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: | Ravenswell |
| Name of provider: | St John of God Community Services Company Limited By Guarantee |
| Address of centre: | Wicklow |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 17 June 2021 |
| Centre ID: | OSV-0003581 |
| Fieldwork ID: | MON-0032231 |

## About the designated centre

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

Ravenswell is a designated centre comprising of two separate residential units located in a larger building within a campus-based setting. Ravenswell provides residential and respite services to eleven adults (male and female) with disabilities. Each resident has their own bedroom decorated to their individual assessed needs and personal preferences. Communal areas within the designated centre include sitting rooms, dining areas, kitchens and a relaxation room. The centre is located within walking distance to a town in Co. Wicklow where residents have access to a range of community based facilities to include cafes, hotels, pubs, parks, shops and shopping centres. Transport is also provided for residents to avail of day trips, outings and holidays. The staff team consists of a person in charge, a deputy manager to the person in charge and a team of qualified social care professionals and nurses. All residents have personal plans in place detailing their social care goals, daily routine and healthcare needs. Residents also have regular and as required access to a range of allied professionals which include GP services, mental health services, occupational therapy, physiotherapy and speech and language therapy. The provider has identified the premises are not suited for their stated purpose and has plans to de-congregate the centre and support residents to transition to community based houses in a phased transition process, which at the time of inspection, was at an advanced stage.

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

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| Number of residents on the date of inspection: | 9 |

## 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 |
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| Thursday 17 June 2021 | 09:30hrs to 16:30hrs | Andrew Mooney | Lead |
| Thursday 17 June 2021 | 09:30hrs to 16:30hrs | Micheal Kelly | Support |

## What residents told us and what inspectors observed

In line with public health guidance the inspectors did not spend extended periods with residents. However, inspectors did have the opportunity to meet and engage with residents briefly and observe staff supporting them.

Residents appeared very comfortable with staff. During the inspection, inspectors observed staff supporting residents in a kind and respectful manner. This included staff spending time with residents and facilitating low arousal activities , such as cooking and this contributed to a friendly environment. There were some environmental restrictions in place, such as locked doors, which the provider deemed as necessary to protect residents, however these restrictions did contribute to a institutional feel within the centre.

During the inspection, inspectors observed good infection control practices in place, which included appropriate COVID-19 precautions. In line with national guidance, visitors access was limited to essential access only. However, the provider did have contingency arrangements in place, to ensure where appropriate, visitors could meet residents in a safe manner. These arrangements were under review in line with new visitors restriction guidance. There was appropriate hand sanitising facilities and staff wore appropriate personal protective equipment (PPE).

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements positively impacted on the quality and safety of the service being delivered.

## Capacity and capability

Overall inspectors found that their were good systems in place within the centre. These systems ensured residents' quality of life were supported and enhanced. However, further strengthening of the overall governance and management of the centre were required to ensure the timely progression of organisational plans, such as the transition of residents to more suitable living arrangements.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. Staff spoken with could clearly identify how they would report any concerns about the quality of care and support in the centre and highlighted that they would feel comfortable raising concerns if they arose. The centre had good oversight arrangements in place, including the completion of six monthly unannounced inspections of quality and safety of care. Additionally, an annual review of the quality and safety of care within the centre was

completed. However, this review did not clearly demonstrate that it had been completed in consultation with residents and their representatives. Furthermore, while the provider had identified that the premises was no longer suitable to meet residents needs, the plan to transition residents to a more suitable living arrangements had not been completed. This demonstrated that while the provider had the capacity to self identify areas of concern, it did not always have the capability to drive change in a timely manner.

Staffing arrangements at the centre were appropriate to meet the needs of residents and reflected what was outlined in the statement of purpose. From a review of the roster it was clear that there was an appropriate skill mix of staff employed at the centre. The person in charge had ensured that there was both a planned and actual roster which was maintained. Staff spoken with were knowledgeable and informed of key areas such as residents' needs, safeguarding and infection prevention and control. The inspectors observed staff supporting residents in a caring and dignified manor during the inspection.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, infection control, fire safety and manual handling. The person in charge maintained a register of what training was completed and what was due. This training enabled staff to provide evidence based care and enabled them to support residents with their assessed needs. However, some pertinent refresher training was overdue, such as fire safety. There were appropriate supervision arrangements in place, which included a supervision schedule for staff. A review of documentation noted that staff were supported well and they received supervision in line with the providers policy.

The statement of purpose accurately reflected the facilities and services provided within the centre. A copy of it was readily available and it had been reviewed as per the Regulations.

A record of all incidents occurring in the centre was maintained and all appropriate notifications had been submitted to the Chief Inspector as required by the regulations.

## Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times, including nursing staff as required. There was a planned and actual rota maintained.

Judgment: Compliant

## Regulation 23: Governance and management

There were clearly defined management structures which identified the lines of authority and accountability within the centre. There was an annual review of the quality and safety of care within the centre. However, this annual review required some improvements, as it was not clear that residents and their representatives were consulted in its development. Furthermore, while the provider had identified that the premises was unsuitable and transitions from the centre were required, insufficient progress had been made with this plan.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose is was in place and included all information set out in the associated schedule.

Judgment: Compliant

## Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date, evidence based practice. However, not all staff had received refresher training training as required. For example not all staff had completed refresher training in fire safety.

