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:	Lios na Greine
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	18 August 2021
Centre ID:	OSV-0002566
Fieldwork ID:	MON-0033433

About the designated centre

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

The designated centre provides 24-hour nurse-led residential care and currently accommodates five adults, with intellectual disabilities. The building is a large detached bungalow on a private site. There is a lobby area and a spacious hallway on entering the house. There are five bedrooms, one of which has an en-suite bathroom. One resident has the exclusive use of a bathroom next to their bedroom, with three other residents sharing a communal bathroom. There are two sitting rooms, one which includes a dining area. There is a kitchen and utility room and an office next door to it. There is a large room for activities and just off this area is a storage room and a staff toilet. There is a large fenced garden out the back of the house with summer furniture and an unused garden shed. The centre is located near a large town, and there are transport facilities for residents to access amenities in the town.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Wednesday 18 August 2021	10:00hrs to 17:45hrs	Eoin O'Byrne	Lead
Wednesday 18 August 2021	10:00hrs to 17:45hrs	Karena Butler	Support

What residents told us and what inspectors observed

This inspection took place in a manner so as to comply with current public health guidelines and minimise potential risk to the residents and staff.

Inspectors met with four of the residents on the day of inspection and they appeared comfortable in their home. While residents were not able to communicate verbally what it was like living in this centre, they appeared relaxed and could freely access all areas of their home. They appeared content in the company of staff and staff were observed to interact with them in a kind and respectful manner.

Inspectors observed some residents doing activities; such as, making a collage with staff, practicing their writing skills as part of their personal goals and getting their hair styled. Staff said that this was very important to the resident as they took pride in their hair being styled properly.

In-house activities were available in the centre; for example, there was an activity room where many games, puzzles and sensory objects were available for residents. Some residents were observed using their own personal electronic tablets which contained communication applications to help with their communication needs.

Inspectors found the house to be spacious, clean and laid out to meet the needs of the residents. Each resident had their own individual bedroom that was decorated to their preferred tastes. There was adequate storage facilities in the bedrooms for residents to store their personal items and clothes.

One resident chose to show an inspector their bedroom. The room was tastefully decorated and had family pictures displayed on the wall. When the inspector chatted to the resident about their pictures they smiled and pointed to other pictures for the inspector to see.

Inspectors did note; however, that there were maintenance works required to the roof and a number of rooms in the centre. An area of the floor in one bedroom required repair which had not been highlighted in the providers own auditing reports. This will be discussed in more detail under quality and safety section of this report.

There was a large back garden with two different types of swing benches and a swing set. One resident was observed to spend a lot of time in the garden alone and this was something that the resident liked doing. This was also noted in their individual personal plan by inspectors. The inspectors also observed the resident communicating this preference to staff and this was respected.

Inspectors reviewed a sample of family questionnaires completed in 2020 as part of the providers own quality review systems. Overall family representatives expressed that they were very satisfied with most aspects of the service provided. Some said

their family members were very happy living in the centre and felt that staff had a great relationship with them. One family member had raised a concern which was followed up by the inspectors with the person in charge where it was found that this had been addressed.

An inspector also got to opportunity to speak to one family the day after the inspection. They expressed that they were happy with the service being provided and commented on how well the centre had managed during the pandemic.

Due to the COVID-19 pandemic restrictions, day service programmes had stopped for the residents in March 2020. In addition, other activities that residents previously enjoyed such as horse riding had also closed. In order to minimise the impact of the restrictions, residents continued to get out for drives and exercise in a variety of locations in the local areas. Residents in the centre had also enjoyed regular walks and some had goals to participate in a number of 5km walks in the coming months.

Staff were also supporting residents to re-engage in their community. Some had recently attended hairdressers to get their hair done and others had started participating in the food shopping for the centre again. This was an activity previously enjoyed by one particular resident. Other activities included days out to forests or the beach.

While there were personal plans and goals in place for residents, many of the same/similar goals had been carried over for a number of years. Meaning that opportunities to explore new interests and experiences were limited and required review.

Residents' meetings took place weekly. A sample of the minutes were reviewed and items such as residents rights, respect, privacy, and advocacy were discussed as standing agenda items. A review of information also captured that the rights of residents were being promoted and respected by the staff team supporting them. Where possible residents were being supported to engage in their preferred activities. Residents were also being supported to maintain family relationships.

Overall, residents appeared to have a good quality of life in this centre. However, significant improvements were required in the premises and minor improvements were required in fire safety, personal plans and the governance and management systems in place.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in this service and how these arrangements impact on the quality and safety of care provided to the residents.

Capacity and capability

The provider had ensured that there was a management structure in place. While

the provider, person in charge, and members of the centre's staff nurse team were completing audits, the inspection found that there were enhancements required to the existing monitoring systems. There was a lack of oversight in a number of areas, including the development of person-centered goals for residents, residents' information, and also aspects of the centre's information. There had also been delays in responding to required repair works to the interior and exterior of the centre; this will be discussed in more detail in the quality and safety section of the report.

The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre as per the regulations. Actions had been identified following these, and there was evidence of some of the identified actions being addressed. The person in charge was also notifying the Chief Inspector of required incidents as per the regulations.

