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

Issued by the Chief Inspector

Name of designated centre:	Suaimhneas Respite
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	27 February 2023
Centre ID:	OSV-0005760
Fieldwork ID:	MON-0039077

About the designated centre

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

Suaimhneas Respite is a designated centre operated by Sunbeam House Services CLG and provides respite supports for up to four men and women over the age of 18 years with a primary diagnosis of intellectual disability that require low to medium support needs. Support provided varies depending on the residents' needs and requirements. The designated centre is located in North Wicklow located within a short walking distance of a large town. The centre is managed by a person in charge who has a remit for two designated centres. They are supported in their role by a deputy manager. The person in charge reports to a senior services manager. The staff complement also includes social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 27 February 2023	09:45hrs to 14:30hrs	Ann-Marie O'Neill	Lead
Monday 27 February 2023	09:45hrs to 15:50hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

The opportunity did not arise for inspectors to meet any residents or their representatives. However, inspectors did meet and speak with members of the management team including the chief executive officer, quality and compliance manager, senior manager, person in charge, and the deputy manager.

The management team spoke about the improvements implemented in the centre since the previous inspection in November 2022 which had found significant levels of non compliance with regulations. The improvements included strengthening some of the governance and oversight systems, enhanced full-time staffing arrangements, and a revision of the statement of purpose to ensure that the service provided in Suaimhneas Respite was more clearly set out, including the types of resident supports that could be catered for in the designated centre. These matters are discussed further in the report.

The person in charge and deputy manager told inspectors that the quality and safety of service provided to residents in the centre had improved, and that overall the atmosphere in centre was calmer and more pleasant. They were satisfied with the service provided to residents which they said met their assessed needs and was in line with the respite service model.

Inspectors began the inspection in the provider's main administration office before visiting the centre. The centre had been recently renovated and redecorated. Holes in walls had been repaired and the centre was painted throughout. The bedrooms were nicely decorated and some had new televisions. The provider also had plans to upgrade the kitchen in June 2023. Some of the fire doors were observed to require self-closing devices.

The centre was also more found to be more homely in aesthetic since the previous inspection, for example, a 'half-door' and plastic screen over the television in the living area had been removed, and nice photos of residents were displayed. Inspectors also observed information displayed in the centre regarding complaints, COVID-19 and infection prevention and control, safeguarding, and fire safety. There was also a visual staff rota for residents to refer to. Overall, the premises was bright, clean, warm, comfortable, and found to be suitable to residents' needs.

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

Capacity and capability

In January 2023, the Office of the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of the centre due high levels of non-compliance and concerns with regards to the fitness of the provider in being able to ensure that the centre was operated in accordance with the requirements of the Health Act 2007 and associated regulations and standards. The provider responded to the notice with a written representation, outlining the actions that they would take to address the areas of concern.

The purpose of this unannounced inspection, was to determine if the provider had carried out the actions as per their written representation, and if they had made sufficient progress in improving the quality and safety of the care and support being delivered to residents.

Overall, inspectors found that the provider had put arrangements in place to respond to and address a number of areas of non compliance including poor governance arrangements, risk management and oversight systems deficits, and a failure to safeguard residents.

This inspection found that the centre had reverted more to it's regular service provision where residents with significant and complex needs were no longer availing of respite services. As a result, this inspection found the provider was demonstrating improved capacity and capability in providing a quality respite service to residents with less complex needs.

Some examples of where the provider had undertaken to strengthen it's oversight and operational management of the centre included, strengthening the arrangements for the admission of residents to the centre. This related to the processes around emergency admissions which the provider had now outlined in the statement of purpose for the designated centre. The provider had also drafted an emergency abandonment policy which was under review within the organisation. The local management team also spoke about developing a written admission policy specific to respite services in the organisation to firmly underpin these new arrangements.

The provider told inspectors about their commitment to escalating and communicating the limitations of the service, in being able to provide a service to residents with complex support needs, to relevant external stakeholders. While these were good initiatives being taken by the provider, inspectors noted the statement of purpose required further refinement and clarification to detail the specific care and support needs that the centre could and could not meet as they continued to be somewhat vague.

The provider told inspectors about their endeavours to enhance their overall staffing resources in the organisation through increased advertising campaigns including open days and engagement with colleges to develop apprenticeship programmes. Within in the centre, the staffing arrangements had improved and the high reliance on agency staff had reduced. Most vacant shifts were now covered by full-time Sunbeam House Services staff. This was contributing to better consistency of care

for residents. However the organisation of the staff rota required more consideration to ensure that the resources were optimally utilised in the centre.

