**Health Information and Quality Authority**
**Regulation Directorate**

**Compliance Monitoring Inspection report**
**Designated Centres under Health Act 2007, as amended**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by The Children's Sunshine Home |
| **Centre ID:** | OSV-0003282 |
| **Centre county:** | Dublin 18 |
| **Email address:** | anne-marie@lauralynn.ie |
| **Type of centre:** | Health Act 2004 Section 38 Arrangement |
| **Registered provider:** | The Children's Sunshine Home |
| **Provider Nominee:** | Philomena Dunne |
| **Lead inspector:** | Deirdre Byrne |
| **Support inspector(s):** | Ann Delany; |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 18 |
| **Number of vacancies on the date of inspection:** | 1 |

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

**Compliance with the Compliance with the Health Act 2007 (Care and Support of Residents in 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 04 June 2014 09:30 | 04 June 2014 18:30 |

The table below sets out the outcomes that were inspected against on this inspection.

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs |
| Outcome 07:  Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

**Summary of findings from this inspection**

This was the first monitoring inspection of this designated centre for adults and children with an intellectual disability by the Health Information and Quality Authority's Regulation Directorate (the Authority). The purpose of the inspection was to assess compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities. At this inspection, inspectors met with residents and staff members, the person nominated on behalf of the provider and the management team.

The Children's Sunshine House (operating as LauraLynn Ireland's Children Hospice) is governed by a board of directors consisting of 10 members, with Philomena Dunne as CEO. Ms. Dunne is also the person nominated on behalf of the provider and will be referred to as the provider throughout the report. Ms. Dunne is supported in her role by the senior management team with a variety of roles and responsibilities, along with the person in charge Anne-Marie Carroll. During discussions, the provider and person in charge demonstrated a commitment to providing a good quality service with good governance systems in place.

The designated centre consists of a two units which were campus based and located in an urban area, in close proximity to city centre and good access to public

transport. Overall, inspectors found that residents received a good quality of service in the centre. The centre can accommodate up to nineteen residents, both children and adults. There were separate living and sleeping facilities for the adults and children. Inspectors met most residents during the inspection. Staff supported residents in making decisions and choices about their lives. The centre had a warm atmosphere and inspectors found the units were nicely decorated.

Inspectors found evidence of good practices across all nine outcomes monitored. Residents were familiar with the staff, and were supported to make choices in accordance with their needs, interests and capabilities. The staff were familiar with the residents needs and were observed to speak to them in a respectful and dignified manner. There were suitable fire safety procedures in place with regular fire drills in the centre.

However, inspectors found areas of non compliance over the nine outcomes monitored. These related mainly to documentation issues, the completion of personal plans, the completion of assessment and review by a multidisciplinary team; also the systems in place for the management of restraint required review. There were improvements required in aspects of medication management.

The arrangements in place to support residents to manage their own finances required improvement and the systems in place for the supervision of staff also required review.

These non compliances are discussed in the body of the report and included in the action plan at the end of this report

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

**Outcome 01: Residents Rights, Dignity and Consultation**
*Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors reviewed only one component of this outcome in relation to residents' personal possessions.

Inspectors found the provider had a policy on the management of residents personal finances in place. There were procedures on the management of transactions from residents personal accounts. However, they did not provide sufficient guidance to staff on the care of residents' property and finances. Furthermore, while the provider and person in charge had put arrangements in place to protect the property and the finances of residents, these were not sufficient to ensure residents' finances were adequately protected and that there was transparency in relation to the use of residents' monies. Some residents' families made a contribution from the residents' disability allowance to the everyday costs of running the service. The amount was not set out in an agreement with the residents and the consent of the resident was not obtained. Some residents did not have their own bank accounts and there was no evidence they had been supported to do so.This matter was discussed with the provider and the person in charge who agreed it improvements were necessary and would undertake to address the matter.

The staff in the centre showed inspectors how some residents were using monies in their account each week. Inspectors reviewed a number of these and noted transactions were being signed by a staff member and countersigned by another staff member.

**Judgment:**
Non Compliant - Moderate

**Outcome 05: Social Care Needs**
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were required in the overall assessment process and development of personal plans for each residents. Improvements were also identified to ensure all residents had opportunities to participate in meaningful activities appropriate to their interests.