Supervision was in place and this supported staff practice and accountability.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and all appropriate notifications had been submitted to the Chief Inspector as required by the regulations.

Judgment: Compliant

## **Quality and safety**

This inspection found that there were good systems in place which enhanced the quality and safety of the centre. Effective systems and procedures were in place to protect residents, promote their welfare and recognise and effectively manage the service when things went wrong. However, improvements were required in how the provider reviewed adverse incidents and the premises remained unsuitable to meet the assessed needs of residents.

The person in charge and provider continued to make positive efforts to enhance the homeliness of the centre. For example, residents' bedrooms were individualised as far as possible and their were pleasant decorations in the common areas. Bathing and toilet facilities were well maintained and provided residents with adequate space and assistive equipment to meet their assessed needs. While these facilities were in place, overall the premises still presented as institutional and could not effectively meet the assessed needs of all residents resulting in required environmental restrictions throughout. The provider had a long standing plan to transition residents to a more suitable living environment that could meet residents' assessed. However, this plan had been delayed considerably which continued to adversely impact he lived experience of residents within the centre.

The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. Despite the providers and staff best efforts their was a outbreak of COVID-19 within the centre. A range of enhanced infection control procedures to protect residents and staff were implemented during this period and all appropriate measures were put in place. The provider engaged with public health authorities for guidance and implemented best practice principles to control the outbreak. There were hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. The provider had ensured adherence to standard precautions and there were ample supplies of personal protective equipment (PPE). At the time of inspection, there remained clear and appropriate arrangements in place to protect residents and staff from acquiring or transmitting COVID-19. However, the provider did not ensure an appropriate post incident review was completed. This review was required to ensure any learning from this outbreak could be identified and shared formally by the provider.

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. The service worked together with residents and their representatives to identify and support their strengths, needs and life goals. Residents were supported to access and be part of their community in line with their preferences and assessed needs. A review of residents assessment of needs, noted that while each resident had a comprehensive assessment competed. Known incompatibility between residents remained, however mitigating arrangements were in place to reduce the likelihood of adverse incidents.

A positive approach to responding to residents' assessed needs was developed. Staff were familiar with the strategies adopted to support residents. Appropriate support

plans were in place to guide staff in supporting residents. Similar to previous inspections it was noted some of the restrictions were required due to compatibility issues between some residents and the unsuitability of the premises to meet residents' assessed needs. For example, access to some communal areas was limited at times ie the kitchen. Some internal doors were locked to prevent residents' access to the upstairs area of the building which was utilised for non-residential purposes. While the premises could not effectively support residents to live in a restraint free environment, the inspector recognised these restrictions were necessary to promote and manage personal risks for residents.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Safeguarding plans were developed and safeguards put in place as required. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in the event of a suspicion or allegation. Residents also had intimate care plans developed as required which clearly outlined their wishes and preferences. These measures ensured residents were protected at all times.

The inspectors observed good fire safety measures in place, including a fire detection and alarm system, fire fighting equipment and fire doors with self closing mechanisms throughout. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire.

## Regulation 17: Premises

The provider had made efforts to refurbish and improve the homeliness of the designated centre. Despite these efforts, the premises was still institutional in nature and did not meet the needs of residents.

Judgment: Not compliant

## Regulation 26: Risk management procedures

Appropriate risk management systems were in place. Risk control measures were relative to any risks identified. Arrangements were in place for identifying and recording of adverse events. However, some improvement was required in the formal review of adverse incidents. For example there was no formal post outbreak review held in the centre, to identify learning from this incident.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

There were appropriate resources in place to support staff and residents during the COVID-19 pandemic.

Judgment: Compliant

## Regulation 28: Fire precautions

Appropriate fire precautions were in place, including a fire detection system, emergency lighting and fire fighting equipment. There was a procedure for the safe evacuation of residents and staff and appropriate fire drills were completed

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

There were appropriate arrangements in place to ensure that residents had a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Appropriate supports were in place for residents with behaviours that challenge or residents at risk from their own behaviour.

Judgment: Compliant

## Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse.

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| 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 23: Governance and management | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Ravenswell OSV-0003581

## Inspection ID: MON-0032231

## Date of inspection: 17/06/2021

**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:<br>To ensure that all family questionnaires complete annually will now be referenced as per regulation in the annual review and not attached as an appendix. The next annual review will take place in early 2022. PIC will send family questionnaires in December 2021.<br><br>Building works have commenced in 1 of 2 of the houses for de-congregation. Transition plans have commenced for 1 house and residents will aim to move to the first house by by March 2022.<br>We are currently in the final stages of planning with the county council on the second home. Once the building is completed the resident will be able to move into this home. This is planned for 31st May 2022. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>8 out of 25 staff were scheduled on date of inspection for fire safety training. All other 17 staff were in date.<br>Since date of inspection only 4 staff remain outstanding and will be complete by 14.9.21 | |

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| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises: | |
| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>To ensure that all adverse risks are formally documented and reviewed.<br>Informal outbreak review meeting took place on 12.2.21.<br>Since date of inspection a formal outbreak review due to take place on 6.8.21 and to be formally documented. | |

## 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 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 | 20/09/2021 |
| 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 | 31/05/2022 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the | Substantially Compliant | Yellow | 31/05/2022 |

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| | service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(1)(e) | The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives. | Substantially Compliant | Yellow | 31/01/2022 |
| 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 | 09/08/2021 |