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## Ballinvoher, OSV-0001529, 06 March 2018

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Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of designated centre: | Ballinvoher |
| Name of provider: | Peter Bradley Foundation Company Limited by Guarantee |
| Address of centre: | Limerick |
| Type of inspection: | Announced |
| Date of inspection: | 06 March 2018 |
| Centre ID: | OSV-0001529 |
| Fieldwork ID: | MON-0020805 |

## About the designated centre

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

Ballinvoher is a four bedded residential neuro-rehabilitation service. It is home to four people with an acquired brain injury. The service is staffed 24 hours a day, seven days a week. The service aims to provide individualised, community-based supports, designed to maximise the quality of life of each person living with an acquired brain injury while fostering autonomy, personal growth and development.

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

| | |
|---|---|
| Current registration end date: | 07/07/2018 |
| Number of residents on the date of inspection: | 3 |

## 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 |
|---|---|---|---|
| 06 March 2018 | 11:10hrs to 20:15hrs | Caitriona Twomey | Lead |

## Views of people who use the service

The inspector met with the three residents living in the centre. All three residents appeared very at ease in the centre and demonstrated positive relationships and regard for the staff working with them. Residents spoke freely with the inspector about what they enjoy doing and their positive experiences of living in the centre and the staff working there.

The inspector also reviewed four questionnaires completed by residents or on their behalf (one related to a resident no longer living in the centre on the day of the inspection). The majority of feedback provided was positive.

## Capacity and capability

There was evidence of good governance in the centre; however areas for improvement were identified. These included consultation with the residents of Ballinvoher in the annual review, the recognition and reporting of restrictive practices and other notifiable events, the maintenance of documentation relating to meetings and some staff records, and the inclusion of all members of the staff team in supervision processes and training. It was also identified that the statement of purpose required review to meet the requirements of the regulations.

The inspector met with four staff during the inspection and all were aware of their own responsibilities and who they reported to. Residents were able to identify the person in charge, who was in the centre a few days a week. There was evidence of ongoing auditing and monitoring of the quality of the service provided to residents in the centre. An annual review had been completed. This referenced, under the quality improvement plan for 2018, the need to upgrade the fire safety system in the centre. The person in charge advised that this had also been raised with the Health Service Executive. The risks posed by the current system in place are outlined under Quality and Safety. Although there was reference to consultation with residents in the annual review, this information related to those accessing services nationally and not those living in Ballinvoher.

The provider appeared to be providing the service as outlined in the statement of purpose. The centre was staffed and resourced to meet the assessed needs of the residents. The person in charge outlined that staff supports can be flexible in the centre to meet residents' needs and gave examples of additional supports provided when a resident first moves in and during some outings while residents are in day services. The centre was allocated its own vehicle.

There was a regular staff team in the centre who were complemented as necessary by a small group of regular relief staff known to the residents. At the time of inspection there were no volunteers working in the centre. The staff met with during the inspection had a good knowledge of the residents and their support needs. On many occasions staff were observed interacting with residents in a positive, respectful and encouraging manner.

Monthly staff meetings were attended by the person in charge and the majority of the staff team. The documented agenda and minutes indicated that a wide range of topics were covered including service planning, quality and standards, health and safety, and learning from adverse incidents. These records also demonstrated that both staff and residents' views were raised and discussed in this forum. The meeting records did not include action plans or review timeframes. It was therefore difficult to ascertain what follow up actions were generated and completed. There was a system in place to support regular one-to-one staff supervision sessions and performance management. However, this system was not implemented with the staff working in the centre on a relief basis.

The person in charge and staff team promoted a restraint-free environment in the centre. This was evident throughout the centre. However, a routine practice of keeping some food items locked in the staff office was identified during the inspection. This had not been recognised as a restrictive practice by the person in charge and was therefore not implemented in line with the organisation's policy or reported to HIQA. It was also identified through a review of incident records that an incident involving the unexplained absence of one resident was not reported to HIQA, as is required by the regulations. There was documented learning and changes to practice as a result of this incident.

## Regulation 14: Persons in charge

The provider met the requirements of the regulations.

Judgment: Compliant

## Regulation 15: Staffing

Not all of the documents and information required by Schedule 2 of the regulations were available for some staff working in the centre.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The annual review did not involve consultation with the residents and representatives living in that centre. Relief staff were not involved in the performance management and supervision processes in place in the centre.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The Statement of Purpose did not include all of the information as specified in Schedule 1 of the regulations including the information set out in the Certificate of Registration and the arrangements made for the supervision of any therapeutic techniques used in the centre. The diagram outlining the organisational structure of the centre was not clear. It was also identified that the whole time equivalent of the person in charge was not accurate.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

Not all incidents involving the unexplained absence of residents and the implementation of restrictive procedures in the centre were notified to HIQA, as is required by the regulations.