While it was demonstrated that staffing resources in the centre had improved considerably since the previous inspection, there continued to be a utilisation of agency workers in the centre at times. As found on the previous inspection, arrangements for inducting unfamiliar agency workers required improvement.

While the provider had agreements in place with the agencies, and the local management team sought assurances from agencies in relation to their training and skills to be able to work in the centre, there was no documented verification that the agency staff working in the centre had actually completed that training to ensure appropriate care and support to residents.

The management structure included a person in charge, senior manager, chief executive officer, and board of directors. There were arrangements for the identification and escalation of issues and risk, such as monitoring systems, audits and governance meetings.

While the findings from this inspection demonstrated the provider was undertaking initiatives to improve the oversight and governance arrangements in the centre, these systems required further embedding and formalisation as part of a wider organisation strategy and policy to ensure they were sustained and consistently implemented should there be a change of management personnel, for example.

The systems for responding to emergencies also required further consideration and these matters are discussed in the quality and safety section of the report.

Regulation 15: Staffing

While there were improved the staffing arrangements in the centre since the previous inspection, overall the centre was continuing to operate with a considerable resource deficit.

On this inspection, inspectors found the significant reliance on agency staff to operate and resource the centre had reduced considerably. For example the February 2023 staff rota indicated eight shifts were covered by agency staff compared to only two shifts in the March 2023. In addition, two full-time staff were due to return from leave by the end of March which would further enhance the staffing arrangements in the centre.

However, despite this improved staffing resource, there would remain approximately 70 vacant hours per month. These vacant hours were and would continue to be covered primarily by the staff team working additional hours, and the remainder worked by agency staff.

Therefore, the centre was not fully resourced with staff to meet the service and

resident needs and to ensure consistency for residents.

The local management team used regular agency staff to support the consistency of care for residents. They were satisfied with the staff complement and skill-mix. However, inspectors found that the organisation of the rota required more consideration to ensure the staff team were appropriately utilised which could further reduce agency use.

While there was an induction programme for the provider's staff, there was none for agency staff. It was not demonstrated that agency were adequately inducted before they commenced working to ensure that they were familiar with the residents' care and support needs, governance arrangements, reporting structures, and other crucial information.

The provider had outlined in their compliance plan response for the previous inspection, that agency staff would be required to start 30 minutes before commencing their shift for induction and handover purposes, however this arrangement had not been incorporated into any written procedure and it was unclear if this procedure was being consistently implemented.

The person in charge communicated specific requirements when booking agency staff, for example, training. Assurances from agency staff providers were verbally received by the provider, however this arrangement required formalisation to ensure that the assurances were documented and verified.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had responded to areas of non-compliance from the previous inspection which led to the notice of a proposed decision to cancel the registration of the centre.

The provider had improved resourcing arrangements in the centre, for example, a reduction in agency workers in the centre, enhanced risk oversight arrangements and repair and maintenance of the premises.

The monitoring and provider's oversight of the centre had also improved. Since the previous inspection, two six-monthly unannounced reports on the quality and safety of care and support provided to residents in the centre had been carried out by the provider's quality team which identified actions to drive quality improvement and compliance with regulations. An infection prevention and control audit was also carried out by a specialist in this area, the audit was comprehensive and with positive findings.

The person in charge was responsible for two designated centres. They were supported in the management of the centres by a deputy manager. The local

management team provided support and direction to the staff team. Outside of normal working hours, staff could contact the senior manager or on-call arrangement. The on-call arrangements were circulated on a weekly basis and displayed in the staff room for staff to refer to.

There were regular management meetings. Scheduled governance meetings between the person in charge and senior manager were to take place at least three times per year or more frequently if required. There were two meetings in February 2023 with a follow-up to take place in March 2023. The most recent meeting minutes were comprehensive and demonstrated improved management oversight of the centre. They reflected discussions on the statement of purpose, inspections and audits, personal plans, incidents, safeguarding, risk, fire, COVID-19, complaints, and restrictions.

The registered provider representative also met with the senior manager on a regular basis including forth-nightly meetings. Minutes of the meetings were not consistently recorded, however minutes from October 2022 noted discussions on safety measures in the centre, correspondence with the provider's funder, and general updates. The senior manager also attended senior management team meetings with their peers and discussed common and centre specific issues such as risk management.

