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Office of the Chief Inspector

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

Name of designated centre:	Morlea House
Name of provider:	St Christopher's Services Company Limited by Guarantee
Address of centre:	Longford
Type of inspection:	Unannounced
Date of inspection:	03 September 2019
Centre ID:	OSV-0001842
Fieldwork ID:	MON-0023823

About the designated centre

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

Morlea House designated centre is made up of two buildings. The main building is a large two story house in, Co. Longford. On the ground floor, there is a bright entrance hall, six bedrooms, of which two are ensuite, an accessible large kitchen and dining area, sitting room, and office space. On the first floor, there is storage and office space. There is an accessible garden and outdoor seating area at the side of the residence. The Gate Lodge is a house adjacent to Morlea House that comprises of two bedrooms one of which is en suite, a kitchen, sitting room, utility room, games room and storage areas. Specialist equipment provided to meet the needs of the individual includes sensory safety equipment and alerts. Morlea House can accommodate a maximum of seven male and female adult residents from 18 years to end of life, where appropriate, who have intellectual disability, with high/intensive support and complex needs and behaviours of concern. All residents are supported by nursing staff and care assistants with one social care worker under the direction of a clinical nurse manager in delivering a person centred model of service provision.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6
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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
03 September 2019	10:00hrs to 18:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

The inspector met with five residents over the course of the inspection. The inspector met with one resident after they had returned from their day service. The resident showed the inspector around their home and was assisted to interact with the inspector by staff member supporting them. The resident appeared comfortable in their interactions with the staff member and was eager to show the inspector around their home. The resident was assisted to inform the inspector about a recent medical procedure and the progress of their recovery.

The inspector spent some time with the other residents as they were having tea. Some of the residents required assistance and encouragement with this. The inspector observed positive interactions between the residents and staff members supporting them. Some residents used their own non verbal communication skills during this time and it was evident that the staff supporting them had a good knowledge of the residents and their abilities. Another resident interacted briefly with the inspector but then returned to their own activities.

Capacity and capability

Overall the residents were being provided with a good quality and safe service. Residents were receiving support from a staff team that were aware of their needs and abilities and were being supported to engage in activities of their choices. Some residents were attending day services and personalised programs had been developed for some residents in order to meet their needs. The provider's capability to provide the highest standard of care was, however, being compromised by staff deficits that were impacting upon the service being delivered.

There was a management structure in place that was led by the person in charge. The person in charge was supported by a team leader and a staff team of nursing, social care workers and care staff. There was evidence that members of the centres management team were being utilised to support or cover staffing deficits as per the centres risk register and assessments. The management team had put auditing systems in place in the centre but their ability to effectively monitor the service provided was being impacted by the staffing deficits. Some areas of the residents information required attention including the tracking of residents individual goals and also contracts for the provision of services.

The provider had ensured that the annual review of the quality and safety of care and support in the centre had been carried out. An unannounced visit had also been carried out by the provider as per the regulations. A written report had been prepared following this visit that reviewed the safety and quality of care and support

provided in the centre. The inspector observed that a plan had been put in place regarding actions raised in the report and that the management and staff team were active in addressing these.

A review of the centres proposed and actual roster highlighted the existing staffing deficits in the centre. Nursing care was being provided to residents but there were nursing staff deficits and the centre was reliant on locum nursing staff members to complete shifts. This did not promote continuity of care. A further review of the roster also highlighted that there were occasions where the provider was unable to ensure that the actual staffing levels on shift were in line with the assessed needs of the residents. There was evidence of staff members completing additional shifts in order to support the care of the residents. However, this was not a sustainable approach to the management of staffing resources which required review as it had the potential to impact on the quality of care being provided to the residents.

The provider had measures in place to ensure that staff were competent to carry out their roles. Staff had received training relevant to their roles, in addition to mandatory training in fire safety, manual handling, safeguarding and behaviour management. There was also a range of additional trainings available to staff.

There was a system in place to respond to incidents which occurred in the centre and to learn from them. The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. There was evidence that adverse incidents were investigated and reviewed appropriately and that learning from incidents was prioritised. The person in charge had also ensured that quarterly and six-monthly notifications were being submitted as set out in the regulations

The provider had made efforts to ensure that residents experienced good care when moving into the centre. The inspector reviewed a transition plan that had been completed for the most recent admission to the centre. The resident and their representative visited the centre before the admission and steps were taken to prepare the resident for the transition. There was also evidence that compatibility assessments had been completed as part of the admission process.

The provider had ensured that contracts for the provisions of services had been prepared for residents. The inspector reviewed a sample of these and found that the auditing of these contracts required some attention as there were duplicates of contracts and information relating to fees to be charged missing from one residents' contract. Following the inspection the person in charge submitted copies of the contracts of care that had been previously completed but were not available on the day of inspection.

The registered provider had a complaints procedure in place. There was an easy read document on how to make a complaint and how the complaints were managed. There was a complaints log in place in the centre and residents were asked if they had any concerns or issues during residents meetings.

