Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Ash House
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	29 May 2018
Centre ID:	OSV-0005306
Fieldwork ID:	MON-0021500

About the designated centre

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

The centre provides residential care and support for three adults. The centre comprises of a single storey detached house on a campus based setting belonging to St John of God Services in County Louth. The premises were warm, clean and personalised to residents' individualised preferences. Each of the residents had their own bedroom which had been personalised to their own taste. There were a number of communal garden areas surrounding the centre and a small private garden area for the sole use of residents was also available. The last inspection in the centre had been completed in July 2017 and as part of this inspection the inspector followed up on the actions from that inspection. The purpose of this inspection was to inform a registration renewal decision.

The following information outlines some additional data on this centre.

Current registration end date:	17/11/2018
Number of residents on the date of inspection:	3

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
29 May 2018	09:30hrs to 17:00hrs	Maureen Burns Rees	Lead

Views of people who use the service

As part of the inspection, the inspector met with the three residents living in the centre and observed elements of their daily lives at different times over the course of the inspection. Although, a number of these residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits. Staff were observed to have a close bond with each of the residents and to easily interpret their verbal and non-verbal cues.

Family representatives of two of the residents had completed a HIQA questionnaire regarding the quality of the service being provided for their loved one. These suggested that they were satisfied with the service and the care being provided. The inspector did not have an opportunity to meet in person with the relatives of any of the residents but it was reported that they were happy with the care and support their loved ones were receiving.

The inspector found that residents were enabled and assisted to communicate their needs, wishes and choices which supported and promoted residents to make decisions about their care. Residents were actively supported and encouraged to maintain connections with their families through a variety of communication resources and facilitation of visits.

Capacity and capability

Overall, there were management systems in place to ensure that the service provided was safe, consistent and appropriate to the resident's needs.

The provider had submitted an application for the renewal of the registration of this centre, to include an increase in the number of residents from three to four. However, the bedroom identified for a fourth resident did not have a bed or any suitable furnishings. At the time of inspection, the identified room was being used to store large pieces of equipment required by current residents. No other storage area for the items was available or had been identified. Additional staffing resources to meet the needs of an additional resident were not in place.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had been in the position since October 2017. However, she had been working with the provider for more than 23 years and had more than three years management experience. She was a registered nurse in intellectual disabilities and held a management qualification. She was on scheduled

leave on the day of inspection but spoke with the inspector on her return from leave. She was found to have an in-depth knowledge of the care and support requirements for each of the residents. She was in a full time post but was responsible for two other centres also located on the campus. She was supported by a clinical nurse manager in this centre and in each of the other centres for which she had responsibility. Staff members spoken with told the inspector that the person in charge was a good leader, approachable and supported them in their role. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the director of care and support who in turn reported to the regional director of care. Effective information governance arrangements were in place to ensure that the designated centre complied with notification requirements.

The provider had completed an annual review of the quality and safety of care in the centre and six monthly unannounced visits to assess the quality and safety of the service as required by the regulations. A number of other audits had been completed by the house manager and there was evidence that appropriate actions had been taken to address issues identified. Examples included, health and safety, medication management, personal plans and finance audits. There was an audit schedule in place.

Each resident had a written contract in place which dealt with the support care and welfare of the resident but it did not specify the fees payable. It did refer to a tenancy agreement. However, in one of the residents files reviewed the fees stated in the tenancy agreement were not consistent with those stated in the financial passport, which was a user friendly document for residents. This discrepancy was rectified on the day of inspection. These had recently been reviewed. However, the resident and or their family representatives had not signed a number of the contracts on file.

There was a statement of purpose in place, dated April 2018. However, it did not meet all of the requirements of the regulations as it incorrectly set out one of the conditions of the centres registration by stating that the maximum number of persons that could be accommodated at the centre was four, but the centre had only been registered for three residents.