There was evidence that residents welfare and wellbeing was maintained by a good standard of care and support, and by staff who were familiar with their health care needs. All of the residents had a moderate to severe disability and required a high level of support and assistance. However, the model of care provided was based on a medical approach that lacked personal interaction and consultation with the residents. Each residents had a "my care passport" that identified the residents care needs, and outlined their likes and dislikes and their personal history. However, the residents plans had a medical focus and did not not provide sufficient information on residents' specific social, emotional, participation needs, preferences and preferred routines. There was no evidence plans impacted positively on the lives of the residents. The residents did not have a personal input and their representatives were not involved in an assessment process. Furthermore, there was no evidence an annual review was carried out that included a multi-disciplinary input. Inspectors were shown a new integrated care plan that was being piloted on a small number of residents. It was anticipated this model of care planning would streamline the assessments of residents and ensure a more clear documented process would be implemented in the centre.

Inspectors reviewed a sample of residents medical plans in place. However, the assessments completed were not evidence based. They were not completed at regular intervals or as required. Furthermore, the care plans in place for residents identified needs were not detailed enough to guide practice regarding issues such as, percutaneous gastronomy (PEG) tube feeding and the management of epilepsy.

There were good links with the community and residents attended regular education and day services. However, inspectors were concerned that not all residents were supported to attend a day service. It was noted one resident had ceased to attend day

service in November 2012. Inspectors read minutes of a meeting held in September 2013. But there was no documented rationale whether this decision was taken based on the residents needs and why the situation continued. There was no evidence the residents quality of life had improved through non attendance at the day service. A letter from the day service seen by inspectors indicated the resident may lose a place through continued non attendance. This was discussed with the person in charge and the provider, who acknowledged improvements were required and undertook to address the matter.

The overall provision of social activation for residents required improvement. Whilst activities were provided and staff engaged with residents. There was a lack of activities based on residents identified needs and likes and interests.

There were systems in place to ensure the residents participated in education and meaningful occupation outside of the centre. The children attended school and there was evidence of interaction and input with these services. The schools provided feedback and worked closely with the service and each residents had an individual education plan.

**Judgment:**
Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**
*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found the provider and person in charge was proactive in ensure the health and safety of residents, visitors and staff was promoted and protected. However, some improvements were required in the overall management of risk both environmental and clinical and in how procedures were documented and finalised.

There was a signed and current health and safety statement in the centre, that incorporated a health and safety policy as required by Regulations. A location specific health and safety audit document was made available and had been acted upon. There was a quality, risk and safety committee in the centre.

There was a risk management policy dated 2014 in place. However, it did not fully meet the requirements specified by the regulations. For example, the missing persons protocol did not outline what to do in the event of a resident, child or adult, going missing from the centre. A risk register was maintained and it did contain evidence of

identification and management of risk. However, not all areas of risk in the centre had been identified and assessed. For example, the storage of latex gloves, unrestricted window openings and hose-piping. This was brought to the attention of provider and person in charge who addressed the matter immediately and later showed inspectors an updated risk register.

There was a system in place for recording incidents or adverse events. However, the management of adverse events required improvement. For example, whilst incidents were recorded there was no evidence of the action taken to prevent similar incidents occurring, or analysis of the information to identify trends and bring about overall improvement.

Records were read that confirmed all staff had received up-to-date training in the moving and handling of residents.

Inspectors saw guidelines on the management of specific infections. However, there was no centre specific infection control policy as required by Regulations. There were appropriate procedures in place that were outlined to inspectors in the event of management of an incident. Personal protective equipment, hand gel dispensers and wash hand basins were available throughout the centre. Clinical waste was managed appropriately.

An emergency plans was reviewed by inspectors and a draft emergency plan was also in development. However, they did not fully guide practice. For example, alternative accommodation was not identified for each resident should this be required.

There were policies and procedures on the management and prevention of fire. Inspectors saw fire exits were unobstructed and read daily checks that were completed by staff. However, checks were inconsistently recorded at weekends. There was evidence that fire drills took place up to three times a year, and both staff and residents participated. Inspectors saw records were maintained for drills and they included the findings and any learning required. However, the records reviewed did not state the year the drills were carried out. The staff were able to tell inspectors what they would do if the fire alarm went off. Inspectors saw documented evidence that fire equipment was serviced regularly such as fire extinguishers, fire alarms and emergency lighting. Fire evacuation plans were displayed throughout the centre. Records reviewed by inspectors indicated that all staff had participated in fire training within the past three years.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided*

*with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
While inspectors found there were measures in place to safeguard residents and protect them from abuse, the overall management of restrictive practices required improvement.

