Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Aspire Residential Unit
Name of provider:	Asperger Syndrome Association of Ireland CLG
Address of centre:	Dublin 16
Type of inspection:	Short Notice Announced
Date of inspection:	19 October 2020
Centre ID:	OSV-0001530
Fieldwork ID:	MON-0030790

About the designated centre

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

Aspire residential service provides a residential service for up to three adults with Asperger syndrome in a suburb of Dublin city. Residents have access to local amenities such as shopping centres, cafes, and restaurants. Residents are supported on a 24-hour basis by a team of social care workers.
Residents have their own bedrooms with en-suites. There are two living rooms, a dining room, and kitchen, and a porch in the unit, and each resident has access to all for recreational purposes.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 19 October 2020	10:30hrs to 16:30hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

Both residents chose not to meet with the inspector.The inspector reviewed residents' weekly meetings; residents regularly expressed that they were happy in their home and with the support provided to them. Residents met with their keyworkers on a consistent basis and there were records displaying residents being supported to express their needs and wishes and develop goals. The inspector noted positive interactions between the residents and the staff team during the inspection. A further review of residents' information showed that residents were supported to develop independent living skills and, when possible, were active in their communities engaging in activities of their choosing.

Capacity and capability

The inspection found that there were improvements required to the quality of the service being provided to residents. The provider had failed to ensure appropriate practices regarding training and staff development, governance and management, monitoring of information, and notification of incidents.

While there was a clearly defined management structure in place in the centre led by the person in charge and a deputy manager, there were improvements required to guarantee that the existing management arrangements were consistent and leading to the effective monitoring of the service being provided to residents. A review of auditing practices displayed that the necessary reviews and reports stated in the regulations had not been carried out. The provider had not carried out an annual review of the quality and safety of care and support provided in the centre; the last review was completed in 2018. The provider had also failed to carry out an unannounced visit to the centre this year and had not prepared a written report on the safety and quality of care as per the regulations.

There was a need to review the provider’s arrangements regarding communication, lines of authority, and accountability. Required improvements had been identified but had not been addressed, including training and staff development and ensuring that there were adequate fire precautions in place. Furthermore, the arrangements in place to ensure that the chief inspector received notifications of incidents as per the regulations were not effective. The chief inspector had not been notified of restrictive practices utilised in the centre, and there were delays in additional notifications being submitted for review.

Before the inspection, the provider had acknowledged that the existing management structure and arrangements were not effective. The inspector reviewed recent correspondences that displayed that steps were being taken to address these

shortcomings. While this process was in its infancy at the time of the inspection, there were some examples of improved practices being implemented.

The centre's management and staff team were carrying out several audits, and the person in charge had devised a monthly task list. These audits ensured that aspects of the centre's information and the service being provided were being monitored and addressed, including the management of adverse incidents.

The provider had not ensured that there were effective arrangements in place to support, develop, and performance manage the staff team. A review of staff training records noted that only two members of the staff team, the person in charge and deputy manager, had received first aid training.The other staff members who worked directly with the residents had not been offered the opportunity to complete the training. The inspector reviewed an action plan that stated that first aid and positive behavioral support training would be completed by staff in 2018, but this had not been completed

The staff team were not receiving appropriate supervision. There were no supervision records available for review. The inspector was informed by the person in charge that supervision had not been carried out in the centre for an extended period.

A review of the centre's roster displayed a consistent staff team in place to support the residents.The provider had ensured that the number, qualifications, and skill mix of staff was appropriate to the needs of the residents. The inspector reviewed a sample of the staff member's information and found that there were improvements required to the monitoring of documents and information relating to schedule two of the regulations. While the person in charge sourced a reference that had not been filled correctly during the inspection, a staff member's Garda vetting disclosure was not available for review by the inspector.

The provider had ensured that there was an effective complaints procedure in place and that residents were supported to understand the complaint management process. There was also evidence of the complaint process being discussed with residents at resident meetings.

Overall, the provider's governance and management arrangements were not leading to effective oversight, and this was impacting on the quality of the service being provided to residents.

Regulation 15: Staffing

The person in charge had not ensured that they had obtained in respect of all staff the information and documents specified in Schedule 2.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had not ensured that there were appropriate arrangements in place for training and staff development.