The person in charge was absent on the day of the inspection, the provider had in line with the regulations ensured that the chief inspector was notified that the

person in charge would be absent from the centre for a continuous period of 28 days or more. The provider had also put appropriate systems in place to manage this absence.

The person in charge and staff team working with the residents were promoting a safe and quality service for residents, However, the staffing deficits in the centre were effecting the providers ability to ensure ongoing effective support.

Regulation 15: Staffing

A review of the centres proposed and actual roster highlighted the existing staffing deficits in the centre. Nursing care was being provided to residents but there were nursing staff deficits and the centre was reliant on locum nursing staff members to complete shifts. This did not promote continuity of care. A further review of the roster also highlighted that there were occasions where the provider was unable to ensure that the actual staffing levels on shift met the assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The centre's staff team had access to appropriate training, including refresher training as part of the staff team's professional development. A sample of staff's supervision records showed that they were receiving supervision regularly and that learning was being promoted.

Judgment: Compliant

Regulation 23: Governance and management

There was a management structure in the centre. The person in charge was supported by a team leader and a staff team of nursing, social care workers and care staff. Members of the centres management team were being utilised to support or cover staff deficits as per the centres risk register and assessments. This had the potential to impact negatively on the provider's capacity to oversee the quality and safety of care. Some areas of the service required improved oversight including residents' goal setting and contracts for provision of services

The provider had ensured that the annual review of the quality and safety of care and support in the centre had been carried out. An unannounced visit had also been carried out by the provider as per the regulations. A written report had been prepared following this visit that reviewed the safety and quality of care and support provided in the centre. The inspector observed that a plan had been put in place regarding actions raised in the report and that the management and staff team were active in addressing these.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed a transition plan that had been completed for the most recent admission to the centre. The resident and their representative visited the centre before the admission and steps were taken to prepare the resident for the transition. There was also evidence that compatibility assessments had been completed as part of the admission process.

The provider had ensured that contracts for the provisions of services had been prepared for residents. The inspector reviewed a sample of these and found that the auditing of these contracts required some attention as there were duplicates of contracts and information regarding fees to be charged missing from one residents' contract. Following the inspection the person in charge submitted copies of the contracts of care that had been previously completed but were not available on the day of inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. The person in charge had also ensured that quarterly and six-monthly notifications were being submitted as set out in the regulations.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider had ensured that the chief inspector was notified that the person in

charge would be absent from the centre for a continuous period of 28 days or more.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place. There was an easy read document on how to make a complaint and how the complaints were managed. There was a complaints log in place in the centre and residents were asked if they had any concerns or issues during residents meetings.

Judgment: Compliant

Quality and safety

In general the quality and safety of care provided to the residents was to a good standard and their health, emotional and social care needs were being supported and provided for. However, some issues were identified with the upkeep and auditing of documentation relating to, individual plans and the centres fire containment measures.

The inspector observed positive interactions between the staff team and residents during the course of the inspection. There was evidence that residents were meeting with their key workers and that residents were being supported to be active in the person centred planning process. A sample of residents' personal plans were reviewed. It was found that the residents availing of the service had received assessments of their health and social care needs and that the plans were individualised and were catered to the changing needs of the residents. There was also evidence that the personal plans were reviewed annually or more regularly if necessary and that the residents key workers were active in promoting and supporting residents.

The inspector observed that goals were being set for residents with their key workers. There were, however, inconsistencies in the tracking of goal achievements for residents in relation to their social care needs. Activities had been identified but it was unclear if they had taken place for some residents.

A sample of residents' files showed that they were receiving appropriate health care. Residents had access to appropriate health information, allied healthcare professionals and were being supported to attend appointments when necessary. The inspector observed that the provider and person in charge had reacted promptly to a resident experiencing swallowing difficulty in the centre. The resident was assessed by a member of the providers multi-disciplinary team and guidance was

provided to staff supporting the resident.

Residents were assisted to communicate in accordance with their needs and wishes. There were communication support plans in place and residents were being facilitated to access assistive technology and aids where necessary.

The provider had ensured that fire drills were taking place on a regular basis and that the staff team had received suitable training in fire safety. Regular fire safety audits and servicing of the fire safety equipment were observed during the inspection. However, the inspector requested information that confirmed that the provider had made adequate arrangements to contain potential fires in relation to the centres fire doors. The provider was unable to supply this information on the day of inspection.

The provider sought specialist advice following the inspection and it was confirmed that the centres fire doors were appropriate but that the fire containment seals needed to be replaced for a number of the fire doors.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. The provider had ensured that there was a risk management policy in place that met the requirements set out in the regulations. There were risk registers specific to the two buildings that made up the centre; these addressed social and environmental risks and were under regular review.

Staff members had received appropriate training in the management of behaviour that is challenging including de-escalation and intervention techniques. There were systems in place to support residents with their behaviours and the inspector observed that these plans were under regular review with some recently being updated. Residents, where necessary, were reviewed at the provider's behaviour of concerns committee that was attended by members of the provider's multi-disciplinary team. Individualised programs had been developed to support residents, there was evidence of the centres staff team meeting to review these plans and ensure that a consistent approach was being provided to support residents with their behaviours of concern.