The procedures followed regarding the management of restraint were not in accordance with the Regulations. Inspectors found all residents had a bed rail in place irrespective of need. Furthermore, practice was not in line with the national policy and the centres policy. For example, risk assessments for the use of bedrails were not completed, and, the rationale on the use of bed rail was not outlined. There was no evidence that alternatives had been considered and that the least restrictive form of restraint was tried. There was no individual care plan developed. This was discussed with the provider and person in charge, who acknowledge it was an area of improvement.

A policy relating to positive behaviour support was read by the inspector, and seen to be operating in practice. There were very few residents with behaviours that challenged in the centre. Inspectors reviewed the positive behaviour plan for one resident. The plan described the underlying causes of behaviours and the least restrictive and most therapeutic interventions to be used. Additionally, these interventions were regularly reviewed to assess their impact on improving challenging behaviour and improving the lives of residents. The staff were familiar with the residents and took every action to ensure all alternatives were followed, and interventions reduced. However, it had not been drawn up in consultation with the resident or the family. This matter was brought to the attention of the person in charge.

There were systems in place to ensure residents were safeguarded and protected from abuse. There was a policy for on and procedures in place for the prevention, detection and response to abuse of vulnerable adults. There was a separate policy and guidelines for the management of an allegation of child abuse. The policy were comprehensive and provided direction to staff. For example, it included a flow chart outlining the reporting procedures in the event of a suspicion or allegation of abuse. There was a named designated liaison person, the internal senior social worker. Inspectors met with the social worker who outlined her role. There were five persons who deputised in the designated persons absence. An information sheet was seen in the nurses station that included photos of each of the named persons along with their contact details. Staff spoken to were knowledgeable of the types of abuse and the reporting arrangements in place. There were records that confirmed all staff had completed training in protection of vulnerable adults and children. Inspectors observed staff treating residents in a warm, caring manner.

A number of allegations of abuse were notified to the Authority prior to this inspection. Inspectors were satisfied they had been adequately investigated, and appropriate measures were put in place to safeguard the residents. A report of the investigations carried out was submitted to the Authority. Inspectors also read residents files and daily records which records any incidents that had occurred in the centre affecting the residents. The person in charge and provider were knowledgeable on how to respond to incidents, allegations or suspicions of abuse.

**Judgment:**
Non Compliant - Major

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found residents were supported on an individual basis to achieve and enjoy best possible health, however, access to general practitioner (G.P.) services and the overall assessment of residents health needs required improvement.

An annual health care review was undertaken in addition to the regular monitoring of residents health. The residents G.P. carries out the review and a document of this review was on file. However, improvements were identified to ensure all residents had timely access to GP services. Inspectors read the review carried out for one resident. Inspectors were informed by staff that it had had been carried out without the G.P. seeing the resident and no physical assessment of the residents had been undertaken in the centre or at the G.P. surgery.

The residents in the centre had a range of differing health care needs that required ongoing clinical support and care. However, inspectors found clinical assessments of residents health care needs were not comprehensive and were not carried out on a regular basis. Therefore the records did not provide full information on residents overall health status or underlying conditions which is pertinent to the care provision. Where residents health care needs were identified and a care plan developed, the plans did not consistently guide practice. For example, the management of epilepsy and percutaneous endoscopic gastronomy (PEG) tube feeding. The action in relation to this is detailed under Outcome 5 Social Care Needs.

There was evidence of regular access to ophthalmic services and dental services

available. The records of these visits and the subsequent outcomes were recorded by staff and demonstrated that resident's health care was prioritised. There was evidence of referral and regular consultation with allied services as required by the residents. For example, there was an in house occupational therapist, dietician and physiotherapist available. There was also a psychology service available in house to provide additional support to the staff where required. The residents were not able to refuse treatments or interventions except with family consultation, there was evidence that this right was respected and documented but also that every support and encouragement was provided to the resident to participate.

Inspectors did not review the end-of-life policy and procedures at this inspection. This would be reviewed at the next inspection.

The residents meals were generally prepared in each of the units kitchenettes. The vast majority of residents were on a modified consistency diet and an individual dietary regime was developed. Each unit in the centre had its own kitchen area and staff prepared meals for residents on a modified consistency diet from here. There was evidence of training provided for staff in food hygiene and safe food preparation. Inspectors read enteral feeding regimes for residents, that were reviewed on a monthly basis. Dietary requirements were supported and where relevant residents are supported with weight dietary advice or special dietary requirements. There was a separate canteen that prepared meals for residents on normal diets.

