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:	Hayden's Park Way
Name of provider:	Peter Bradley Foundation Company Limited by Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	06 September 2023
Centre ID:	OSV-0005602
Fieldwork ID:	MON-0040192

About the designated centre

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

Hayden's Park Way is a designated centre operated by Peter Bradley Foundation Company Limited by Guarantee. The centre is a four bed residential neuro-rehabilitation service located in Co. Dublin. All residents are over the age of 18 years of age and the maximum number of people that can be accommodated is four. Hayden's Park Way is in a location with access to local shops, transport and amenities. The centre provides single occupancy bedrooms, bathrooms, sitting room, kitchen and garden space is provided for the residents. The service is managed by a person in charge and a team leader. There is a team of Neuro Rehabilitation Assistants to support residents according to their individual needs.

The following information outlines some additional data on this centre.

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
Wednesday 6 September 2023	10:00hrs to 17:10hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection of the designated centre. The most recent inspection of the centre was an infection prevention control (IPC) inspection which took place in April 2023. That inspection found that the centre was not compliant with the National Standards for Infection Prevention and Control in community settings. The provider submitted a compliance plan detailing the actions that they would take in order to address the risks identified. The current inspection aimed to monitor the provider's progress in implementing their compliance plan and also explored a wider range of regulations.

Overall, the inspector found that the provider had made gains in enhancing their oversight of the designated centre and had addressed the IPC risks previously identified. There were some areas for improvement which will be described further in the next two sections of the report.

The designated centre is located in a busy town close to many public amenities. The centre is registered to accommodate four residents and there were no vacancies at the time of inspection. Residents in this house each have their own bedroom and share a kitchen, living room and utility. Some residents have en-suite bathrooms while others share a bathroom. There is also a large, landscaped back garden with a garden room available for use by the residents. The inspector saw, on arrival, that the centre was well maintained and welcoming at the exterior. A staff member greeted the inspector and made contact with the person in charge who attended the centre to facilitate the inspection.

The centre was seen to be clean and homely. New furniture had been provided in the sitting room which was clean and comfortable. There were facilities for relaxation including a TV, DVDs and board games. Communal areas were decorated with residents' photographs. The inspector asked two of the staff on duty about the enhancements that had been made to centre since the last inspection. Staff described additional training that they had completed and pointed out the increased availability of hand hygiene facilities and PPE in the centre. The inspector saw that there was ready availability of hand hygiene facilities and saw staff engaging in good hand hygiene practices throughout the inspection.

The inspector had the opportunity to meet all four of the residents on the day of inspection. Two residents chose to speak to the inspector in more detail regarding their experiences of living in the designated centre. Both residents said that they were happy living there and that they could talk to the staff if they had any concerns or problems. One resident described the other residents and staff as being like their "second family".

Both residents told the inspector that they accessed day services or employment during the week as well as social and community based activities. One resident

showed the inspector their timetable and talked through their planned routine for that week. They had recently commenced in a new day service and had been supported to learn the public transport route to their day service. This enabled the resident to travel independently which was something that they said was important to them. Another resident worked part-time in the community. They described their work activities and told the inspector how they were saving their money for a personal, family-related goal.

Both of the residents spoken with also showed the inspector their bedrooms. The inspector saw that residents' bedrooms were individually furnished and decorated. One resident showed the inspector copies of FETAC awards that they had gained as well as photographs of their family and pets.

A resident told the inspector that some residents occasionally could become frustrated. They said that they understood the reasons behind other residents' frustrations and felt confident that they could talk to staff if they had any worries or concerns. The inspector saw other residents coming and going from the centre independently during the course of the day. Staff spoken with described a culture of positive risk-taking whereby residents were encouraged and supported to be autonomous as possible in their activities of daily living. Overall, the inspector saw that residents were happy in their home and were living in a clean, safe and homely environment.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. The inspector found that the provider had enhanced their oversight arrangements subsequent to the last inspection of the centre. Infection prevention and control risks had been mitigated and the provider had implemented an enhanced series of audits to support them in driving continuous quality improvement in the centre. There was one area for improvement identified, which was the submission of monitoring notifications to the Chief Inspector as required by the regulations.

There were clear lines of authority and accountability in the designated centre. The centre was staffed by a full team of rehabilitation assistants who reported to a person in charge. The person in charge reported to a service manager. Staff spoken with were clear on their roles and responsibilities and of how to escalate concerns or risks through the chain of command to the provider level.