Judgment: Not compliant

Regulation 23: Governance and management

The providers governance and management systems were not effective in ensuring that the care being provided to residents was appropriately monitored.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had failed to submit the necessary quarterly notifications for review by the Chief Inspector as per the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had ensured that there was an effective complaints procedure in place.

Judgment: Compliant

Quality and safety

Residents were receiving a service that was based on their needs and wishes. Residents were being supported to engage in their local community and lead as independent lives as possible. There were, however, a number of areas that required attention regarding the provider's arrangements for fire precautions,

monitoring of residents' social care goals, risk management, and infection control.

The provider had failed to fully address actions relating to the installation of appropriate fire containment doors identified from the previous HIQA inspection in September 2018. The inspector was shown correspondences between the person in charge and contractors seeking to address the actions, but there were still inadequate fire containment measures in place.

Furthermore, there were improvements required to the completion and recording of fire drills. he records of drills completed did not list all persons involved. Also, the recordings for the length of time it took residents and staff members to evacuate the centre had not been documented correctly. The person in charge was in the process of addressing the issues regarding fire drills after completing recent fire safety training.

While the provider had developed a risk management policy, it did not contain the necessary information set out in the regulations. The provider had also developed a safety statement that was not accurate. The statement listed fire evacuation and containment measures that were not in place in the centre, including a fire escape ladder for residents and staff to evacuate the building from the first floor if required. The person in charge had highlighted the necessary actions to improve the document to the provider. There was evidence of steps being taken to address the actions, but this had yet to be completed.

Individual risk assessments had been developed for residents. These assessments were detailed and were under regular review by the person in charge and the staff team. There were also systems in place to review adverse incidents and learn from them.

The provider had not completed the COVID-19 assurance framework published by HIQA to support social care services improve infection prevention and control. The person in charge was informed of the document by the inspector and completed it during the inspection. The provider had developed an infection control guidance document, but this required attention. There was no evidence of the document being reviewed or adapted following updates from the Health Protection Surveillance Centre (HPSC).

The provider had, however, introduced several key procedures concerning infection control as a result of the COVID-19 pandemic. The inspector observed staff members wearing appropriate personal protective equipment; residents and staff had access to hand gels and mounted hand sanitizer’s throughout the house. Residents and staff members were also completing twice-daily temperature checks as per guidelines.

The person in charge had ensured that assessments of residents’ health and social care needs were completed. Residents had access to appropriate healthcare professionals, and there were clear recordings of appointments and any follow-up actions required. The staff team and a resident had also developed healthy eating plans and a goal relating to residents' health care needs.

The inspector reviewed detailed monthly and biannual reports furnished by the resident's keyworkers regarding residents' progress and areas where they may require support. This review system ensured that the care and support being provided to residents was adapted to their changing needs and wishes. While there was evidence of many goals being set for both residents, there were inconsistencies in the monitoring and documentation practices regarding their progress or achievement. One residents' goals had been set, but there was no further evidence of the goals being achieved or progressed. The person in charge had identified this before the inspection and was in the process of implementing a standardised approach.

A review of resident meetings and documentation of key working sessions and meetings displayed that residents were being consulted with and participating in the operating of the centre. The inspector observed that the staff team supporting the residents had implemented communication supports and that these had been effective.

Residents had access to therapeutic supports if required and had been supported to access these through video link during COVID-19 travel restrictions. The inspector reviewed individual stress management plans. These were detailed and outlined how best to support and respond to each resident. Alternative measures had been considered before the implementation of restrictive procedures, and there was a clear rationale for the implementation of the procedures in place. There were also systems in place to respond to safeguarding concerns, and the staff team supporting the residents had received the appropriate training.

The person in charge had identified before the inspection that there were required works to ensure that the premises was kept in a good state of repair externally and internally. The inspector reviewed correspondences between the provider and person in charge and was assured that the required actions were now being progressed.

Regulation 10: Communication

Residents were being assisted and supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had failed to ensure that there were appropriate risk management procedures in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had not ensured that the COVID-19 assurance framework published by HIQA to support social care services improve infection prevention and control had been completed. The provider had also failed to review and update its own infection control guidance document and ensure that the most up to date information was available for the staff team to follow.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to fully address actions relating to the installation of appropriate fire containment doors identified from the previous HIQA inspection in September 2018.