There were effective recruitment and selection arrangements in place for staff. The inspector reviewed a sample of four staff files and found that they contained the majority of the documents as required by schedule 2 of the regulations. However, in one of the files reviewed evidence of a staff members identity, including a recent photograph was not available. Overall, the staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents. The full complement of staff were in place. The majority of the staff team had been working in the centre for a prolonged period. It was noted that a small consistent number of agency staff were

used for occasions when staff were on leave. This ensured consistency of care for the residents. On-call arrangements were in place for staff.

There were staff supervision arrangements in place. However, it was not always undertaken in line with the frequency proposed by the provider. The inspector reviewed a sample of staff supervision files and found that supervision undertaken was of a good quality but it was not always undertaken in line with the frequency proposed by the provider. This meant that staff may not have been adequately supported to perform their duties to the best of their abilities.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place which was coordinated by the providers training department. Training records showed that overall staff were up-to-date with mandatory training requirements. Other training to meet specific needs of residents had been sourced.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application for the renewal of the registration of this centre, to include an increase in the number of residents living in the centre from three to four. However, at the time of inspection the centre did not have the facilities or resources in place to accommodate four residents living in the centre.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge was found to be an experienced and qualified manager with an in-depth knowledge of the care and support requirements of the residents, and of the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The full complement of staff were in place and found to have the appropriate skills to meet the needs of residents.. However, in one of a sample of four staff files reviewed evidence of a staff members identity, including a recent photograph

was not available.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided for staff to improve outcomes for residents. However, staff supervision was not always undertaken in line with the frequency proposed by the provider.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a written contract in place which dealt with the support care and welfare of the resident,and the service provided. However. the fees payable by the resident were not clear and some contracts in place had not been signed by the resident or their family representatives.

Judgment: Not compliant

Regulation 3: Statement of purpose

The centre had a publicly available statement of purpose, dated April 2018. However, it incorrectly set out one of the conditions of the centres registration by stating that the maximum number of persons that could be accommodated at the centre was four, but the centre had been registered for three residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occuring in the centre was maintained and, where required, notified to HIQA.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality, safe, person centred and which promoted their rights.

The residents' well-being and welfare was maintained by a good standard of evidence-based care and support. Each of the residents had a personal support plan which reflected the assessed needs of the individual resident and outlined the support required to maximise their personal development. Personal plans in place were reviewed at regular intervals with the involvement of the resident's multidisciplinary team, the resident and family representatives. An accessible version of the personal plan were available. Meaningful personal and social goals had been identified for residents and their was evidence that progress in achieving goals was monitored on a regular basis and recorded on priority goal tracking forms. Where the assessed needs of individual residents infringed on their community participation, there was evidence that decisions reached were approved by members of the multidisciplinary team and the providers rights review committee.

The residents were each supported to engage in meaningful activities in the centre, on the campus and within the community. There was a small animal petting farm, a coffee shop and swimming pool on the campus. A number of other regular activities were facilitated on the campus. These included, Jamboree, arts and crafts, reflexology and art classes. Staff facilitated and supported the residents to participate in activities that promoted community inclusion such, the cinema, nature walks, meals out, concerts and overnight trips. Individual daily and weekly schedules were in place for residents.

Residents' healthcare needs had been assessed and were being met by the care provided in the centre. Specific health plans were in place for residents identified to require same. It was a nurse led centre with a staff nurse available 24/7. This meant that there was suitable expertise readily available to meet the residents needs. Each of the residents had completed a recent health check with their general practitioner who was located in a nearby town. There was a GP on the campus five days per

week and an out of hours doctors service available.

The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A policy on person directed medication management, dated September 2016 was in place. There were secure storage arrangements in place. There was a registered staff nurse on duty at all times who was responsible for the administration of all medications. Staff were observed to follow appropriate medication management practices and medications were administered as prescribed. Assessments had been completed to assess the ability of individual residents to self manage and administer medications. These indicated that it was not suitable, at the time of inspection, for any of the residents to be responsible for the management and administration of their own medications. Individual medication management plans were in place. There were systems in place to review and monitor safe medication management practices which included regular counts of all medications and periodic audits of practices.