Judgment: Not compliant

## Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent

The provider met the requirements of the regulations.

Judgment: Compliant

## Quality and safety

It was found that a high quality, individualised service was being provided to residents in the centre that aligned with their assessed needs and preferences. To further support the provision of a quality service, the documentation outlining the supports in place regarding specific areas of need required review to ensure it was comprehensive and useful and informative to the residents and staff team. In addition, the documentation of residents' house and keyworker meetings required improvement. Some staff training gaps were also identified. There was a significant safety risk posed by inadequate fire precautions in the centre.

A person-centred approach to service planning and provision was evident in the centre. Two of the three residents attended day services for half days, a few days a week. The activities available in these centres matched the personal interests that residents had expressed to the inspector. The third resident had previously attended a similar service but did not wish to continue. At the time of inspection, staff were in the planning stages of supporting this person to attend a community based hub which matched his interests and abilities. It was evident that within the centre residents were encouraged to participate in activities of daily living that both matched their preferences and further developed their skills, interests and independence. All residents regularly spent time in the local community and were supported to maintain strong family relationships. Residents were regularly visited in the centre. Visitors were welcomed to the centre by the staff team and residents.

Residents' meetings were held monthly. According to the records reviewed, a wide variety of topics were discussed that reflected residents' participation in the running of the centre and their own supports. There was also documentation to support the regular occurrence of one-to-one keyworker meetings for each resident. As with staff meetings, there were no action plans documented for the resident or keyworker meetings. It was therefore difficult to ascertain if residents' wishes and suggestions were implemented. Evidence of resident participation was seen on various individualised assessments and plans.

Each resident had an Individual Rehabilitation Plan which outlined their individualised, specific and measurable goals. These goals were reviewed quarterly and revised annually. Residents' personal plans also documented their social and healthcare needs. The personal plans had been reviewed in the last 12 months, with input from multidisciplinary professionals.

Behaviour Support Plans reviewed by the inspector contained both proactive, preventative strategies and response guidelines for staff to implement. Although the majority of the staff team had received training in this area, it was identified that not all staff were trained to support residents should they display behaviours that challenge.

The personal plan documentation relating to each resident was divided across a number of individualised files. As a result, all of the information relating to a particular assessed need was not always filed together. For example, although there was a support plan in place to address a specific need for one resident, this plan was insufficient and did not reflect all of the supports required and outlined in other

documents filed elsewhere.

The centre was clean and bright and decorated in a comfortable and homely manner. There was a garden to the rear of the centre that was well maintained and accessible from the kitchen area. Residents appeared at ease in the centre and the feedback received regarding the premises was mostly positive. However, two residents reported in the completed questionnaires that the centre can be cold at times. The person in charge and social care worker advised the inspector that the heating in the centre was being monitored to prevent a reoccurrence of this issue. There was a compliments and complaints box on the wall in a communal area of the house. A resident explained its purpose to the inspector.

It was identified that the centre was not equipped to meet the regulatory requirements regarding fire precautions. This situation posed significant risk to residents and staff should a fire occur. Although smoke detectors were provided these were not interconnected and as such may not alert residents and staff throughout the building to the outbreak of fire. As outlined previously, the person in charge was aware of this and had submitted a funding request to the Health Service Executive to address this issue. The majority, but not all, of the staff team had received centre-specific fire training. There was fire fighting equipment in the centre, a number of precautionary processes in place including daily, nightly and monthly fire safety checks, and both an evacuation procedure for the centre and personal emergency evacuation plans for each resident. However, a review of fire drill records in the centre also identified areas for improvement.

## Regulation 11: Visits

The provider met the requirements of the regulations.

Judgment: Compliant

## Regulation 13: General welfare and development

The provider met the requirements of the regulations.

Judgment: Compliant

## Regulation 17: Premises

The provider met the requirements of the regulations.

Judgment: Compliant

## Regulation 28: Fire precautions

A review of fire drill records completed in the previous six months identified that in 50% of drills, including the only one completed in night time conditions, not all residents evacuated the centre. There was no evidence of measures taken to address this identified issue. There were no available drill records where the centre was staffed by one person, as is the staffing ratio overnight in the centre.