A review of the planned and actual staffing rosters demonstrated that there was a large staff presence on duty each day. The staff team was made up of staff nurses and care assistants. Overall, residents were receiving continuity of care as there was a well-established staff team in place that, through discussions with inspectors, demonstrated that they were knowledgeable of the residents' needs. There was one consistent agency staff member being utilised, and this was again supporting the continuity of care. One of the inspectors reviewed staff information and documents, and found that the person in charge had ensured that all required information had been obtained as per Schedule 2 of the regulations.

Staff meeting minutes were reviewed and inspectors found that information sharing and learning was promoted. Actions were identified during these meetings however, there were delays in some of these actions being addressed. For example, the need to improve personal goal setting practices for residents had been identified during meetings. While the provider had systems in place to identify areas that required improvement, these actions were not being addressed and as a result had impacted upon residents in a negative manner.

Inspectors reviewed the training needs analysis that had been developed by the provider. The annual review for 2020 had identified that there was outstanding training in a number of areas. There was evidence of the majority of this training being completed since the review. There were still some staff that required refresher training in basic life support however, inspectors saw evidence that this training was planned to take place in the days following the inspection. An inspector also reviewed a sample of staff members' supervisions and found that they were taking place as per the provider's policies and procedures.

Overall, inspectors found that there were improvements required to aspects of the providers management arrangements in order to ensure that residents were receiving the best possible service.

Regulation 15: Staffing

The provider had ensured that the number, and skill-mix of staff was appropriate to the number and assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had ensured that staff development was prioritised and that the staff team had access to appropriate training.

Judgment: Compliant

Regulation 23: Governance and management

The provider had failed to ensure that the existing monitoring systems were appropriate. This failure had impacted upon person-centered goals being identified for residents, ensuring that the premises were appropriate for residents, and ensuring that appropriate fire containment measures were in place.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was notifying the Chief Inspector of required incidents as per the regulations.

Judgment: Compliant

Quality and safety

A review of a sample of residents' information demonstrated improvements were required regarding the monitoring of residents' information. There was particular attention required regarding supporting residents to set and achieve new goals. The review of information demonstrated that goals had been identified for residents but that some goals had been carried over for a number of years despite residents

achieving them.

For the most part, residents' files contained information that directed staff to best support them. There were, however, enhancements required to documentation practices. While, inspectors saw that programmes had been developed for residents by members of the providers multidisciplinary team, there was no information on whether the programmes had been trialled or completed. An inspector spoke with staff regarding the implementation of some of the programmes. Staff members discussed the programmes with the inspector, but there was no documentation to demonstrate that the programmes had been implemented.

As mentioned earlier, the staff members supporting residents were knowledgeable of the residents' needs. There were, however, improvements required to ensure that this knowledge was effectively captured in residents' information. An inspector also found that there had been significant delays in person-centered planning meetings being held for residents. The person in charge did assure inspectors that these were due to take place in the coming weeks.

The inspectors found the house to be spacious and laid out to meet the needs of the residents. As noted earlier, there had, been delays in addressing required works to the exterior and interior of the building. There was a long-standing issue with part of the centre's roofing that was resulting in regular leaks. Inspectors observed that there was painting required to a number of rooms in the house. There was also damage to the flooring in a number of rooms which the provider had identified as potential trip hazards. The person in charge facilitated an inspector to be shown around the building; during this time, the inspector observed that there were some small patches of mould growing around some windows and one ceiling. There were required repairs to the flooring in a resident's bedroom. There was also staining noted on the floor of the main bathroom and a number of doors and presses that required repair. In general, the premises was designed and laid out to meet the needs of the residents. The provider had, however, failed to ensure that it was kept in a good state of repair externally and internally and that the building was suitably decorated.

In general, the provider had ensured that there were effective fire safety management systems in place; inspectors did observe that there were repairs required to a number of fire containment doors. These doors had previously been repaired but were damaged at the time of the inspection. Regular fire drills were being carried out, and the provider had demonstrated that they could safely evacuate all residents and staff members. The staff team had also completed a fire safety training module.

A review of residents' information demonstrated that the healthcare needs of residents were appropriately identified. Healthcare plans directed staff on how to support residents to experience the best possible health. Residents were facilitated to attend appointments with healthcare professionals as required such as G.P, chiropodists, and psychologists. There was a delay accessing a speech and language therapy review for a resident in relation to their communication however following a

review of the information the inspectors were satisfied with the reason for the delay.

The provider had ensured that there were suitable systems in place to respond to safeguarding concerns. There was a well-established staff team that were aware of the residents' needs and that had received appropriate training about the safeguarding of residents. Residents were also being provided with information regarding safeguarding practices as part of their residents' meetings.

Where possible residents were being supported to engage in their preferred activities. Activities included days out to forests or the beach. Residents participated in activities in their home and community. The staff respected residents' choice for alone time when residents communicated this. Residents were also being supported to maintain family relationships.

