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

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| Name of designated centre: | Graifin House |
| Name of provider: | The Rehab Group |
| Address of centre: | Dublin 18 |
| Type of inspection: | Unannounced |
| Date of inspection: | 12 September 2022 |
| Centre ID: | OSV-0002636 |
| Fieldwork ID: | MON-0037658 |

## About the designated centre

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

This community based residential centre provides a high support residential service for four adults with Prader-Willi Syndrome (PWS). The house is a two-storey, six bed roomed building located on a main road in a suburban area in Co. Dublin. Residents can also access the building from a side entrance. A large garden area is available to the front and side of the premises. Each resident has their own single room with one located on the ground floor and four on the first floor. The house is close to a broad range of services and amenities, with a public transport system also locally available.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 4 |

## 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 (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 |
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| Monday 12 September 2022 | 09:30hrs to 16:30hrs | Sarah Cronin | Lead |
| Monday 12 September 2022 | 09:30hrs to 16:30hrs | Michael Keating | Support |

## What residents told us and what inspectors observed

This unannounced inspection took place to monitor compliance with the regulations following an inspection in June 2022. Due to poor findings on this inspection, a warning meeting was held with the provider and assurances were sought on safeguarding arrangements and on the suitability of the premises for the residents. The Office of the Chief Inspector received two pieces of unsolicited information since the last inspection. Provider assurance reports were sought following receipt of this information. These reports were used to inform lines of enquiry for this inspection. The provider had submitted a clear plan to the Authority to re-locate all of the residents to more suitable accommodation within ten months. This inspection demonstrated that some improvements had been made in safeguarding arrangements, with a reduction in the number of incidents occurring in the centre. However, inspectors found that there were poor governance and management arrangements in place and improvements were required in fire precautions, individualised assessments and personal plans and notification of incidents.

The house is a large six bedroomed house located on a busy road in a suburban area of south Dublin. Downstairs comprises a kitchen, dining room, sitting room, office, gym, small toilet and a resident has a bedroom and an en suite on this floor. Upstairs there are five bedrooms, one of which is used as a staff sleepover room, an office and two bathrooms. There is a garden to the side and rear of the property with a garden room for residents to use. Regulation 17 (Premises) has had a level of non compliance on every inspection of the centre since 2015. The provider informed inspectors that an apartment had been sourced for one resident to live alone with staff support while another property had been sourced for the remaining three residents.

On the day of the inspection, the inspectors carried out a walkabout of the premises with the person in charge and had the opportunity to meet two of the residents. The other two residents were in hospital and staying with family. A resident told inspectors that they were excited to move to an apartment of their own. They spoke about their new day service and activities they were doing such as dancing, drama and bocce. The resident appeared happy and staff reported that the resident was now 'hopeful for their future'. The second resident was in a day service in the morning and an inspector greeted them on their return in the afternoon. The resident appeared happy and content. They chose not to engage with inspectors any further. Inspectors also spoke with two staff members and a family member during the inspection.

As found in previous inspections, compatibility of residents remained an issue. Due to safeguarding incidents which occurred in the house, there were a number of complaints from residents. However, the provider had put a number of measures in place which included an increase in staff support, access to more activities outside of the home and securing new accommodation for residents. The number of notifications of alleged psychological abuse had dropped since the last inspection,

demonstrating that measures were leading to a reduction in the number of incidents. However, the risk of recurrence of incidents remained high as long as these residents continued to live together. It was also of note that there was a reduced number of residents in the house in the previous month and increased staff presence which had a positive impact for the residents in the centre at that time.

Since the last inspection, the provider had carried out a review on residents' rights to privacy and dignity, particularly in relation to hourly checks at night-time. These had been discussed with the residents and with relevant healthcare professionals and discontinued where it was deemed appropriate to do so. There was one restriction in place in the centre which pertained to access to food and this was well documented, explained to residents and regularly reviewed.

Overall, inspectors found that while residents were well cared for, staff were endeavouring to provide a service in a premises which continued to be unfit for purpose. Governance and management arrangements required improvement to ensure that quality improvement plans were tracked to ensure all actions were completed. The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management arrangements affects the quality and safety of the service being delivered.