At the time of inspection it was not clear if these enhanced arrangements were being implemented locally or underpinned by a wider organisation governance strategy.

Therefore, the enhanced oversight arrangements and structures required further formalisation to ensure that they were embedded in the overall governance and management procedures within the organisation, which would support the consistency and effectiveness in the implementation and sustaining of improvements

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The written statement of purpose had been recently reviewed by the provider, however further revisions were required.

The statement of purpose required more detail on specific care and support needs that the centre was intended to meet to ensure that all future admissions would be in line with the service that was to be provided in the centre.

Further information was also required in relation to the variances in service provided to the majority of residents and other residents who used the service on a more frequent basis.

Subsequent to the inspection, the provider made further refinements to the

statement of purpose and submitted it to the Office of the Chief Inspector as part of an application to vary a condition.

Judgment: Compliant

Quality and safety

Inspectors found that the centre was providing safer and an improved quality of service for residents using the service since the previous inspection. In addition to the improvements discussed earlier in the report, other improvements were found in relation to the premises, safeguarding of residents, management of risk and assessment of residents' needs.

Safeguarding concerns had considerably reduced since the previous inspection, and this was attributable to the service no longer providing services to residents with complex needs. The provider had also scheduled additional safeguarding training for their staff to attend to ensure that they had the knowledge to appropriately respond to, detect, and report any potential safeguarding concerns.

The person in charge had ensured that residents' needs were assessed to inform the development of personal plans. The assessments and plans viewed by inspectors provided sufficient information and were up to date. There were also arrangements to ensure that they were appropriately maintained.

Risk management procedures and oversight mechanisms had improved since the previous inspection. The management team demonstrated improved understanding on the arrangements for identifying, assessing and escalating risks in the centre through the levels of management responsibility. There were now arrangements for all staff, including agency workers, to record incidents to ensure that incidents were properly documented, reviewed and assessed.

However, some improvement was required. The provider had not put in place a procedure for the management of low staffing resource. As found on the previous inspection there had been a staffing resource crisis in the centre resulting in the centre being predominantly staffed by unfamiliar agency workers which had in turn resulted in poor quality outcomes for residents and high levels of non-compliance with the regulations.

The provider was required to assess this risk and devise a standard operating procedure on how to mitigate and manage this type of crisis event should it occur again.

Since the previous inspection, the premises had been renovated and redecorated to a good standard. Some further maintenance works were scheduled by the provider, such as replacement of the kitchen in June 2023. Overall, the centre was found to clean, bright, comfortable, and appropriate to the needs of residents using the

service.

Regulation 17: Premises

The centre had been renovated and redecorated since the previous inspection.

The provider had undertaken to repair a number of walls throughout the centre where previously there had been holes and dents.

The centre had also been repainted throughout and some additional furnishings put in place which overall enhanced the centre's homely aesthetic.

There were further plans to upgrade and modernise the kitchen area which would further contribute to the enhancement of the premises and improve the quality of service provision for residents on short respite stays in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had improved their systems for reporting, responding and managing risks in the centre.

Risks assessments were completed by the local team and escalated to the senior manager as required. The senior manager could further escalate risks to the corporate risk register. High risks were discussed at senior management team meetings attended by the chief executive officer to ensure that the required controls could be determined.

The provider had circulated information to the centre on providing agency staff with access to their electronic information system to enable them to record incidents. Some of the agency staff in the centre had already been granted access, and the local management team planned to facilitate access to any new agency staff. Incidents were reviewed by the local management team as they happened, and by the senior manager on a regular basis.

The provider had also commissioned a serious incident review of the centre. The review was underway and sought to make recommendations to improve safety and reduce the the risk of recurrence of similar incidents in the centre.

However, there was no procedures for the management of crises such as serious staffing constraints or significant changes to residents' needs that the centre could not manage. While the statement of purpose had outlined arrangements to be followed in the event of a significant change to a resident's changing, the

arrangements were not aligned to a corresponding written procedure. The absence of these procedures posed a risk to the safety and quality of service.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Overall, it was found that the centre was suitable for the purposes of meeting the needs of the current resident cohort.

