

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Rosanna Gardens
<b>Centre ID:</b>	OSV-0001711
<b>Centre county:</b>	Wicklow
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Sunbeam House Services Company Limited by Guarantee
<b>Provider Nominee:</b>	John Hannigan
<b>Lead inspector:</b>	Karina O'Sullivan
<b>Support inspector(s):</b>	Michael Keating
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	13
<b>Number of vacancies on the date of inspection:</b>	0

## **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 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 19 January 2017 10:15 To: 19 January 2017 18:00

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

Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

This was the sixth inspection of the designated centre, the last inspection took place in February 2016. Previous inspections of the designated centre had identified repeated failings in relation to safeguarding issues, inability to meet the assessed needs of residents and in the governance and oversight of the designated centre. Each inspection had generated an action plan where the provider detailed plans to address the areas of non-compliances. Additionally, the provider was requested to attend meetings with HIQA where additional reassurances were sought. These meetings also generated plans to address the identified issues.

All plans submitted by the provider identified the need to address the inappropriate residents mix in the designated centre, acknowledging significant issues in managing the current diverse support requirements of the existing residents. Following each inspection the submission of an action plan from the provider was required, inspectors found the provider had failed to complete their action plan to address the issues impacting on residents.

Following the last inspection, the provider submitted a plan which they stated they were confident would be implemented and would be effective in addressing the issues impacting on residents. The designated centre was registered with an additional condition of registration requiring the provider to implement their own action plan by 31 October 2016 this timeframe was determined by the provider.

This inspection found the provider had failed to meet this obligation, and the

commitments given were not fulfilled.

How the inspectors gathered evidence:

The inspection took place over one day and the person in charge and the senior service manager facilitated the inspection. Inspectors spoke with the person in charge and the senior service manager throughout the inspection in relation to the needs of the residents and the services provided in the designated centre to meet the needs of the residents. Inspectors also spoke with three staff members.

Inspectors met with four residents. Some residents spoken with expressed their frustration with the lack of progress in relation to their needs being met. They stated they wanted to go out more and could not because there are not enough staff. They also referred to not being allowed to move to a new house. They also provided clear examples of where group practices operating in the designated centre where impacting upon their daily lives, such as in relation to having to be brought out on a bus to bring other residents to day services.

Documentation such as personal plans, staff rosters, risk management plans, staff training records and internal audits were also reviewed.

Description of the service:

The designated centre comprised three units (houses) located on the same grounds. The designated centre was operated by Sunbeam House Services Limited (hereafter called the provider) which is a company registered as a charity. It is governed by a Board of Directors with Mr John Hannigan the CEO (Chief executive officer) nominated to act on behalf of the provider.

Overall judgment of findings.

Inspectors found the designated centre continued to operate in breach of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013. Staffing supports were not consistently provided in line with the assessed needs of residents. Significant safeguarding issues were identified. Residents identified as requiring one to one support were not provided with this care provision. High levels of self-injurious behaviours were occurring as a result. In addition, the staffing arrangements were directly leading to institutional care practices and a lack of meaningful activity for many residents within the designated centre. This inspection focused upon four outcomes in response to findings from previous inspection. The outcomes inspected against were all found to be in major non compliance:

- Health and safety and Risk management
- Safeguarding and Safety
- Governance and Management
- Workforce

The reasons for these judgments are explained under each outcome in the report and the regulations not being met are 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, 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.**

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

This inspection focused upon the actions the provider stated would be implemented following the last inspection. While elements of the actions in this outcome had been completed they had not been effective in achieving improvement for residents. In each of the previous action plans, the provider had identified the recruitment of additional staff was a critical element in reducing the number of recurring incidents and in order to appropriately respond to risk. As detailed throughout this report this was not achieved.

Inspectors noted some decreases in the recording of incidents within the designated centre. However, the person in charge identified incidents had occurred but had not been recorded. Inspectors were informed some relief and agency staff were not documenting these. Inspectors were also informed of an audit completed within the designated centre this also identified within their preliminary feedback of some incidents were not being reported. Inspectors found the unreliable arrangements for documenting incidents within the designated centre meant the provider could not ensure effective risk management or facilitate the accurate review of incidents to identify the potential causes or additional control measures required.

Quarterly reviews of recorded incidents were now taking place as was an annual health and safety audit. This audit was overseen by a health and safety officer. A health and safety audit report has been completed for this designated centre in October 2016. The last 'quarterly review of recorded clients' adverse events had taken place on 27 October 2016. This review detailed clear actions required to be taken in order to identify and minimise known triggers to incidences.

However, while the audit had identified measures to address areas of concern, they had not been effective in reducing the regular, on going incidents of peer to peer aggression and regular verbal insults. Failure to manage these issues was having a significant impact on the safety and wellbeing of residents and this had been a finding on all of the previous inspections. Furthermore, this issue was exacerbated by residents moving

between each of the three 'homes' uninvited and this had not been resolved, which was an action from the previous inspection.

Inspectors found a sharps disposal box within one house which was provided to ensure the safe discarding of syringe needles. The box was closed but there was an exposed needle resting on the top of the lid. Inspectors found this was not safe practice as residents could be exposed to a needle stick injury.