It was identified that the centre did not have an adequate fire detection and alarm system, emergency lighting, or containment arrangements to ensure means of escape.

Relief staff had not received fire training.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

The documented plans did not always reflect the supports required to meet the resident's assessed needs.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

Relief staff had not received training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

The provider met the requirements of the regulations.

Judgment: Compliant

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 33: Notifications of procedures and arangements for periods when the person in charge is absent | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Ballinvoher OSV-0001529

## Inspection ID: MON-0020805

## Date of inspection: 06/03/2018

**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:**

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:<br>The documents missing from staff files have been copied from National Office or provided by the staff member as necessary.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>In addition to the national uSpeq survey, residents will be given the opportunity to complete a local feedback process each year.<br>Relief staff are now included in quarterly Support & Supervision meetings, as well as the annual Performance Management process.</td></tr>
<tr><td>Regulation 3: Statement of purpose</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>The Statement of Purpose for the centre has been updated, including the organisational structure and whole time equivalent for the PIC.</td></tr>
<tr><td>Regulation 31: Notification of incidents</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>The centre has begun quarterly notification of the identified restrictive procedure. The PIC will ensure that any future incidents involving the unexplained absence of residents are reported within 3 days.</td></tr>
</table>

| Regulation 28: Fire precautions | Not Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

*This compliance plan response from the registered provider did not adequately assure the office of the chief inspector that the actions will result in compliance with the regulations.*

A fire drill has been completed in the early morning when only one staff is present and was repeated until a full evacuation occurred. A night or early morning fire drill when one staff is on duty will be conducted every 3 months.

The relief staff member, outstanding for fire safety training, will complete fire safety training prior to returning to duty. All staff will have completed fire safety training again by 31/07/2018.

A recent inspection by a fire safety expert has recommended a new external door from the back bedroom downstairs. The HSE have been requested to provide funding for this work.

The centre will be fitted with the appropriate fire alarm, emergency lights and fire doors.

The staff roster will be reviewed to ensure the safest possible environment is provided with the available staff.

| Regulation 5: Individual assessment and personal plan | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A number of resident's health care plans have been updated to more accurately reflect the number of support systems in place.

| Regulation 7: Positive behavioural support | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The relief staff member, outstanding for positive behaviour support training, will complete this training during 2018.

## 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(5) | The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2. | Substantially Compliant | Yellow | Completed 30/04/2018 |
| Regulation 23(1)(e) | The registered provider shall ensure that the annual review referred to in subparagraph (d) shall provide for consultation with residents and their representatives. | Substantially Compliant | Yellow | 31/10/2018 |
| Regulation 23(3)(b) | The registered provider shall ensure that actions plans and reviews are in place to follow up on any issues raised at the staff or residents meetings with | Substantially Compliant | Yellow | Completed 11/05/2018 |

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| | regard the quality and safety of the care and support provided to residents. | | | |
| Regulation 28(2)(c) | A fire safety inspection of the residence will be carried out by an external body<br><br>The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Orange | Completed 30/04/2018<br><br>31/7/2018 |
| Regulation 28(3)(a) | Conference call with HSE National Disability Specialist – Operations re funding<br><br>The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires through the installation of a fire detection system | | Orange | Completed 03/05/17<br><br>31/7/2018 |
| Regulation 28(3)(b) | The registered provider shall make adequate arrangements for giving warning of fires. | Not Compliant | Orange | 31/7/2018 |

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|---|---|---|---|---|
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Not Compliant | Orange | 31/7/2018 |
| Regulation 28(4)(a) | The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents. | Substantially Compliant | Yellow | 31/07/2018 |
| Regulation 28(4)(b) | The registered provider shall ensure by means of fire safety management and fire drills at suitable intervals, that staff and residents, are aware of the procedure to be followed in the case of fire with a minimum of one simulated night fire drill per quarter | Not Compliant | Orange | Completed 30/04/2018 |

| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | Completed 30/04/2018 |
|---|---|---|---|---|
| Regulation 31(1)(e) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre including any unexplained absence of a resident from the designated centre. | Not Compliant | Orange | Completed 30/04/2018 |
| Regulation 31(3)(a) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre including any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. | Not Compliant | Orange | Completed 30/04/2018 |

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|---|---|---|---|---|
| Regulation 05(4)(a) | The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs. | Substantially Compliant | Yellow | Completed 30/04/2018 |
| Regulation 07(2) | The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques. | Substantially Compliant | Yellow | 31/7/2018 |