There were behaviour management arrangements in place that directed staff clearly as to how best to support residents' with their emotional, mental health needs and behaviours of distress or concern. These included mood charts and behaviour support plans. Plans were created by a senior clinical psychologist and reviewed annually. Inspectors found that there were a range of restrictive practices being utilised in the centre. These were under regular review and were being implemented to promote and maintain the safety of the residents.

An inspector reviewed the centre's adverse incident log and noted that there were frequent recordings, the residents living in the centre presented with complex needs including behaviours that challenge. An appraisal of a sample of resident-specific risk assessments demonstrated that these were under regular review. The provider and person in charge were reviewing control measures to ensure that they were effective. The provider also had arrangements to identify, record, investigate, and learn from adverse incidents. Overall there were systems in place to promote and maintain the safety of residents.

An inspector reviewed documentation related to COVID-19 preparedness, associated policies, training, and infection control processes. In general, the provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority. However, the review found that there were some adaptations required to residents' COVID-19 risk assessments. In particular, there was attention required to existing plans regarding residents' self-isolating if they were to be identified as a potential or diagnosed as a confirmed COVID-19 case. This was brought to the attention of the person in charge, who addressed the issue before the completion of the inspection.

Inspectors found that there were a number of areas that required attention to reach compliance with the regulations. Despite this, the inspection found that residents were, in general, provided with a service that was meeting their needs.

Regulation 13: General welfare and development

Where possible the residents were being supported to engage in activities in accordance with their interests, capacities and needs.

Judgment: Compliant

Regulation 17: Premises

The provider had failed to address the required maintenance works to the interior and exterior of the building. This was, as a result, negatively impacting the appearance of the residents' home.

Judgment: Not compliant

Regulation 26: Risk management procedures

The centre had appropriate risk management procedures in place. There were also policies and procedures for the management, review and evaluation of adverse events and incidents.

Judgment: Compliant

Regulation 27: Protection against infection

The provider and the person in charge had adopted procedures consistent with the standards for the prevention and control of healthcare-associated infections.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors observed that there were repairs required to three fire containment doors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that there were improvements required to ensure that residents were being supported to set and work towards meaningful personal goals. There were also enhancements required to ensure that the most up to date information regarding residents was being captured in their personal plans.

Judgment: Substantially compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were arrangements in place that ensured that residents had access to positive behavioural; support if required.

Judgment: Compliant

Regulation 8: Protection

The provider had ensured that there were suitable systems in place to respond to safeguarding concerns. There were policies and supporting procedures to ensure that each resident was protected from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a

range of daily activities and had their choices and decisions 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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially 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 Lios na Greine OSV-0002566

Inspection ID: MON-0033433

Date of inspection: 18/08/2021

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The arrangements to strengthen the governance monitoring systems have been reviewed to ensure a consistent and safe quality service;

The Person in Charge has sole responsibility for this one designated center since 06-09-2021.

A Review of all Individual Person Centered Plan (PCP) goals was complete by 13-09-2021. Each resident has new meaningful goals identified for progression.
A "Person centered goal" audit tool has been developed. Audits will be carried out by the PIC each month. This audit tool assesses goals identified and ensures they are meaningful, realistic and tracks progress on goal implementation.

Oversight of the fire safety precaution has been reviewed. A weekly fire door check has been implemented throughout the centre since 19-08-2021.

A system to tracking progress of maintenance issues has been implemented by the PIC weekly.
The governance communication arrangements include daily phone contact between the line manager and PIC and weekly site visits to the designated centre for operational and strategic planning.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Tracking of maintenance issues that have not been addressed in a timely manner now in place and will be checked by the PIC weekly and followed up accordingly.

Outstanding maintenance works identified on the day of inspection all rectified by 24-09-2021.

Bedrooms and other parts of the centre have been repainted.
The flooring in rooms have been repaired and all finishes provided to mitigate any trip or falls hazard.
All ceiling areas and windows have been cleaned.
Doors and presses have been repaired.

Cleaning of window frames incorporated into daily cleaning schedule on 19-08-2021.
Cleaning schedule checked and counter signed by the nurse in charge at the end of each shift to ensure fully complete.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The fire door magnets have been repaired and all other fire safety doors examined to ensure they are in proper working order. The HSE Fire Officer has undertaken an assessment of the fire containment door magnets to ensure the effectiveness of the systems in place are robust and meet the needs of the service and required fire safety precautions.

Weekly fire door checks implemented into practice on the 19-08-2021.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A Review of all Individual PCP goals was complete by 13-09-2021 and new meaningful goals implemented.

A "Person centered goal" audit tool has been developed and will be carried out by the PIC each month. This audit tool assess that goals identified are meaningful, realistic and tracks progress on goal implementation.

Monthly audits of Individual Person Centered Plans (PCP's) are now in place. Audit criteria assess all documentation is reviewed within the specified time frame as per the centre's policy and that information is relevant and person centered to the individual. Referral to MDT members for clinical reviews complete and copy of referral in place. The PCP monthly audit tool will identify need to follow up on outstanding referrals or assessments. All referrals and reviews now reflected in all PCP folders.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	24/09/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	19/08/2021
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	06/09/2021

Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	19/08/2021
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	13/09/2021