## Capacity and capability

Inspectors found that the governance and management arrangements were not adequate to ensure that there was appropriate monitoring and oversight of the quality and safety of residents' care. It was unclear to inspectors if the provider had actioned commitments which were given to the Authority following the last inspection. For example, the provider committed to monthly and weekly service reviews taking place. Local management informed inspectors that these were not taking place, while senior management informed them that it was taking place at senior level. Therefore, there was a lack of clear communication between senior and local management.

The provider had carried out an annual review and six monthly unannounced provider visits as required by the regulations. Action plans were developed in required areas and these plans were kept in different locations, with some on paper and others on the provider's action tracking database. It was unclear how the provider was maintaining oversight of all required actions arising from inspection activity and internal auditing. The person in charge reported that they were in very regular contact with their manager. However, there were not systems in place to document these meetings and record actions. Additionally, the person in charge had not been in receipt of formal supervision for a number of months.
The provider had resourced the centre with an appropriate level of staff to meet the residents' assessed needs. Maintenance of the roster had improved and full staff

names were now on all rosters and shift leaders were identified. Two new staff had been recruited and were in the process of completing induction.

The staff training matrix indicated that staff had completed mandatory training in areas such as fire safety, medication management and safeguarding. It was evident that the training needs of staff were identified and planned. Formal supervision was taking place with staff. This was carried out by team leaders, who in turn received supervision from the person in charge.

Inspectors viewed the provider's incident and accident log, the complaints log and the list of notifications. For the most part, incidents which were notifiable to the Authority had been submitted within required time lines. However, inspectors found that there was an incident which had occurred and a notification had not been submitted. This was subsequently notified on the day of the inspection.

## Regulation 15: Staffing

Inspectors found that there were adequate numbers of staff in place to meet residents' assessed needs. Two new staff members had joined the team since the last inspection and were in the process of completing their induction period. Planned and actual rosters had improved and clearly recorded the full names of staff on each shift. Schedule 2 files were not checked as they were not held in the centre.

Judgment: Compliant

## Regulation 16: Training and staff development

The inspectors viewed the staff training matrix and found that staff had completed mandatory training in areas such as fire safety, safeguarding and medication management. Training gaps which were identified on the last inspection had been completed. It was evident that the provider was identifying areas which required further training such as the management of cellulitis and the provision of personal and intimate care. These were planned for the week following inspection. Staff supervision was taking place, with the team leaders providing supervision to staff. In turn, team leaders received supervision from the person in charge. A sample of supervision records was viewed and the inspector found that sessions had set agenda items in place such as progressing with residents' goals, training needs and personal development.

Judgment: Compliant

## Regulation 23: Governance and management

Inspectors found that the governance and management arrangements were not adequate to ensure that there was appropriate monitoring and oversight of the quality and safety of residents' care. There was a lack of clarity on progress with commitments which were given to the Authority in the provider's compliance plan. For example, weekly and monthly service reviews were reported by local management as not taking place. However, senior management later informed inspectors that these were in fact occurring. Monthly reports for the board were prepared by the person in charge and the person participating in management. However, upon review of the most recent report, inspectors found that it did not contain sufficient detail to reflect current challenges in the centre and the changing care needs of residents.

Six monthly unannounced visits had taken place in addition to an annual review in line with regulatory requirements. Action plans were developed from these reports. A provider tracking system was in place on the provider's online system. However, inspectors found there to be a number of different action plans for six monthly reviews, the annual review and the compliance plan. Some of these were in paper format and others online. It was therefore unclear to inspectors which actions had been completed and how the provider maintained oversight of all of these actions.

Finally, there were not suitable arrangements in place for the person in charge to receive formal supervision. They reported to be in very regular contact with their manager. However, supervision was not occurring and there were no documented meetings taking place to review progress with all required actions.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Inspectors found that most notifiable incidents had been notified to the Authority within required time frames. However, there was one incident which was not notified. This was submitted on the day of the inspection.

