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:	Special Dementia Unit - Sonas Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Announced
Date of inspection:	19 April 2023
Centre ID:	OSV-0003746
Fieldwork ID:	MON-0030629

About the designated centre

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

The designated centre is based on a campus setting in suburban area of North-West County Dublin and provides specialist dementia care to persons with intellectual disabilities some of whom have end of life support needs. The centre is comprised of one large building which was constructed in 2013 and currently operates as two separate units within the one premises. Services are provided through 13 long term beds and one respite bed. There is a staff team of clinical nurse managers, staff nurses, care assistants and household staff employed to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Wednesday 19 April 2023	09:30hrs to 15:30hrs	Sarah Cronin	Lead
Wednesday 19 April 2023	09:30hrs to 15:30hrs	Michael Keating	Support

What residents told us and what inspectors observed

This announced inspection took place to inform a decision on renewal of the registration of the centre. Inspectors found that residents were living in a centre which delivered specialist dementia services and in turn, supported them to have best possible health and to engage in meaningful activities. Inspectors found high levels of compliance with regulations inspected and these are discussed in the body of the report.

The designated centre is set on a campus. It was purpose-built for residents with dementia in 2013 and has won an award for excellence in design. The centre provides full-time residential care to residents who have an intellectual disability and dementia up to and including the provision of end-of-life care. The centre is divided into two units. One unit provides full-time residential care for seven residents and a respite bed was due to re-open in the weeks following the inspection. The second unit is home to six residents, all of whom have advanced to late -stage dementia. The building is well suited to residents' assessed needs. Each resident has their own bedroom and en-suite bathroom. Tracking hoists were available in some of the rooms and the building is wheelchair accessible throughout. There are two large kitchen and dining areas. The centre has an internal courtyard which is accessible from both units. The centre had a designated activity room and a number of sitting areas for residents to spend time in. The centre was beautifully decorated, with large colour photographs of the residents on the walls. Each residents' room was personalised in line with their life story. For example, for one resident who had worked in a library, staff members had sourced lighting and wall paper of books in line with that residents' interests. A staff member presented inspectors with work they had done with a resident to compile a multimedia life story using the resident's own words. This was then used to support new staff to get to know the resident and to inform their personal plans.

There were 12 residents in the centre on the day of the inspection. Inspectors met all residents in the centre over the course of the day. Residents in the centre had a diagnosis of mid to late-stage dementia. Some residents interacted verbally, while for others, they communicated using their general presentation, eye contact, body language and vocalisations. This meant that staff were required to know each resident well in the context of their life story to provide person-centred care. In order to gain insight into the residents' views , inspectors met with each resident and engaged briefly with them, where they were alert and able to do so. Some residents were asleep in bed, or in their wheelchairs and they were observed from a distance. Inspectors also observed residents in their daily routines and noted that residents appeared calm and content. Interactions observed by both inspectors were warm and friendly and there was a sense of fun during the day, with staff dancing and singing with residents. All of the residents were very well presented and staff were aware of things which were important to each resident such as having hair accessories or scarves on and continued to support them to wear these items in line

with their expressed preferences.

Two residents had transferred into the centre in the months prior to the inspection. Transitions were found to be well managed, with each person being supported by staff from their previous centre for a number of days. This ensured that all key information about the persons' preferences and their life history was passed onto the new team, in addition to providing consistency and familiarity to the resident at that time.

Routines were led by how each person presented throughout the day. For example, some residents preferred to eat breakfast later to other peers, based on their levels of alertness and desire to eat. This was facilitated. Other residents had access to a range of activities, both within the centre itself and in a day activation centre which was located on the campus. Activities included music, karaoke, dancing, baking, art. Each resident had an individualised ' menu' of activities which staff had available to support residents engage in activities which were meaningful to them. Residents engaged in activities within the centre and with a day activation centre based on the campus. Some residents had done baking in the morning, others were due to go out for coffee and other residents enjoyed doing their 'chores' in the centre. For those residents who were resting, there was a quiet and calm atmosphere, with soft music playing in the background. Later on in the day, the centre had a visit from a therapy dog which residents were observed to enjoy.

Inspectors received 15 resident questionnaires which were used to gain further insight into residents' lived experiences in the centre. Two of these were completed by family members, while the remaining questionnaires were completed by staff on behalf of residents they supported. Questionnaires seek feedback on service-related areas such as food and mealtimes, bedrooms, rights, visitors, activities, care and support and staff. Feedback was largely positive. Families used the word 'welcoming' a number of times when describing staff. Another said ' they show excellent skills relating to my relative'. One resident wrote that they 'wake up when they want', which was of importance to them. Inspectors also viewed family feedback to the provider as part of their annual review. Feedback from families were positive , with family members complimenting the staff team, and acknowledging the care and support provided by the staff team following a bereavement.