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found there were policies and procedures on the management and prescribing of medication in place. However, improvements were required to ensure the policies were comprehensive enough to protect residents and guide staff.

There was a detailed policy on the management of medication that was reviewed by inspectors. However, improvements were required as it was not fully implemented in practice. For example, a sample of medication prescription and administration sheets were reviewed. Although inspectors found that staff were careful in the administration of, storage and accounting for medication overall, improvements were identified in the

documentation of one residents medication prescription sheet. These are outlined as follows:

- the name of the residents G.P. was not included on the prescription sheet
- some medication were not prescribed an administration time
- crushed medications were not individually prescribed.
- the maximum dose for "as required" (PRN) medications were not prescribed.
- discontinued medication was not signed by a G.P.

Furthermore, while staff were clear on what they would to dispose of medications, there were no documented procedure on the safe disposal of out-of-date medications. Additionally, there was no documented procedure in place for the safe management of medications for residents who attended respite care. Inspectors saw an admission and discharge form was completed that included each of the medications received for the residents.

There were suitable procedures on the management of medicines that required strict controls (MDAs). No residents were self-administering medication at the time of inspection. All staff had completed medication management training and competency checks upon commencement of their role in the centre as mandatory. However, staff had not had received refresher training at regular intervals since initial training. This is discussed further under outcome 17.

There was evidence that medication was being reviewed regularly by the appropriate G.P. A medication monitoring group carried out spot checks and audits of medication practices. A formal medication audit was undertaken by the pharmacy and any discrepancies were noted and acted upon. There was a documented system for the return of medication.

**Judgment:**
Non Compliant - Moderate

**Outcome 13: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors did not fully review this outcome at the inspection. However, an aspect of the outcome, that related to the type of service being provided to residents required

improvement.

There was a draft statement of purpose seen by inspectors. While it outlined the services to be provided, it did not accurately reflect the service that is provided in the centre. The centre provided care for adults in long term care and respite care for children. However, the provider informed inspectors that a small number of children were accommodated in the respite unit of centre on a long term basis. While this was stated in the Statement of Purpose, the service did not fully meet the needs of these residents as it was primarily a respite care unit. They lived in the centre along side respite residents coming for short stays. Although the provider and person in charge acknowledged this arrangement was not suitable, the children had been in the service for a number of years.

This matter was brought to the attention of the provider who acknowledged they were aware of the issues and were actively attempting to address the long term care arrangement for the children its care.

**Judgment:**
Non Compliant - Moderate

**Outcome 14: Governance and Management**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that there was an appropriate management structure in place which supported the delivery of safe care and services.

The provider had established a clear management structure, and the roles of managers and staff were clearly set out and understood. There was a system of monthly management team meetings which provided reports to the nominated provider. There was risk review group which regularly met and provided guidance and support to the person in charge on managing areas of risk and compliance with the Regulations. There was a strategic organisation plan that had individual service plans for the service. There were quarterly reviews of departments outcomes. A system of unannounced audits which was in the process of being rolled out at the time of inspection. The results of

some of these audits were reviewed by inspectors. The person in charge and provider acknowledged the audits required further action to effect change and drive improvement.

Inspectors found that the person in charge of the centre was suitably qualified and met the requirements of the Regulations. She was knowledgeable regarding the requirements of the Regulations and the National Standards for Residential Services for Children and Adults with Disabilities. She had a very good knowledge of the health and support needs of the residents and demonstrated a strong commitment to improving outcomes for them. The person in charge was clear about her roles and responsibilities and about the management and the reporting structure in place. She maintained good records and demonstrated very good knowledge in relation to the protection and safeguarding of vulnerable adults.

**Judgment:**
Compliant

**Outcome 17: Workforce**
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**
Responsive Workforce

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The provider had ensured that there were suitable staff and skill mix to meet the assessed needs of residents. There were recruitment processes in place to ensure staff employed in the centre were suitable to work with vulnerable adults and children. However, some improvements were identified to meet the requirements of the Regulations and the completion of supervision meetings with staff.

Inspectors reviewed the records relating to staffing and found that they contained most of the information outlined in Schedule 2 of the regulations. However, an area of improvement was required to ensure compliance. For example, photographic identification for some staff was missing. A number of agency staff were used to cover staff leave. There was a service level agreement with the agency.

Training records were reviewed by inspectors for staff of the designated centre. Training was overseen by a dedicated training department and inspectors reviewed staff files in this unit in detail. All staff had up-to-date mandatory training and a range of other

training was provided to staff to meet the assessed needs of residents. As discussed under outcome 12, an area of improvement was identified in relation to the provision of refresher medication management training.