Judgment: Not compliant

## Quality and safety

As stated earlier in the report, it was evident to inspectors that residents appeared to receive a person-centred service in what was a difficult situation, with

incompatibility issues and an unsuitable premises. All residents had an annual assessment of need carried out and this informed their care plans. Residents had person-centred plans in place and residents were consulted with in relation to their preferences and their goals. This was reviewed with key workers regularly. However, one resident required a comprehensive assessment from a health and social care professional to enable them to return home from hospital safely. It was unclear on the day of the inspection whether this referral had been made and what the status of this was.

All residents had positive behaviour support plans in place which were updated where required. Staff had now received training in the management of actual or potential aggression and had training specifically on the residents' condition. The restriction present in the house was documented, discussed with staff and regularly reviewed. There was a plan in place to work with residents to reduce this risk.

As outlined at the beginning of the report, while safeguarding remained a concern, the number of incidents had reduced since the last inspection. The provider had implemented a number of control measures in addition to progressing the plan for a resident to live alone. There had been a reduced number of residents in the centre in the weeks prior to the inspection and these factors combined had a positive outcome for the residents remaining in the centre. Personal and intimate care plans were in place and found to have sufficient detail to guide staff appropriately. Staff were to receive specific training in providing personal care in the weeks following the inspection.

Inspectors found that the provider had appropriate risk management systems in place to identify, assess and mitigate against risks in the centre. The risk register was regularly reviewed and updated where required. Adverse events were documented and reported in line with the provider's policy.

The designated centre had fire detection and containment equipment in place in addition to emergency lighting and fire fighting equipment in place. These were checked regularly to ensure they remained in good working order. Residents personal emergency evacuation plans (PEEPs) had been updated. Hold-open devices had been installed on fire doors. However, the oversight and monitoring of fire drills required improvement to ensure that all staff took part in fire drills in order to ensure that residents could evacuate the centre in a reasonable time in the event of a fire.

## Regulation 17: Premises

The premises remained unsuitable to meet residents' current and future accessibility needs and was in a poor state of repair in some areas. Some remedial works had taken place since the last inspection. The provider was in the process of purchasing two properties for residents to live in, which were reported to be suitable to meet their assessed needs.

Judgment: Not compliant

## Regulation 26: Risk management procedures

Inspectors found that the provider had risk management systems in place to ensure that risks were identified, assessed and managed, including a system for responding to emergencies. The provider had a risk management policy in place which met regulatory requirements.The risk register was viewed and found to be regularly reviewed and updated where required. Risk assessments pertaining to residents were clear in their care plans.Where adverse events occured, these were noted to be documented and reported in a timely manner.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had detection and containment measures in place in addition to fire fighting equipment and emergency lighting. Regular checks of fire doors, escape routes, equipment and lighting took place and were documented. Staff and residents had completed training in fire safety. All of the residents personal emergency evacuation plans were updated following the last inspection. However, oversight and monitoring of fire drills required improvement. One staff member who had worked in the centre for a year had not taken place in any fire drill. Records of other drills indicated that only four staff members had participated in fire drills in 2022 to date. In 2021, only five staff had taken part. Where difficulties had occured during a fire drill (for example, a resident refusing to leave the centre), documentation was not clear on what actions were required to mitigate this risk.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents had an annual assessment of need carried out which were used to inform their care plans. Each resident had a person-centred plan in place which was regularly reviewed with their key workers. The provider identified that one of the residents required a comprehensive assessment from a health and social care professional prior to a discharge from hospital. It was unclear what the status of this referral was and there was no documentation provided to inspectors to indicate that this action was complete. The provider had identified the need to adapt a room downstairs to have a more accessible bedroom for this resident. However, on the

day of the inspection, this room remained as an office and there was not a clear plan in place to ensure the premises would be suitable to the resident upon discharge from hospital.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Residents had access to a behaviour support therapist. Residents had positive behaviour support plans in place which outlined proactive and reactive strategies for staff to use with each resident in different situations. One of the residents' plans was updated in response to a change in circumstance. There was one restriction in place in the centre and this was found to be regularly reviewed and discussed with all residents. There was a plan in place to reduce this restriction with control measures in place.