There was evidence of residents' rights being considered and upheld in all aspects of their care. Residents' life stories and history were documented and used by staff as a way of engaging with residents. Staff had all completed training on rights and were noted to observe and engage with residents to gauge their preferences within each moment. Rights assessments were in place for each resident and reviewed their access to their possessions, their wider environment, their will and preferences and where it was required, actions were developed from these assessments.

In summary, from what the inspectors observed, it was evident that residents' were well cared for by a staff team who were familiar with both their assessed needs in a pleasant environment. The next two sections of the report discuss the governance and management arrangements in the centre and how these arrangements

impacted on the quality and safety of the service being delivered.

Capacity and capability

The provider had strengthened and improved the governance and management arrangements in the centre, with improved systems of oversight and monitoring of residents' care evident. There were significant improvements in the levels of compliance across a number of regulations since the last inspection, with clear systems now in place to track identified actions from audits and provider visits. The annual review and six monthly unannounced provider visits had taken place in line with regulatory requirements. The person in charge carried out a number of audits in a number of areas and these were used to drive quality improvement in the centre.

The centre was appropriately resourced to meet residents' assessed needs. There were some vacancies on the day of the inspection. However, there was evidence that staff resources were well managed to ensure that residents had consistent care from familiar staff. Staff training was for the most part, up to date. Where gaps were found, these were already identified by the provider and staff had booked onto the relevant courses they required.

The provider had a Statement of Purpose in place which met regulatory requirements. All events which were notifiable events had been appropriately submitted to the Authority within specified time frames. The provider had a complaints policy in place. Complaints were documented and logged, and this log was regularly reviewed by senior management. However, one complaint from a family member had not been closed, nor had the complainant been informed of the outcome of their complaint.

Regulation 15: Staffing

Inspectors viewed the planned and actual rosters for the month prior to the inspection taking place. These were well maintained and showed all staff on duty by day and night. There remained some vacancies on the team. However, staffing resources were well managed, with a consistent staff team supplemented by regular agency staff who were familiar with the residents. There were appropriate numbers of staff with the required skills in line with residents' assessed needs. A sample of staff files were reviewed prior to the inspection and these were found to contain all information required under Schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the staff training matrix and found that staff had the required skills and knowledge to manage and deliver person-centred, safe and effective services to residents in the centre. Staff were supported and supervised in their roles. Some gaps in staff training were evident in areas such as syringe drivers for nursing staff, refreshers in safeguarding and manual handling. These were booked in for relevant staff over the weeks following the inspection. Weekly information and training sessions had taken place for the staff team on various aspects of dementia care. These were led out by the clinical team.

Judgment: Compliant

Regulation 22: Insurance

The registered provider effected a contract of insurance against injury to residents and other risks in the centre in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The provider had strengthened governance and management arrangements since the last inspection. There were good oversight, monitoring and auditing systems in place to ensure that the service provided was safe, appropriate to residents' needs. The centre was effectively resourced to ensure the effective delivery of care and support of residents in accordance with the statement of purpose and residents' assessed needs. The provider had carried out an annual review and six monthly unannounced visits to the centre. The annual review included consultation with residents and family members.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a detailed Statement of Purpose which contained information required by the regulations and this was reflective of the service inspectors found on

the day of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors found that the provider had notified the Office of the Chief Inspector of all incidents required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had an effective complaints procedure in place and information about the complaints procedure was displayed in a prominent location in the centre. A complaints log was kept and this was reviewed with senior management regularly. However, in the case of one complaint, the complainant had not been informed of the outcome of their compliant which had been made in the months prior to the inspection.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents were receiving a person-centred service in a comfortable and spacious home which was well suited to their current and future needs.The service is a nurse-led service, which specialist input from clinical nurse specialists in dementia. Residents had assessments of need carried out and this information was used to inform dementia-specific care plans. It was evident that staff used a person-centred approach in developing residents' care plans. Residents were supported to enjoy best possible health and had access to a range of health and social care professionals. Records of appointments were kept and clear health action plans were in place where they were required. Since the last inspection, a small number of residents had positive behaviour support plans in place to ensure staff were guided on responding to responsive behaviours. Safeguarding incidents continued to occur between peers in the designated centre. However, the provider had put a number of measures in place to reduce and manage the risk of incidents occurring. Incidents were trended and reviewed by management and evidence viewed indicated that safeguarding measures were effective in reducing the

likelihood of recurrence and in managing incidents where they did occur.

The provider had a risk management policy in place which met regulatory requirements. There were systems in place in the centre for the identification, assessment, management and review of risk. Incidents were trended on a monthly basis and it was evident that incidents were reviewed to ascertain possible causes of incidents and any follow-up actions required. Incidents and accidents were reviewed with the staff team each month to ensure that any learning or actions were shared and discussed. Inspectors viewed the centre's safety statement, the risk register and individual risk assessments. The risk register required review to ensure that all risks in the centre were identified and rated appropriately.

