018-10-04, Disability Services Report, Disability, Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended
Publisher	Health Information and Quality Authority
Rights	Y
Download date	2026-03-13 05:09:10
Link to Item	<a href="https://hdl.handle.net/20.500.14765/87440">https://hdl.handle.net/20.500.14765/87440</a>



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

Name of designated centre:	Glebe
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	14 February 2018
Centre ID:	OSV-0003615
Fieldwork ID:	MON-0021223

## About the designated centre

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

St John of God Community Services Company Limited By Guarantee have a statement of purpose in place that offers a description of the service provided in Glebe (Glebe House). This document outlines the following description of the service. Glebe house is home for five male residents. Glebe House opened in January 2013. Four of the five residents in the designated centre transferred from the campus in St. Mary's Drumcar. St John of God North East Services is a voluntary organisation and is funded by the Department of Health.

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

Current registration end date:	04/04/2020
Number of residents on the date of inspection:	5

## How we inspect

To prepare for this inspection the inspector or 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
14 February 2018	10:00hrs to 16:00hrs	Conor Brady	Lead

## Views of people who use the service

This was a triggered (unannounced) risk based inspection, the primary focus of this inspection was to follow up on information received by HIQA pertaining to a safeguarding incident that occurred in the centre in 2015. The purpose of this inspection was also to inspect current safeguarding and risk management arrangements in place to assess the safety of residents.

There was limited opportunity to meet with residents on this inspection. The house was empty on the inspectors arrival with residents gone to their day programmes. Two residents were met by the inspector and communicated on their own terms over the duration of the inspection. Residents who lived in the centre presented with complex support needs.

## Capacity and capability

The inspector found that the safeguarding incident that occurred in this centre in 2015 was not managed, investigated or responded to appropriately by the provider. While a number of governance, management and personnel changes had occurred (since this incident), the inspector had concerns regarding a number of the issues reviewed on this inspection. The person in charge that was in place in this centre was in post since October 2017 and the previous person in charge (who transferred to another part of the service) also participated in this inspection as they were responsible for the centre at the time of the incident in 2015.

The inspector found that the person in charge did not demonstrate oversight of incident/accident reporting on the day of inspection and therefore could not demonstrate effective oversight and monitoring of same. While some verbal assurances were given regarding risk oversight, the incident reports, records, monitoring system could not be found/accessed on the day of inspection. The person in charge was not appropriately aware of the contents of the notification submitted to HIQA regarding the notified incident.

The inspector found regulatory failings regarding managerial risk oversight and post incident response, protection and safeguarding of resident's, their finances and personal information and the promotion of residents rights.

While there did not appear to be immediate risks to residents in this centre the inspector was not assured by the systems and oversight in place based on the

evidence gathered on this inspection.

### Regulation 15: Staffing

Staffing in the centre at the time of the notified incident was found not to be sufficiently supervising residents in line with their assessed needs.

Judgment: Not compliant

### Regulation 23: Governance and management

Effective governance and oversight was not in place at the time of the incident reviewed. In addition, there were current shortfalls in oversight and governance found on this inspection.

Judgment: Not compliant

### Quality and safety

The inspector had concerns regarding managerial oversight, monitoring and response to key risk areas and safeguarding practices.

The safeguarding incident that was subject to the notification (that triggered this inspection) was reviewed and was not found to be appropriately investigated, managed or responded to by the provider. The previous person in charge highlighted the resident was not provided with any medical assessment post allegation/incident. An undated and unsigned safeguarding report appeared to uphold an abusive interaction took place however this report contained inconsistent information.

The two residents involved in the incident remained living in bedrooms next to each other with the main control measure implemented being a keypad lock on one residents bedroom door to stop the other resident having access to him. The inspector queried what other measures were considered following this incident, however no alternatives to the approach taken were highlighted. This did not demonstrate all safeguarding considerations were taken to protect the resident.

The levels of behaviours of concern and potential risks were of a very serious nature in this centre. While the person in charge highlighted some good understanding and knowledge of this, further oversight and risk assessment and management was

required. For example, the trending and analysis of all incidents/accidents, continuous review of risk assessments and control measures. The compatibility of residents in this centre also required review in terms of the assessed needs of all residents living there.

In reviewing resident's finances and records the inspector found that the two residents whose finances were checked were both down €100 in their cash balances. When discovered the person in charge inquired with staff who stated other staff must have taken it out for resident activities. The inspector found that this was not appropriately protecting resident's monies as there was an absence of any system in place for signing out these residents monies and therefore the whereabouts of the money was unclear.

In addition to the above, the inspector found a lot of residents personal information and incident reports were kept in an unlocked press on an upstairs corridor of the house. This information should be secured for residents privacy and confidentiality.

In summary the inspector found that in the areas inspected further improvements were required in this centre in terms of risk management and safeguarding practices.

### Regulation 26: Risk management procedures

Managerial risk oversight was ineffective. Some risks were not evident on the risk register or assessed and some were inappropriately risk rated.

Judgment: Not compliant

### Regulation 8: Protection

Residents were not adequately protected and safeguarded from the systems in place.

Judgment: Not compliant

**Appendix 1 - Full list of regulations considered under each dimension**

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
<b>Quality and safety</b>	
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant

# Compliance Plan for Glebe OSV-0003615

Inspection ID: MON-0021223

Date of inspection: 14/02/2018

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

## Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

### Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ol style="list-style-type: none"> <li data-bbox="220 904 1449 981">1. Risk assessments for the two residents will be reviewed and amended as/if required for current circumstances.</li> <li data-bbox="220 1021 1449 1173">2. Following the 2015 incident, all staff were reminded of each resident's potential to engage in inappropriate/unwanted behaviors', the PIC review and discuss supervision needs of residents (based on revised risk assessments) with all staff during a staff meeting.</li> <li data-bbox="220 1214 1449 1249">3. Actions will be documented and completed by 31<sup>st</sup> May 2018.</li> </ol>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ol style="list-style-type: none"> <li data-bbox="220 1527 1449 1603">1. Risk assessment in place around these behaviors has been reinstated and will be reviewed for adequacy of control measures in place.</li> <li data-bbox="220 1644 1449 1720">2. Supervision of staff will include specific discussion around the need to remain vigilant around inappropriate/unwanted interaction between residents (on going).</li> <li data-bbox="220 1760 1449 1868">3. The potential for inappropriate interaction between residents will be highlighted regularly at team meetings, supervision meetings, and staff handover (immediately and on going)</li> </ol>	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. All related risk assessment control measures will be implemented.
2. NIMs trends and analysis will be reviewed monthly within the Designated Centre.
3. All related risk assessments in Designated Centre are being reviewed in relation to adequacy of controls and staff supervision.
4. All risk assessments will be included on risk register. |

Regulation 8: Protection

Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

1. Staff will meet with individual residents, and then in a group, to discuss appropriate/inappropriate interactions, and how they can report an incident or concerns.
2. All residents will take part in a 'Protect Yourself' programme.
3. Staff will be encouraged to remain hypervigilant around the supervision needs of residents and the adequacies of controls in place will be regularly reviewed as a team.
4. Any incidents involving the residents in the DC will be investigated in accordance with the applicable policy or guideline, and with immediate effect.
5. The security of personal information will be improved by locked access to archive room.
6. All residents' monies are signed out, as well as in, rather than only being signed back in as per current practice. |

## 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.	Not Compliant	Orange	31 May 2018
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31 May 2018
Regulation 26(2)	The registered provider shall	Not Compliant	Orange	30 June 2018

	ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	30 June 2018
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30 April 2018