Inspectors viewed four residents PEEP's (personal emergency evacuation plans) they did not provide up to date information based on the current needs of residents to guide staff.

**Judgment:**

Non Compliant - Major

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Adequate measures had not being taken to protect residents. 668 incidents of self-injurious behaviour and peer to peer verbal abuse had been recorded during the period 1 January 2016 and 1 October 2016. Residents were subjected to name calling and offensive language frequently during the inspection. Management spoken with during the inspection clearly stated this was an on going issue and described funding as the issue linked to the inappropriate mix of residents.

Inspectors viewed some behavioural support plans and found the specific issues identified on the previous inspection had been addressed. However, inspectors found the learning from this action had not been used to inform other behavioural support plans which were unclear and presented in multiple versions.

Inspectors found staff members were not guided effectively in the management of restrictive practice in relation to some residents requiring medication to alter behaviours. There was no guidance provided in relation to the administration of p.r.n. medicine

(medicine only taken as the need arises) for some residents.

Inspectors viewed a p.r.n medication administration procedure however, this document made no reference to the residents behavioural support plan in order to guide staff to non medicated interventions. Another p.r.n procedure was dated 08 July 2016 with no reference to the residents updated behavioural support plan.

Behavioural support plans had been updated since previous inspection. Appropriate staff responses were clear and well planned. Creative distraction and de-escalation techniques were documented such as providing cigarettes to a resident in response to increased anxiety levels. A review of incidents had also identified a need to source external expertise in relation to behavioural management. A behavioural therapist had now been sourced and was commencing a review of behavioural assessments.

Inspectors discussed the reporting process in relation to allegations of abuse with staff members on the day of inspection. Some staff were very unclear in relation to the procedure to follow. Inspectors found the guidance for staff displayed on the wall was inaccurate as staff members no longer in post were identified as designated officers.

The service was using a significant number of agency staff and inspectors were informed agency staff were not trained in the area of adult safeguarding and protection. While measures had made taken to rectify this through the organization providing this training on the day of inspection one member of staff required training.

**Judgment:**

Non Compliant - Major

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Measures had been taken to improve the monitoring of the care provided to residents; subsequent actions were not being taken to support the delivery of safe, quality care services. Six monthly unannounced visits were carried out on behalf of the provider and



detailed issues and actions required. The most recent report of a visit which took place on the 01 and 08 December 2016 this identified many of the issues raised within this and previous HIQA inspection reports. However, even though the provider was aware of the issues which impact significantly on the safety and the wellbeing of residents, the provider had failed to take effective action to keep residents safe.

**Judgment:**

Non Compliant - Major

**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):**

Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**

Following previous inspections, the provider informed inspectors the assessed needs of a number of residents could not be met within the current staffing resources. Residents were not provided with a continuity of care due to an over reliance on agency staffing and a high turnover of staff.

Following the previous inspection, the provider stated additional, appropriately skilled staff would be recruited and in place by 31 October 2016. This was also confirmed in an updated action plan to HIQA in September 2016 identifying the revised staffing arrangements would be in place by 31 October 2016.

Efforts had been made to recruit staff, to date these had been unsuccessful. While staff were being recruited, other staff were leaving the designated centre and the provider had not made substantial progress in addressing the staffing issues. This has been an on going issue since the first inspection in this designated centre.

The reliance on agency staff was also creating challenges for consistency of service to these very vulnerable residents. From a review of the rota it was noted that there were 5.5 vacancies within the existing staffing allocation. On the day of inspection there were four staff on duty, three of these staff were agency staff. The inconsistent staffing arrangements was resulting in practices of care which were institutional in nature. For example, residents who were identified as requiring one to one support were regularly taken out of bed and brought on the designated centre's transport when other residents

were being brought to day services. This was because they did not have a dedicated one-to-one support and could not be left in the designated centre with some of the other residents and/or staff members.

Also, during the inspection it was noted many residents were left to wander around the designated centre all day without staff support. This included residents deemed 'high risk' and in need of one-to-one support. These residents were clearly trying to engage with staff and inspectors at any opportunity. Staff spoken with confirmed it was not possible to meet residents social needs most days due to other priorities.

**Judgment:**

Non Compliant - Major

**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:***

Karina O'Sullivan  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Sunbeam House Services Company Limited by Guarantee
<b>Centre ID:</b>	OSV-0001711
<b>Date of Inspection:</b>	19 January 2017
<b>Date of response:</b>	15 March 2017

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### 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 policy and procedures in place identified the measures required to mitigate risk to residents these were not being implemented in practice.

**1. Action Required:**

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

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

**Please state the actions you have taken or are planning to take:**

- One resident now has 1:1 support for 12-hour shift on 7 days per week. This is put in place to control the number of incidents around aggression and violence.
- Risk assessment has been updated and now reflects how 1:1 support is going to reduce incidents. The Behaviour Support Plan has been updated. With the 1:1 support in place, the resident is now able to engage in more activities and to develop skills towards self-directed living.
- A Behaviour Therapist has been contracted in to work with the resident and staff for a period of 6 months. This should to help improve the resident's quality of life and should lead to a reduction of incidents.
- The Behaviour Therapist is currently engaged and has agreed to meet monthly with staff and resident to review the plan.
- The PIC, Key Worker and SDL (Self Directed Living) Manager will also meet monthly for update.