The provider had suitable fire safety management systems in place. This included detection and containment systems, fire fighting equipment and emergency lighting. Fire drills were regularly carried out and indicated reasonable evacuation times. Inspectors reviewed the medication management policy and observed medication administration during the inspection. The provider had suitable systems in place for prescribing, ordering, receipt, storage and disposal of medication. This included systems for storage of controlled drugs. Actions from the previous inspection had been implemented.

Regulation 17: Premises

As outlined in the opening section of the report, the premises was found to be clean, warm, beautifully decorated and very well suited to meet residents' assessed needs. The centre was specifically designed to suit the needs of people with dementia and there were a number of spaces where residents could spend time alone, or in company. Residents had their own bedrooms and bathrooms.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register and risk assessments required review to ensure that all risks in the centre were identified and assessed and to ensure that ratings were proportionate and reflective of those identified risks. For example, in one unit two residents were assessed as being at high risk of choking. However, the rating on the centre register was low risk. Staff training and gaps in training was not identified as a potential risk in the centre. This was of particular importance where staff were carrying out palliative care interventions.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had safe and effective fire safety management systems in place. There were detection and containment systems, fire fighting equipment and emergency lighting in place. Equipment was regularly checked, serviced and maintained. Residents had personal emergency evacuation plans in place and there was evidence of these plans being updated following fire drills. Fire drills were well documented. The provider planned to enhance fire precautions in the centre through widening doors of residents' bedrooms to allow for bed evacuations.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that the provider had appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines. There was a clear system in place for storing out-of-date and controlled drugs in line with regulations. Staff were found to be knowledgeable about each residents' medication and how best to administer it , in line with their assessed needs. Administration records were well kept and there was a clear system in place to identify and investigate any medication errors in line with the provider's policy. The provider had installed locked cupboards in the pantry area for residents' thickener and dietary supplements to be stored since the last inspection. These now had each residents' name on them to ensure that they were used in line with their prescriptions. PRN medications had protocols documented to ensure consistent and safe use of PRN medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents in the centre were in receipt of dementia-specific care, guided by quality dementia care standards. Each resident had a comprehensive assessment of need and from this, a dementia care plan was developed which was clearly laid out, with a hierarchy of needs documented. Communication support plans and health action plans were in place and regularly reviewed.

Judgment: Compliant

Regulation 6: Health care

Residents were well supported to have best possible health in the centre. They had access to a GP who was very familiar with the service and their needs and access to on-call support as required. Residents had input from specialists in dementia on the units and had support from health and social care professionals such as occupational therapy, speech and language therapy and physiotherapy. Residents preferences and supports in relation to end-of-life care were considered and placed in a prominent position in their care plans. This was discussed at advance care planning meetings with residents and family members and included resuscitation status and transfer to hospital.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans were now in place where they were required. These were detailed and had a traffic light system, with appropriate staff responses at each stage of a cycle of responsive behaviours. Weekly reviews of behaviour support plans took place with input from behaviour specialists and the clinical nurse specialists. Restrictive practises in place related to health and safety such as use of bed rails and lap straps. These were assessed and regularly reviewed with input from relevant healthcare professionals. Restrictive practises were reviewed on a quarterly basis and reviews used a human-rights based approach to consider the impact of restrictive practices on residents' rights.

Judgment: Compliant

Regulation 8: Protection

The provider had a safeguarding policy in place which was in line with national policy. There had been a high number of notifications of allegations of abuse reported in the months prior to the inspection taking place. These were peer-to-peer incidents. Due to this increased level of incidents, the provider carried out a safeguarding review on a quarterly basis which reviewed contributory factors and identified control measures such as an increase in staffing at key times of day and the development of behaviour support plans. All incidents were appropriately documented, reported and investigated in line with national policy. A sample of residents' personal and intimate care plans were reviewed. These were suitably detailed to guide staff practice and reflected the residents' preferences and consent to care interventions. Safeguarding was on the agenda at each staff meeting.

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 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Special Dementia Unit - Sonas Residential Service OSV-0003746

Inspection ID: MON-0030629

Date of inspection: 19/04/2023

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Provider has contacted the complainant of the one complaint that had been identified as remaining open during the inspection and informed of the outcome. Complainant satisfied with same and documented accordingly. The Provider will ensure that in the event of a complaint, the complainant will be informed promptly of the outcome of the complaint and given details of the appeals process in line with organisational and national policy. The Provider will ensure that the nominated person maintains an appropriate record of all complaints, outcomes and actions identified and will ensure the outcome of the resident is documented.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: A review will be undertaken of all risks in the designated centre and all identified risks will be inserted into the designated centre's risk register which will be maintained on an ongoing basis All risk assessments will be reviewed to ensure all risk ratings are proportionate and reflective of those risks identified. The Provider will ensure that any risks pertaining to Palliative Care Practice will be	

identified and will have appropriate control measures implemented.

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 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.	Not Compliant	Orange	30/06/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Substantially Compliant	Yellow	30/06/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation	Substantially Compliant	Yellow	30/06/2023

	into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			