There were restrictive practices being utilised in the centre. However, there was evidence that the person in charge was ensuring that the least restrictive procedure was being utilised for the shortest duration of time. The centre had a restrictive practice log in place that was reviewed by the person in charge and also by members of the providers multi-disciplinary team

There was safe guarding information available to residents in the centre and the staff team supporting residents had received appropriate training in relation to safeguarding residents. The provider and person in charge were proactive in relation to safe guarding residents. A review of safeguarding plans showed that the provider was following national guidelines and were reporting incidents as per the regulations. The provider had identified compatibility issues between certain residents. The provider and person in charge had addressed this issue by developing individualised plans for some residents outside of the centre and this was reducing

the amount of time residents were spending with one another.

The person in charge had ensured that the centre had appropriate and suitable practices in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines. There was also evidence that staff members working in the centre had received adequate training to administer medication safely. However, medication errors had been recorded in the centre and there was evidence of these errors being reviewed and systems being put in place to address same. Adaptations had been made to the centres medication recording sheets and medication kardexs had been updated in order to reduce potential errors.

The inspector found that residents appeared happy, relaxed and content. Staff members were observed by the inspector to be warm, caring, kind and respectful in all interactions with residents.

Regulation 10: Communication

Residents were assisted to communicate in accordance with their needs and wishes. There were communication support plans in place and residents were being facilitated to access assistive technology and aids where necessary.

Judgment: Compliant

Regulation 17: Premises

The inspector visited both of the centres houses and found that they were laid out to meet the aims and objectives of the service and the number and needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. The provider had ensured that there was a risk management policy in place that met the requirements set out in the regulations. There were risk registers specific to the two buildings that made up the centre; these addressed social and environmental risks and were under regular review. The person in charge and team leader reviewed incidents quarterly or more regularly if required and learning was then fed back to the team supporting the residents.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured that fire drills were taking place on a regular basis and that the staff team had received suitable training in fire safety. Regular fire safety audits and servicing of the fire safety equipment were observed during the inspection. However, adequate arrangements were not in place for fire containment. The inspector requested information that confirmed that the provider had made adequate arrangements to contain potential fires in relation to the centres fire doors. The provider was unable to supply this information on the day of inspection.

The provider sought specialist advice following the inspection and it was confirmed that the fire seals needed to be replaced for a number of fire doors.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured that the centre had appropriate and suitable practices in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines. There was also evidence that staff members working in the centre had received adequate training to administer medication safely. Medication errors had been recorded in the centre and there was evidence of these errors being reviewed and systems being put in place to address same.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Samples of the residents' personal plans were reviewed, it was found that the residents availing of the service had received assessments of their health and social care needs. There was evidence that residents support plans were reviewed annually or more regularly if necessary and that the residents key workers were active in promoting and supporting residents. However, there were inconsistencies in the setting and tracking of goal achievements for residents in relation to their social care needs.

Judgment: Substantially compliant

Regulation 6: Health care

A sample of residents' files showed that they were receiving appropriate health care. Residents had access to appropriate health information, allied healthcare professionals and were being supported to attend appointments when necessary.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff members had received appropriate training in the management of behaviour that is challenging including de-escalation and intervention techniques. There were systems in place to support residents with their behaviours and the inspector observed that these plans were under regular review with some recently being updated.

Judgment: Compliant

Regulation 8: Protection

Residents were supported to develop knowledge around self-awareness, understanding and skills needed for self-care and protection. A review of safeguarding plans showed that the provider was following national guidelines and were reporting incidents as per the regulations.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Morlea House OSV-0001842

Inspection ID: MON-0023823

Date of inspection: 03/09/2019

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider’s response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: A full center staffing review will be undertaken by Senior Management and the Person in Charge based on completed individual assessment of needs. The outcome of this evaluation will be discussed with the funder. The service will in the interim continue to recruit staff nurses for the current vacancies and utilise the existing staff nurse locum panel. The service will continue to ensure all locum staff. Irrespective of grade will be fully inducted to meet the support and care needs of each resident.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge was absent for a period of more than 28 days and has since the inspection returned in full capacity.</p> <p>The CNM1’s role is fully supported to oversee the quality and safety of care and support. The contracts of support and care were submitted to the Authority post inspection and each resident’s goals have been reviewed and an action plan has commenced within the centre under the direction of the Person in Charge</p>	

Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: An assessment was completed for four doors in an occupied area of the centre, which was submitted to the Authority. Remedial works to the doors to comply with relevant legislation will be completed by 31/12/2019.</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: Each resident's goals have been reviewed and an action plan has commenced within the centre under the direction of the Person in Charge.</p>	

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	13/11/2019
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.	Substantially Compliant	Yellow	24/10/2019
Regulation 28(3)(a)	The registered provider shall make adequate	Not Compliant	Orange	31/12/2019

	arrangements for detecting, containing and extinguishing fires.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	24/10/2019