Inspectors viewed a sample of residents' assessments and personal plans. They were up to date and provided sufficient on their needs and the associated care and supports they required. There was also information on resident' personal preferences and interests to guide staff in ensuring that they had a pleasant experience in the centre. One frequent respite user was due to transition to full-time residential service at the end of the month, and the person in charge had ensured that their assessments and plans were current and comprehensive to support the move.

The person in charge maintained a personal plan tracker to ensure that residents' plans were kept up to date and that the required plans were in place. The senior manager also checked a small sample of the plans during their governance meetings with the person in charge to ensure that they were adequately maintained.

The provider had arranged for their quality team to support the staff team in enhancing residents' respite goals. The quality team had met with the local management team and was planning to provide training to the team on developing and maintaining respite goals. The provider's electronic information system has also been enhanced to promote the better recording of progress and updates on goals.

Judgment: Compliant

Regulation 8: Protection

The safeguarding of residents in the centre had improved since the previous inspection.

Inspectors found that there were no active safeguarding concerns, and this was mostly attributable to the discharge of some residents.

One safeguarding plan remained open as it was relevant to the planned discharge of another resident.

The permanent staff team had completed training to prevent, detect and respond to

safeguarding concerns. The provider had also arranged additional in person training to enhance their understanding.

Staff were scheduled to attend the training which was taking place across five dates in the coming months.

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	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Suaimhneas Respite OSV-0005760

Inspection ID: MON-0039077

Date of inspection: 27/02/2023

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 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
From the 7th of April all staff will have returned from long term sick leave. All shifts are currently covered by the current staff complement. There is however a shortfall of 70 hours across the month, these 70 hours are to cover staff leave. Only one staff is permitted to take leave per shift. Every effort will continue to be made to ensure that there is minimum of one core staff per shift. The Rota has been reviewed to utilize staff efficiently to complete their contractual hours in the designated center in so far as is reasonable possible.

An induction folder has been made available for agency/relief staff containing all information required to manage a shift on this location.

- Daily running/duties
- Resident's Personal Profile Folders with care and support needs of residents.
- Phone numbers/Codes/Emergency contact numbers/ Senior Management On Call arrangements
- Internal reporting systems – Login – How to Use.
- Access to organizational policies and procedures

An induction check list in place for agency/relief staff.

All attempts are made to use regular agency staff to provide continuity of care.

Local management has been in contact with the agency provider with a request to confirm required training for agency staff working in the center.

In emergency staffing situations every effort will be made to get this information in relation to training of the agency staff prior to beginning their shift.

It has been communicated to the agency that where they place a new or unfamiliar staff

to the center an additional 30 minutes will be facilitated at the beginning of the shift to allow for induction and time to receive handover.

Senior Management will draft an organizational procedure in relation to agency induction / booking by June 1st 2023. This procedure is proposed to include directions in relation to, residents' support needs, governance arrangements, reporting structures.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There continues to be a reduction in the use of agency staff, we continue to recruit staff manage roster to ensure that core staff are in place to support residents.

The meetings between the provider representative and PPIM will be recorded.

Senior Management will draft an organizational procedure in relation to Agency Induction / booking by June 1st 2023. This procedure is proposed to include to include directions in relation to, residents' support needs, governance arrangements, reporting structures.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Statement of purposes has been updated to set out clearly the supports the designated center can offer to residents.

Each year an assessment of need will be completed, or sooner if required, where there is a change of need a meeting of MDT will be scheduled if required.

Where a change of needs is identified that cannot be managed in line with the SOP, the resident will not receive respite until such time as appropriate supports can be put in place to meet the needs of the resident. If there are no appropriate supports that can be put in place, the entry, transfer and discharge policy will be followed and the primary funder will be alerted to same with a view to finding an appropriate alternative placement to meet the identified needs of the resident.

Senior Management will draft an organizational procedure in relation to Agency Induction / booking by June 1st 2023. This procedure is proposed to include to include directions in relation to, residents' support needs, governance arrangements, reporting structures.

Where there are serious staffing constraints, the admission of residents to the designated center will be reduced in order to provide a safe service in line with the staff resource available. The entry, transfer and discharge policy will be updated to reflect crisis issues such as staffing constraints and changing needs in relation to respite by 1st June 2023.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	01/06/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	01/06/2023
Regulation 23(1)(a)	The registered provider shall	Substantially Compliant	Yellow	01/06/2023

	ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	01/06/2023
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	01/06/2023