While supervision arrangements were carried out on a monthly basis in the past, inspectors were advised these had ceased to be held and took place at staff meetings. There were annual appraisals carried out for each member of staff and a sample of these were read by inspectors. Many staff have been working in the centre for a long period of time, and had an in depth knowledge of the residents, staff were observed supporting and engaging with residents in a person centred, professional and friendly manner. Staff also discussed residents in a very respectful and positive way, and were very knowledgeable in relation to individual needs of the residents.

There were a large number of volunteers attending the centre. A volunteer coordinator oversaw the recruitment and supervision of volunteers. Inspectors spoke to a number of volunteers who were visiting residents at the time of inspection. The person in charge was aware of the documentation requirements for volunteers, and inspectors reviewed a sample of files that included An Garda Siochana vetting and a written agreement.

**Judgment:**
Non Compliant - Minor

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Deirdre Byrne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**


**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by The Children's Sunshine Home |
| **Centre ID:** | OSV-0003282 |
| **Date of Inspection:** | 04 June 2014 |
| **Date of response:** | 11/08/2014 |

## Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

## Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents' finances were not managed in line with the Regulations.

**Action Required:**
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

**Please state the actions you have taken or are planning to take:**
Personal Accounts will be established for each adult in residence to ensure their finances managed in line with regulations:
• A communication has been sent to all relevant families informing them of actions

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

required to transfer all individual's personal income into their own name. 07/07/14
• Met with National Advocacy Services for guidance on supporting adults in managing personal finances on 29/05/14
• Met with AIB with regards to opening Persons in Care Accounts
• Contact Department of Social Welfare & Protection with regards to allowances each adult is currently in receipt of.
• Personal Finances are routinely placed on individual's Person Centred Planning Agenda
• Finance Policy to be reviewed to incorporate policy for personal property, possessions and finances
• Meet individual families to commence transfer of resident's personal finances into their accounts, commenced July 2014.

**Proposed Timescale:** 31/12/2014

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that a comprehensive assessment of residents needs was carried out on an annual basis.

Assessments tools used to identify residents health care needs were not evidence based.

**Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
As a first step in our drive for further improvements in our care planning 'The Care Planning and Assessment Project Team' is actively in the process of designing and piloting a new comprehensive assessment of need.
Two key members of this team are leading on the implementation of this initiative initially with a small number of residents as an interim measure. This work will be reported back to the project team by early September 2014. Feedback from this pilot initiative will be sought from residents (in so far as this is feasible) and/or their nominated representatives as well as from the multidisciplinary team involved in care planning. This feedback will inform the plan for a full implementation of a new and better comprehensive assessment of need for each adult and child living permanently in the service to be achieved by December 2014.
Our goal is to achieve a stronger comprehensive assessment of need with an improved multidisciplinary focus in partnership with families. In order to support this goal the Service has established a new monthly multi-disciplinary forum to strengthen assessment and care planning processes across health and social care disciplines to

bring greater direction and co-ordination to the multiple and diverse health and social care needs of all individuals.

**Proposed Timescale:** 30/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were clinical and did not outline residents individual needs, aspirations and choices.

Plans did not positively impact on the lives of residents.

**Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**
The Service acknowledges the inspectors complimentary comments on the 'Care Passport' feature of our existing care planning process. This will be further enhanced by the introduction of Social and Recreational Care Plans for all of our residents. Individual profiles will be included in care plans in consultation with residents and families to identify individuals preferred routines, choices, likes and dislikes as well as goals and aspirations.

Given the complexities of many individuals disabilities The Service is committed to supporting ongoing effective communication with external services to build on the positive working relationships we have with schools and day services in order to further enrich the lives of individuals through inclusion, friendships and achievement.

• A review of the quality of life for residents completed in October 2013.
• A Quality of Life Group established October 2013, with Multi Disciplinary Team and Volunteer participation the group focuses on the enhancement of the quality of life of residents and meets monthly, resulting in increased opportunities to access community social activities through the development of a programme of activities.
• Choice for residents has been addressed by a sub group of the Quality of Life group, new initiatives include the introduction of pictorial menus and improved choice of meals
• Social and Recreational Care Plans will be in place by the end of December 2014.
• Keyworker system is in operation
• Link worker system with schools and day services is in operation to achieve a co-ordinated approach in supporting individuals with their wishes and goals.
• Interagency communication protocol to be completed by 31st August 2014.
• The Care Planning & Assessment team have introduced 'Special Moments Journals' to be complied with residents and families to record special moments to share with families and friends. Work has commenced on these.