The staff team were in receipt of regular supervision, support and training. A training matrix was maintained for the centre which showed a very high level of compliance with mandatory and refresher training. Dates for refresher training had

been scheduled for those staff who were due this in the coming months.

In light of the finding of not compliant on the most recent IPC thematic inspection, the provider had commissioned a report into the causation factors which contributed to the poor infection prevention and control standards in the centre. This report made several recommendations to mitigate against future occurrences. In speaking to the person in charge, it was evident that several of these recommendations had already been implemented or were in progress. These actions included enhanced training for the local management team and clearly defining the roles and responsibilities of the local services manager and the team leader.

Additionally, the person in charge had implemented an enhanced suite of audits to support them in having oversight of the centre and to mitigate against risks. These audits included regular walk-throughs of the designated centre by the person in charge to identify any IPC risks. Local operating procedures had been enhanced to support increased consistency. For example, two staff were required to sign off on cleaning schedules when completed. Other audits in place included health and safety audits, medications audit and housekeeping audit. These audits were used to inform a quality improvement plan for the centre.

The provider had effected a complaints policy along with an accessible complaints procedure. Residents were well-informed regarding the complaints procedure and were aware of how to make a complaint should they wish to do so.

While the provider had submitted some monitoring notifications to the Chief Inspector, the inspector noted, on reviewing the incident log and the staff meetings record, that not all incidents of alleged or confirmed abuse were notified to the Chief Inspector. This required review by the provider and person in charge to ensure notifications were submitted in line with the statutory requirements.

Regulation 15: Staffing

The centre was operating with a full staff complement. The roster for the centre was reviewed and the number and qualifications of staff were in line with the statement of purpose.

The inspector saw that there were sufficient staff on duty on the day of inspection to provide individualised care and support to the residents.

There was a small panel of relief and agency staff in place which was used to fill any gaps in the roster. This was supporting continuity of care for the residents.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was maintained for the designated centre which showed that there was a high level of compliance with mandatory and refresher training. All staff were up-to-date with required training in areas such as safeguarding, fire safety, first aid, and IPC.

Staff were in receipt of regular supervision and support through monthly staff meetings, quarterly supervision sessions and biannual performance management and development reviews. Records of these meetings were maintained in the centre.

Staff reported to the inspector that they felt well-supported in their roles and were confident that any issues or concerns would be responded to by the provider.

Judgment: Compliant

Regulation 23: Governance and management

The provider had enhanced their oversight of the designated centre subsequent to the previous inspection. There were clear lines of authority and accountability. Staff were aware of the reporting structure and of how to escalate concerns to senior management.

The centre was adequately resourced to meet the needs and the number of residents. There were structures in place to support and performance manage staff. The inspector reviewed the minutes of staff meetings and saw that they were comprehensive.

The provider had commissioned a safety incident investigation subsequent to the last inspection and had drafted a report which identified contributory factors to the risks found on that inspection. An action plan was developed from this report in order to address risks and prevent future similar occurrences. The inspector spoke to the person in charge and saw that actions had been implemented as recommended by the report. For example, both the person in charge and the team leader had received further training and a suite of additional audits had been implemented to ensure effective oversight of risks.

The provider had also completed a six monthly unannounced visit in June 2023. This identified areas for improvement and set out a smart action plan in this regard. The inspector saw that actions set out in this audit had been completed or were in progress.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector saw that not all notifications were submitted in line with requirements of the regulations. There were three recorded incidents of alleged or confirmed abuse of residents in recent months in the designated centre. While these were recorded and responded to locally, the required notification had not been submitted to the Chief Inspector in respect of these incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had effected a complaints policy which had been reviewed within the past three years. A copy of the complaints procedure was available to the residents in the centre.

The inspector saw that residents were informed of their right to make a complaint and the process by which to do so at residents meetings. Residents told the inspector that they were familiar with the complaints procedures. There were no active complaints at the time of inspection.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector found that residents felt safe in their home and were in receipt of a good quality service. However, there were enhancements required to the reporting and monitoring of restrictive practices and safeguarding risks in the centre to ensure that residents' rights were fully upheld.

The inspector completed a walk-through of the designated centre and saw that it was clean and generally well-maintained. There were adequate communal and private areas. Storage facilities had been enhanced since the last inspection. Large filing cabinets had been removed from the upstairs landing and this contributed to a more homely feel in the centre. There were some minor areas for upkeep seen on the day of inspection. These included painting and the repair of bathroom flooring. The inspector was told that the provider was in the process of sourcing quotes for painting works.