There were also improvements required to fire evacuation recording practices.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were improvements required to the monitoring and progression of residents' goals.

Judgment: Substantially compliant

Regulation 6: Health care

The provider had ensured that the residents were receiving or being offered appropriate healthcare.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were systems in place to meet the behavioural support needs of the residents.

Judgment: Compliant

Regulation 8: Protection

There were appropriate systems in place to respond to safeguarding concerns.

Judgment: Compliant

Regulation 9: Residents' rights

The provider was ensuring that the rights of residents were being promoted and respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Aspire Residential Unit OSV-0001530

Inspection ID: MON-0030790

Date of inspection: 19/10/2020

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC has ensured that all staff employed in the Centre have a vetting disclosure completed. The staff member who did not have a vetting disclosure completed on site no longer works in the service. The PIC has completed Garda Vetting Training (05.11.20) and is now Aspire's Garda Vetting Officer. This gives full autonomy to the PIC to carry out Garda Vetting on all perspective incoming staff.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has been booked in to complete Manual Handling Instructor Training on November 18th, 19th, 20th, 23rd and 24th. On completion of the course the PIC will provide Manual Handling Training to all staff members by December 17th. Following numerous cancellations the PIC has now rebooked First Aid Instructor Training on December 15th and 16th. On completion of this course the PIC will provide First Aid Training to all staff by January 20th. Informal supervision had been taking place in the Centre. A supervision template has been developed and staff are now receiving appropriate supervision. This commenced 04/11/20, This will be provided at 8 week intervals.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
An updated management structure has been put in place, which clearly defines lines of responsibility, authority and accountability. Roles and detailed responsibilities are specified for all areas of service provision and includes arrangements for the management of the Centre during absences of the PIC.

The newly appointed Registered Provider will take full responsibility in partnership with the PIC for the operational governance of the Centre. The Provider shall ensure that management systems are safe, appropriate and effectively monitored through providing management support and supervision, monthly meetings with the PIC and Centre visits to liaise with the PIC, staff and residents.

The newly appointed Registered Provider will carry out unannounced visits to the Centre at least every six months or more often if required. This will ensure the quality of care, safety of residents and support provided is appropriate to service needs. The first unannounced visit will be completed by the 30.04.2020.

The newly appointed Registered Provider in conjunction with the PIC has completed the annual review on the 16.11.20. All improvement plan actions will be carried out within a reasonably time frame.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC submitted a notification (NF39) to HIQA on the 19/10/20 regarding any occasion on which a restrictive procedure including physical, chemical or environmental restraints was used for the previous quarter.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Registered Provider has updated the risk register in line with the current pandemic COVID-19 The Registered Provider has reviewed and updated the risk management policy. The policy now includes measures and actions to control the following specified risks: The unexpected absence of any resident, Accidental injury to residents, visitors or staff, Aggression and violence, and Self-harm	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: The Registered Provider has completed a self-assessment on preparedness, planning and infection prevention for COVID-19. This process will be repeated at 12 weekly intervals. Hand Towel dispensers have been delivered and will be mounted in the toilets by 30/11/20	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A new fire door has been provided to the second Residents bedroom. This is a certified sixty minute fire door. The work was completed on the 05.11.20 The Fire Wardens currently carry out two fire evacuations annually. The Registered Provider shall ensure this will be further increased to four evacuations annually, one which will include a night time evacuation. The actual evacuation time will be documented, reviewed and an action plan will be put in place when required. This process was commenced on the 13.11.20, with a night time evacuation. The recorded evacuation time was 1 minute 24 seconds.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Each Residents goals are set out in consultation with them. The PIC will ensure that the staff responsible for actioning and documenting the objectives in the plan are achieved within an agreed time frame, The process has begun and will be ongoing in line with the Residents PCP.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	05/11/2020
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/01/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2020
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Substantially Compliant	Yellow	31/12/2020

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Red	13/11/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the	Not Compliant	Red	30/04/2021

	chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	13/11/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/12/2020
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	31/12/2020

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	05/11/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/12/2020
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical,	Not Compliant	Orange	19/10/2020

	chemical or environmental restraint was used.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/11/2020