**Proposed Timescale:** 30/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not in an accessible format for residents

**Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

**Please state the actions you have taken or are planning to take:**
As part of the brief of the Care Planning and Assessment Project team the Service is committed to consulting with residents in so far as this is feasible and with their families on making care plans more accessible.

Given the profound nature of many individuals' disabilities the Service is actively engaged in a series of consultations with families to ascertain their views and promote a stronger sense of working together.
• An information meeting is planned for families on 28th August 2014 to discuss the implementation of the Standards.
• The services of professional advocacy agencies have also been engaged to support this drive for continuous improvement.

**Proposed Timescale:** 30/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents had no input into their personal plans and plans were not kept under regular review.

**Action Required:**
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

**Please state the actions you have taken or are planning to take:**
The Service has begun a process of consultation with individual families to review the physical, emotional, social and spiritual needs of each resident. Our clinical leadership and key worker system is supporting this review process. It is planned that this will be achieved by November 2014.

• The implementation of our monthly multi-disciplinary forum will strengthen the monitoring and review care planning process by promoting effective communication

between health and social care professionals and via co-ordinating a regular revision of all care plans.
• The National Advocacy services have been engaged with regards to enhancing residents and families involvement
• Annual person centred plan reviews are in operation, will be reviewed and closely monitored

**Proposed Timescale:** 30/11/2014

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The missing person protocol did not meet the requirement of the Regulations.

**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
The Service had a Missing Child/Adult Procedure (Ref No: ND017; Rev: 01; 26/05/14) in operation during the date of inspection. The Service subsequently emailed a copy of the Missing Child/Adult Procedure to the Inspector on 25th June 2014.

**Proposed Timescale:** 11/08/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all areas of risk as outlined in Outcome 7 of the report had been identified, assessed and monitored.

**Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
In relation to the three areas of risk identified during the inspection
• Latex Gloves – placed on Risk Register, risk assessment completed, Procedure for the safe storage and disposal of latex gloves developed and implemented, item removed from Risk Register
• Hose Reels – placed on Risk Register, wall mounted hose reel box purchased, item

removed from Risk Register
• Window restrictors – previously identified by service, restrictors included on infrastructural plan, residential areas addressed as a priority

Current Risk Management processes in the Service include
- Risk Management policy
- Adverse Event Reporting Form
- A Risk Review Working Group meet weekly to support the Risk Management process in reducing the risks of adverse events occurring in the Service. The group systematically identify, assess and review the risk of adverse events, and then seek ways to prevent their occurrence. The focus of the Risk Review Working Group is to empower line managers to proactively manage risk at the lowest possible level in the Service.
- Weekly feedback of reported adverse events and near misses is incorporated in Nursing and Care team meetings
- A Quality, Risk and Safety Committee is in operation and is responsible for ensuring the health and safety of children, adults, staff, families and visitors. The Committee reports to the CEO and the Clinical Governance Committee on all aspects of Quality, Risk Management, Health and Safety, and Prevention and Control of HealthCare Associated Infections (HCAI's).
- A Risk Register is in operation when the risk matrix is rated 9 or greater. It includes the implications and rating for the risk and the associated strategy. It is monitored, maintained and updated by the Quality, Risk & Safety Committee meeting every month. If issues of a serious nature arise outside of this forum, items can be added to Risk Register by chair of Quality, Risk & Safety Committee, Health & Safety Officer, CEO or any senior manager in the service. All risks inputted to the Services overall Risk Register must be addressed and removed within a month of the date of occurrence or an explanation as to why it is not remedied.

Earlier in 2014 the Board of Directors engaged an individual to chair a Risk Management Committee and lead on a review of the Risk Management processes in place on behalf of the Board of Directors.

**Proposed Timescale:** 11/08/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system for investigating and learning from all adverse events required improvement.