The centre was found to be suitable to meet the resident's individual and collective needs in a comfortable and homely way. Each of the residents had their own bedrooms which had been personalised to their tastes and choices. At the time of the last inspection, it was identified that the layout and design of the kitchen was not appropriate to meet the residents needs and that a suitable garden area was not available for residents. Since that inspection, the kitchen layout had been appropriately modified and a suitable private garden area had been established. This promoted the resident's independence, dignity and comfort.

Residents' communication needs were met. Individual communication requirements were highlighted in residents' personal plans and reflected in practice. There was a policy on total communication approaches, dated April 2016. A number of the residents were non-verbal. Staff were observed to communicate well with these residents using visual cues such as, picture exchange and objects of interests. These were noted to assist residents to choose food choices, activities, daily routines and journey destinations. There were communication passports on file for individual residents which provided a good level of detail to guide staff. Each of the residents had their own Ipad and a number were attending information technology training. Internet access was not available in the centre but was in the process of being sourced.

The residents were provided with a nutritious, appetizing and a varied diet. The timing of meals and snacks throughout the day were planned to fit around the needs of the residents. A weekly menu was agreed with residents at a weekly meeting. Some of the residents had specific feeding eating and drinking plans in place which had been compiled by an appropriate professional. These were being complied with.

The health and safety of residents, visitors and staff were promoted and protected. There were risk management arrangements in place which included a detailed risk management policy, and environmental and individual risk assessments for residents. These outlined appropriate measures in place to control and manage the risks identified. A 'living' risk register was maintained in the centre. Health and

safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. Suitable fire safety arrangements were in place.

Residents were provided with appropriate emotional and behavioural support. The inspector found that the assessed needs of residents were being appropriately responded to. Behaviour support plans were in place for residents identified to require same and these provided a good level of detail to guide staff in meeting the needs of the individual residents.

Regulation 10: Communication

The communication needs of residents had been appropriately assessed with appropriate supports put in place where required.

Judgment: Compliant

Regulation 17: Premises

The centre was homely, accessible and promoted the privacy, dignity and safety of each resident.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were provided with a nutritious, appetizing and varied diet.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of residents, visitors and staff were promoted and protected.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable precautions were in place against the risk of fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were systems in place to ensure the safe management and administration of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support.

Judgment: Compliant

Regulation 6: Health care

The health care needs of residents were being met.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were provided with appropriate emotional and behavioural support.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Ash House OSV-0005306

Inspection ID: MON-0021500

Date of inspection: 29/05/2018

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The application, seeking to increase occupancy from 3 to 4, will be amended back to 3. Timeframe: 31/07/18	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staff files will be audited for compliance and updated/amended as required. Timeframe :18/07/18	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Regional Director North East has issued a local standard operating procedure clarifying that while the National Staff Supervision Policy is under review, formal staff reviews will be conducted six monthly. Timeframe : 31/07/18	

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

1. Contracts of care will be reviewed to ensure that the fees payable by the resident are made clear.

2. While most residents of the service were admitted decades prior to the requirement for a signed contract of care, and most family representatives have subsequently declined to sign one since their intoduction; the PIC will maintain records of communication with families in pursuit of their signature(s).

Timeframe: 31/07/18

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

An amended statement of purpose will be submitted to reflect the approved maximum number of persons permitted to reside in the centre.

Timeframe: 31/07/18

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 5(3)(h)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a statement of the maximum number of residents who will be accommodated at the designated centre at any one time during the period of registration, and for which the registered provider is requesting approval by the chief inspector in the application for the registration or the renewal of registration of the designated centre.	Not Compliant	Yellow	31/07/18

Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	18/07/18
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/18
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Yellow	31/07/18
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/07/18