The centre was very clean and tidy. Staff told the inspector that the centre had been deep-cleaned subsequent to the last inspection and that there had been improvements to the IPC facilities. These included increased availability of personal protective equipment (PPE) and hand hygiene stations throughout the house. Staff also described having completed training in IPC and were aware of their roles and responsibilities in this regard. Staff were knowledgeable regarding the IPC risks in the centre and of the control measures to mitigate against these.

The inspector saw that there were adequate fire detection and prevention measures in place. The provider had ensured that all residents could be evacuated in the event of an emergency. Staff had received fire safety training and were knowledgeable regarding the fire evacuation arrangements.

Residents' files were reviewed by the inspector. They were found to contain up-to-date assessments of need which were written in a person-centred manner and informed comprehensive care plans. Residents who required them also had recently reviewed positive behaviour support plans on their files.

Since the last inspection, the provider had removed many of the restrictive practices in place in the centre including a lock on the downstairs toilet and signage allocating certain areas as staff only in the building. The staff team had identified two remaining restrictive practices, one of which had been notified to the Chief Inspector. The other restrictive practice had only been recently implemented and the inspector was informed, it would be notified to the Chief Inspector in the next quarterly monitoring notification submission. Work had been completed with residents to support them to understand the rationale for these restrictive practices and to gain their consent to them.

Through discussion with the staff team and the person in charge, it was identified that there was an additional restrictive practice in the centre. This involved the supervision of some residents in communal areas in order to mitigate against safeguarding risks. While this was being largely effective in supporting staff to intervene and de-escalate incidents of peer to peer abuse before they occurred, the supervision of residents had not been identified as a restrictive practice and therefore had not been recorded as such. Additionally it was not established that residents' had been consulted with or given their consent to this practice.

The inspector also found that incidents of peer to peer verbal abuse had not been reported to the Chief Inspector in line with the requirements of the regulations. Furthermore, a referral had not been made to the National Safeguarding Office in respect of these incidents. While residents told the inspector that they felt safe in their home, a review of the recording and reporting of safeguarding issues was required to ensure that the provider was in compliance with their statutory obligations.

Regulation 17: Premises

The premises was generally well maintained and homely. The inspector saw that there had been enhancements made to the premises of the centre since the last inspection. These included the purchase of new sitting room furniture and the removal of institutional type signage throughout the house. There were adequate communal and private facilities for residents. Several residents showed the inspector their bedrooms and appeared proud of these.

There were some minor premises works which were required. These included painting throughout the house and repair of flooring in the main bathroom. The provider had identified that painting was required and was in the process of obtaining quotes for this work at the time of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had taken comprehensive action to address the infection prevention and control issues identified on the last inspection. All staff in the centre had received and were up-to-date with IPC training. Staff spoken with were knowledgeable regarding their roles and responsibilities pertaining to IPC. Staff were informed of the local operating procedures for the management of centre specific IPC risks.

The inspector saw that there was increased availability of hand hygiene facilities and saw staff engaging in good hand hygiene practices over the course of the inspection.

The centre had been deep cleaned since the last inspection. There was an enhanced cleaning schedule which was supporting the ongoing maintenance of a clean and safe environment for the residents.

Risk assessments were in place for IPC specific risks.Control measures were proportionate. Staff were informed of these control measures and described how they apply them in their everyday practice.

Judgment: Compliant

Regulation 28: Fire precautions

There were adequate mechanisms in place to detect, contain and extinguish fires in the centre. Fire alarms and fire extinguishers were serviced regularly. Fire doors with automatic door closers were also in place throughout the centre.

Staff had received and were up-to-date in fire safety training.

Fire evacuation drills had taken place regularly in the centre and demonstrated that all residents could be evacuated from the centre in a timely manner.

Personal evacuation plans were available for all residents and clearly detailed the supports required to assist each resident with an emergency evacuation from the designated centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A sample of residents' files were reviewed. The inspector saw that these residents had an up-to-date and comprehensive assessment of need. The assessments of need were written in a person-centred manner and were used to inform care plans for each assessed need. Many of the residents' care plans were aligned to their individual goals.

Residents accessed a variety of multi-disciplinary professionals for their assessed needs. Care plans were informed by the relevant multi-disciplinary professional where required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents, who required one, had a recently updated positive behaviour support plan available on their file. These behaviour support plans detailed proactive and reactive strategies to assist staff when required. Staff were well-informed regarding the behaviour support plans and of how to implement strategies. Staff had also received training in positive behaviour support and were scheduled for refresher training in October 2023.