**Action Required:**
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

**Please state the actions you have taken or are planning to take:**
Current Risk Management processes in the Service include
- Risk Management policy
- Adverse Event Reporting Form
- A Risk Review Working Group meet weekly to support the Risk Management process in reducing the risks of adverse events occurring in the Service. The group systematically identify, assess and review the risk of adverse events, and then seek ways to prevent their occurrence. The focus of the Risk Review Working Group is to empower line managers to proactively manage risk at the lowest possible level in the Service.
- Weekly feedback of reported adverse events and near misses is incorporated in Nursing and Care team meetings
- A Quality, Risk and Safety Committee is in operation and is responsible for ensuring the health and safety of children, adults, staff, families and visitors. The Committee reports to the CEO and the Clinical Governance Committee on all aspects of Quality, Risk Management, Health and Safety, and Prevention and Control of HealthCare Associated Infections (HCAI's). The committee review adverse events and near misses monthly, looking at trends and solutions.
- A Risk Register is in operation when the risk matrix is rated 9 or greater. It includes the implications and rating for the risk and the associated strategy. It is monitored, maintained and updated by the Quality, Risk & Safety Committee meeting every month. If issues of a serious nature arise outside of this forum, items can be added to Risk Register by chair of Quality, Risk & Safety Committee, Health & Safety Officer, CEO or any senior manager in the service. All risks inputted to the Services overall Risk Register must be addressed and removed within a month of the date of occurrence or an explanation as to why it is not remedied.
- The Medication Monitoring Group work in close consultation with other disability services in relation to trends that present and looking for solutions to areas such as incomplete prescriptions from multiple GPs

Earlier in 2014 the Board of Directors engaged an individual to lead on a review of the Risk Management processes in place on behalf of the Board of Directors.

**Proposed Timescale:** 30/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The emergency plan for the centre was at draft stage and not implemented in practice.

**Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
A system for responding to emergencies is held in the Services Health & Safety

Statement of Policy.

The Service is in the process of engaging a Health & Safety Consultant to finalise the existing draft Emergency Management Plan.

Alternative accommodation will be identified for each child and adult in their individual care plan, in the case of an emergency and will be located in the child/adults personal file.

Alternative accommodation for different groups of residents will be listed in the Emergency Management Plan

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no centre specific policy for the prevention and control of infection.

**Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
The Service had a Policy for the Prevention and Control of Health Care Associated Infections (Ref No: 7.3; Rev: 03; 28/05/14) in operation during the date of inspection. The Service subsequently emailed a copy of the Prevention & Control of Health Care Associated Infections to the Inspector on 25th June 2014.

**Proposed Timescale:** 11/08/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements for checking fire exits were unblocked required improvement.

**Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
Managers and staff in all houses have been instructed on the requirements to ensure

that Section 2 of the unit Fire Register is completed at weekends.

The Fire Register is checked every week to ensure that all checks have been conducted.

**Proposed Timescale:** 11/08/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The overall management of physical restraint was not in accordance with the Regulations.

**Action Required:**
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**Please state the actions you have taken or are planning to take:**
• The Restrictive Practices Policy has been amended to state that restrictive practices risk assessments will be carried out for all service users relating to the use of bed rails, and evidence of consideration for alternative measures where applicable will be documented.
• Restrictive Practice Risk Assessments for all child and adult residents have now been completed with specific recommendations for use detailed for each resident.
• Individual Care Plans have been updated with recommendations from restrictive practices risk assessments.
• Respite children will be individually assessed on a phased basis going forward dependent on their given respite dates for next admissions when therapists will have access for assessment.

**Proposed Timescale:** 11/08/2014

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all residents had been seen by their GP to fully review their health care needs.

**Action Required:**
Under Regulation 06 (2) (a) you are required to: Ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available.

**Please state the actions you have taken or are planning to take:**
The Service engages the comprehensive services of a GP practise to support the medical needs of the residents, this includes annual medical reviews and three in house clinics per week. The GPs work in close consultation with the nursing and clinical team. In instances where resident's families have opted for alternative GP arrangements the service supports such arrangements and endeavours to work collaboratively with the GP.

In relation to concerns raised by Inspectors specific to a resident;
• Referral to the National Advocacy Services actioned
• A Family communication has been sent with regards to the regulations in relation to access to medical practitioner
• Communication sent to a GP advising of importance of collaborative working with clinical and nursing team and requesting a meeting to ensure processes in place to support resident
• A meeting with Director of Nursing, Clinical Services Coordinator and GP to ensure collaborative approach held.
• Nursing and clinical assessment commenced.
• Family meeting with senior members of nursing and clinical team actioned to remediate matters.
• Weekly meeting with family and service proposed.

**Proposed Timescale:** 11/08/2014

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The procedures for prescribing medications required improvement.

**Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
The service has a procedure for the prescribing of medications, which is monitored under the medication management audit, carried out monthly and quarterly.
• The Medication Monitoring Group and Nursing Clinical Advisory Group will review and where required, amend the Prescribing of Medication Procedure (Ref: 6.1.1; Rev. 03; 10.03.14) for residential and respite services.
• The residents' prescription sheet has been reviewed and updated in line with the Services Prescribing Procedure
• A comprehensive review of all other residents Prescription Sheets has commenced with immediate effect.

**Proposed Timescale:** 29/08/2014

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no documented procedures for the safe disposal of out-of-date and unused medications.

**Action Required:**
Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**
The Service had a Procedure for the Storage, Stock Management and Disposal of Medication (Ref No: 6.1.5; Rev: 03; 10/03/14) in operation during the date of inspection. The Service subsequently emailed a copy of the Storage, Stock Management and Disposal of Medication Procedure to the Inspector on 25th June 2014.

**Proposed Timescale:** 11/08/2014

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no procedure for the safe management of respite residents medications.

**Action Required:**
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

**Please state the actions you have taken or are planning to take:**
The Service had a Procedure for the Storage, Stock Management and Disposal of Medication (Ref No: 6.1.5; Rev: 03; 10/03/14) in operation during the date of inspection which covers residential adults/children and respite children. The Service subsequently emailed a copy of the Storage, Stock Management and Disposal of Medication Procedure to the Inspector on 25th June 2014.
• The Service operates a Routine Admission Procedure for respite children which includes receiving, checking and documenting medications on admission.
• The Service operates a Routine Discharge Procedure for respite children which

includes the checking and safe return of medications to parents.
• The Service operates Medication Management Audits which incorporates the storage of medications.
• The Nursing & Clinical Advisory Group has commenced a review of the existing procedures for the safe management of respite children's medications.

**Proposed Timescale:** 26/09/2014

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre was not operating in line with the services outlined in the Statement of Purpose.

**Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The Service currently supports a small number of families of children with profound disabilities with residential care. This service is no longer available for new admissions in keeping with current strategy and national policy. There are a small number of young adults residing in the service who have lived here for many years.
The service has evolved to meet the needs of children with life limiting conditions, while this has evolved the service continues to support a small disability service. The Service is conscious that the children's service is a respite home and are engaging with the HSE to address this.
• Draft Statement of Purpose and Function to be reviewed, amended and approved by the Board of Directors.
• Engagement with the HSE in relation to the needs of children requiring appropriate full-time residential accommodation commenced
o raised at IMR meeting June 2014
o formal request sent to HSE requesting a review of the needs of children requiring appropriate full time residential accommodation
• Action plan to be formed in conjunction with the HSE to address the needs of children requiring appropriate full-time residential accommodation
• Transition planning to commence for children requiring full-time residential accommodation
• Transfer of all full-time residential children to a more suitable full-time service

**Proposed Timescale:** 30/06/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were some gaps in the information required for staff as per Schedule 2 of the Regulations

**Action Required:**
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

**Please state the actions you have taken or are planning to take:**
Photo ID's to be placed on file for all outstanding staff.

**Proposed Timescale:** 11/08/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The system of supervision requires review.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The Service will carry out a review of existing systems of supervision with a view to implementing an enhanced system for supervision of staff in a planned and systematic manner.

Current systems of support for staff in place in the Service are
• Handover meeting every morning and evening, nursing, care and clinical team members
• 15 minute 'stand up' morning meetings for front line nurse managers, senior nurse managers and senior management team
• Weekly team meetings
• Audit of practice including medication management, Hand Hygiene, clinical hygiene
• Checklists in operation and monitored by front line managers
• Annual Performance Development Reviews
• Staff Performance Improvement Plans
• Daily presence of front line managers in the residents houses
• Training of staff supported by Practice Development, Clinical Nurse Manager and Education & Research department, including mandatory training, clinical education and competency assessed clinical training

**Proposed Timescale:** 30/11/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Refresher training for staff in medication management require improvement

**Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

**Please state the actions you have taken or are planning to take:**
The Service presently operates a competency assessed training programme for all registered nurses on medication management; registered nurses are not permitted to administer medications until training complete. Risks identified are referred to the Medication Monitoring Group for retraining staff. Practice Development oversee the training of registered nurses.

• The Nursing & Clinical Advisory Group have completed a review of existing training and support for staff.
• The Service has commenced an e learning support programme for all registered nurses to undertake the e-learning programme through the HSE Learning Centre
• Medication Management Refresher Training is included on the Services Mandatory Training Plan.

**Proposed Timescale:** 11/08/2014