Judgment: Compliant

## Regulation 8: Protection

The number of safeguarding incidents had reduced since the last inspection. The provider had put a number of control measures in place to ensure the safety of all residents. These included increased staff supervision, providing more activities for residents and progressing the long term plan of residents living separately. All staff had received training in safeguarding and safeguarding was a standard agenda item on team meetings. Where residents required personal care plans, these were found to contain sufficient detail to guide staff to ensure that residents' rights to privacy and dignity were upheld.

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 (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 | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Graifin House OSV-0002636

## Inspection ID: MON-0037658

## Date of inspection: 12/09/2022

**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 | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• Weekly reviews between ISM and PIC will be conducted until ongoing issues are resolved, first documented weekly review took place on 7/10/22.<br>• Monthly Oversight reviews with senior management are scheduled monthly, first meeting was conducted on 6/10/22. This meeting is also attended by members of the Quality & Governance Directorate, the purpose of these meetings is review progress towards compliance with actions plans and address any new issues ast they emerge.<br>• PIC completed a supervision on 15/09/22 and have been scheduled monthly thereafter.<br>• The Provider's action tracking system has not been accessible since cyber-attack in March 2022. The Provider is in the process of developing a new system, tracking of actions arising from HIQA inspections has now commenced on this system and work is ongoing to add the internal reviews to the same system. It is anticipated this will be live in January 2023.<br>• As interim measure the PIC will update the internal audit document with action updates. The progress of these actions will be reviewed between the PIC and ISM at regular intervals and will be further reviewed by the provider at the next 6 monthly internal review.<br>• At local level the PICs provides a monthly update to the board on current issues, additional detail was provided in the September report.<br>• At provider level the progress of actions arising from non-compliances are tracked by the Quality & Governance Directorate and reported on to the board each month. | |
| Regulation 31: Notification of incidents | Not Compliant |

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| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>• NF07 was completed on 12/09/22.<br>• The PIC and Staff Team will review the requirements in terms of notifications at next Team Meeting on 19/10/22. | |
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>• The Provider is currently in the process of purchasing two properties to meet the needs of the residents. One resident has chosen to live alone and an apartment has been purchased for this purpose. A four bedroom house has been identified and is in the process of being purchased to meet the needs of three of the residents. The plan is that all transitions will have been facilitated by 30/06/2023. | |
| Regulation 28: Fire precautions | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>• Q3 fire drill completed on 22/09/22, 3 staff members who had never completed a fire drill took part. Q4 fire drill will incorporate the remaining 2 staff members.<br>• The PIC will draw up a schedule for monitoring staff's participation in fire drills to ensure all staff participate at least once per year. This will be completed by 15/10/22.<br>• The PIC has sought advice from the Behaviour Therapist in relation to the support required by one resident who occasionally refuses to evacuate during fire drills. | |
| Regulation 5: Individual assessment and personal plan | Not Compliant |
| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>• Community OT referral was submitted by the hospital in June 22. To date no appointment has been received despite several phone calls by the PIC.<br>• PIC is currently trying to secure a private OT assessment in order to determine the | |

current support needs of the resident.
• Second contractor visited site on 1/10/22 to measure window to be changed in order to transform office into downstairs bedroom. It is anticipated that this will be completed by 31/12/22.

## 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)(a) | The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | Not Compliant | Orange | 30/06/2023 |
| Regulation 17(6) | The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre | Not Compliant | Orange | 30/06/2023 |

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| | to ensure it is accessible to all. | | | |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. | Not Compliant | Orange | 07/10/2022 |
| 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. | Not Compliant | Orange | 07/10/2022 |
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they | Substantially Compliant | Yellow | 07/10/2022 |

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| | are delivering. | | | |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 31/12/2022 |
| Regulation 31(1)(g) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation of misconduct by the registered provider or by staff. | Not Compliant | Orange | 19/10/2022 |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual | Not Compliant | Orange | 15/12/2022 |

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| | basis. | | | |
| Regulation 05(3) | The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 31/12/2022 |