**Proposed Timescale:** 08/03/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The management and on going review of risk to residents within the designated centre was not effectively managed in order to mitigate to risk to other residents.

**2. 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:**

- One resident now has full time 1:1 support 24 hours a day, 7 days per week. This resident has been reviewed by a Consultant Psychologist who has recommended that the 1:1 supervision can be provided by qualified Social Care staff and Nursing staff, both male and female. Relevant training planned for Social Care Staff with suitably qualified trainer.
- A second resident has 1:1 support for 12 hours, 7 days per week. This will be supported by Self Directed Living Team following focussed recruitment.
- Residents who did not have keyworkers are now being allocated keyworkers.
- A skill mix of Nurses and Social Care Staff is in place.
- All files have been reviewed and updated.
- Personal Emergency Evacuation Plan has been updated for those Clients who need this plan.

Completed 01/03/2017

- The PIC, Key Worker and SDL (Self Directed Living) Manager will also meet monthly for update following staff recruitment.

- Monthly meetings for the period of 6 months with the Behaviour Therapist and staff to review the progress of his recommendations.  
Completed 08/03/2017
- Monthly audit of incidents.  
To be completed by 03/04/2017

**Proposed Timescale:** 03/04/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some incidents were not being recorded within the designated as identified by a culture audit and the person in charge.

**3. Action Required:**

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**

A focused recruitment drive to fill permanent positions and reduce reliance on agency staff. This will provide consistency of care to residents and documentation updates in line with best practice. SHS is currently recruiting. Completion date for immediate recruitment 31/03/2017

Proposed Timescale: For all recruitment 01/09/2017

**Proposed Timescale:** 01/09/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The procedure for administering p.r.n. medication to alter behaviour was unclear as identified in the previous inspection.

**4. 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:**

- PRN Protocol updated to include positive behavioural interventions as identified in Positive Behavioural Support Plans.

Completed 01/03/2017

- Notice will be put on the Medication Kardex informing all staff that there is a PRN Protocol attached to each Kardex.
- The PRN Protocol which identifies the process and administration of PRN Psychotropic medication will be discussed with all staff and all staff will sign to confirm that they have read same. Team Meeting is on 20/03/2017
- Information that there are protocols in place is also in the Induction folder for Agency and New Staff.
- Four residents are being reviewed at clinic on 16/03/2017 in relation to PRN prescription.

To be completed by 16th March 2017

**Proposed Timescale:** 16/03/2017

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Some members of staff were not trained in the area of adult protection and safeguarding

**5. Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**

- All staff have completed Protection and Safeguarding training except one member of staff who is now booked for training on March 1st 2017. Policy and discussion of best practice guidelines have been discussed with staff member. All staff due to attend Refresher Protection and Safeguarding have been booked to attend course.
- As new staff are recruited, they will be booked in for training also.

**Proposed Timescale:** 31/12/2017

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Some staff members were concerned about the quality and safety of care provided to residents within the designated centre.

**6. Action Required:**

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

**Please state the actions you have taken or are planning to take:**

Staff meetings have set agenda item to report concerns to PIC.

Complaints process in place for staff member to utilise if necessary. Agenda item at next staff meeting.

**Proposed Timescale:** 31/03/2017

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The management system in place had consistently failed to ensure that the service provided was safe and appropriate to residents.

**7. Action Required:**

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**

- Culture Audit carried out with staff team in January 2017. Follow up training will take place on 20th March 2017.
- Staff meetings have set agenda item to report concerns to PIC.
- Complaints process in place for staff member to utilise if necessary. Agenda item at next team meeting on 20/03/2017.
- Risk assessment has been updated and now reflects how 1:1 support is going to reduce incidents. The Behaviour Support Plan has been updated. With the 1:1 support in place, the resident is now able to engage in more activities and to develop skills towards self-directed living.
- A Behaviour Therapist has been contracted in to work with the resident and staff for a period of 6 months. This should to help improve the resident's quality of life and should lead to a reduction of incidents.  
Completed 01/03/2017
- Supervision Meetings are held with staff where they can raise any concerns.  
To be completed by end March 2017

**Proposed Timescale:** 31/03/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

Residents were not receiving continuity of staff due to an over reliance upon agency staff.

**8. Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**

Focused recruitment process currently in place. Six Social Care staff have been recruited and will take up positions in the coming weeks. This will reduce reliance on agency staff and provide continuity of support. A recruitment drive is also in place for a relief panel.

**Proposed Timescale:** 01/09/2017

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The number and skill mix of staff was not meeting the assessed needs of residents.

**9. Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**

- One resident has full time 1:1 support 24 hours 7 days per week.
- A second resident has full time 1:1 support 12 hours 7 days per week.
- A skill mix of Nurses and Social Care Staff is in place.

Completed 01/03/2017

- Currently recruiting for more staff.

To be completed by 01/09/2017

**Proposed Timescale:** 01/09/2017