There was one restrictive practice in the centre that had been notified to the Chief Inspector through the quarterly monitoring notifications. However, on reviewing the provider's policy and through discussion with the person in charge and staff, it was identified that there were two additional restrictive practices in the centre. These restrictive practices were the locking of the utility door when the washing machine was in use. This was due to an identified risk in relation to the management of linen and laundry. The second restrictive practice involved the supervision of some residents in the communal areas of the centre.

Residents had been consulted with regarding the revised laundry arrangements and

had given their consent in a written format however there was no consent in place for the supervision arrangements. Additionally, there was no restrictive practices log in place although the person in charge stated that they were in the process of implementing one.

A review of the restrictive practices was required to ensure that all restrictive practices were logged, regularly reviewed and to ensure that residents had been informed of and consented to them.

Judgment: Substantially compliant

Regulation 8: Protection

Residents in this centre told the inspector that they felt safe and happy in their home. The inspector saw that there were kind and supportive interactions between staff and residents.

However, staff told the inspector that there were occasional incidents of peer to peer negative verbal interactions in the centre. Staff stated that these were managed by ensuring supervision of residents and by implementing the residents' behaviour support plans.

The provider had implemented a safeguarding policy which had been revised in July 2023. This was found to be comprehensive and clearly detailed the process by which safeguarding incidents were to be responded to and managed. The inspector was not assured that this policy was being fully implemented in the designated centre. For example, the minutes of the last two staff meetings detailed two incidents of peer to peer abuse and one allegation of omission of care by staff. However, the provider's safeguarding policy had not been adhered to as a referral had not been made to the designated officer in respect of these incidents. Additionally, a safeguarding report had not been made to the national safeguarding office.

Judgment: Substantially 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	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	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	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Hayden's Park Way OSV-0005602

Inspection ID: MON-0040192

Date of inspection: 06/09/2023

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 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Refresher training completed by LSM and team leader on HIQA notifiable events – information also passed from LSM to team leader to ensure HIQA notifications are still submitted when LSM is on leave. Further communication passed onto full team to ensure all staff are reporting all incidents to team leader and LSM immediately so the appropriate courses of action can be taken, and the appropriate internal (Designated Officer) and external (HIQA/ Safeguarding and Protection Team) bodies can be notified. This has already been done so improvement of HIQA notifications will be immediate and ongoing. The provider will monitor incidents monthly to ensure that reporting obligations have been followed up on.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Two quotes for painting have been obtained and a third quote submitted to provider. However, due to shortages in trade industries, a compliance date for the completion of painting will be put for 30.04.2024 to ensure appropriate time to secure a contractor and come into compliance with Reg 17. Bathroom floor will be replaced / repaired by 30/11/23.	

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A review of restrictive practices at the centre will take place. A comprehensive Restraint Register will be established which will include clinical support and direction on implementing newly identified restrictive practices. Consent and consultation from residents will also be provided. This will include the development of a risk assessment and intervention plan, a restraint checklist and bi-monthly audit of same. Any additional restraints identified will be notified to HIQA on the NF39 Quarterly Notification by 31.10.2023 for July, August, and September. The provider will ensure to thoroughly audit same during their unannounced inspections of the centre. An ongoing action regarding the maintenance of these records for the Chief Inspector has been added to the centres QIP to be monitored for ongoing compliance by the provider.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The provider provides assurances that the providers safeguarding policy will be followed by the PIC and team at the centre.

Reporting obligations discussed between provider, LSM & team leader re: consistency of safeguarding plan implementation along with relevant HIQA and safeguarding notifications. The team have been communicated with and are aware of their reporting obligations for same. The provider has added an ongoing action to the centres QIP for the PIC to notify HIQA and designated officer within the required timeframes of any safeguarding / NF06 related incidents. The provider will review incidents monthly to ensure this is being adhered to. Quality and Safety Support Officer has liaised with the local Safeguarding and Protection Team who have confirmed that all safeguarding is closed to them and to be managed locally via local safeguarding plan / risk assessment unless any further incident occurs.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2024
Regulation 31(1)(f)	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, suspected or confirmed, of abuse of any resident.	Not Compliant	Yellow	10/10/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic	Substantially Compliant	Yellow	31/10/2023

	interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/10/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	10/10/2023