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:	Delta Hazel
Name of provider:	Delta Centre Company Limited by Guarantee
Address of centre:	Carlow
Type of inspection:	Unannounced
Date of inspection:	13 October 2021
Centre ID:	OSV-0007990
Fieldwork ID:	MON-0032565

About the designated centre

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

Delta Hazel is a designated centre located close to the town of Carlow. The centre can provide residential care for three adults, male and female, with intellectual disabilities aged 18 years and upwards. The centre comprises two separate bungalow buildings, both located in residential areas. Residents have individual bedrooms, and can access kitchens, living areas and outdoor garden space. Local amenities in Carlow include shops, cafes, restaurants, salons, GAA clubs and a cinema. Delta day service and sensory gardens are located close by and are available for residents if this is their preference. The staffing team consist of social care workers and support workers. Residents also have access to a staff nurse in the Delta centre if needed.

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 13 October 2021	09:30hrs to 18:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

Overall, the findings of this inspection indicated that the provider was striving to achieve consistent quality across the service to ensure residents' specific needs were being met. However, the oversight and monitoring of the centre was not always sufficient to ensure this consistent standard could be maintained at all times. Improvements were required across a number of regulations.

This was the first inspection of this centre. This centre was initially registered in March 2021 for one individual. The provider submitted an application to increase bed numbers and number of buildings in this designated centre later in the year. The designated centre is now registered for three individuals. Currently, two individuals live in the designated centre, one resident in each home. There were no immediate plans to move in a third resident.

The inspector had the opportunity to meet and spend some time with both residents. In the first house, the resident welcomed the inspector into their new home. They had just got up and were getting ready to leave for their day service. They had moved into their new home 10 days previously. The resident appeared relaxed and comfortable in their home and was observed to move freely around their home and independently get ready for their day.

Their home was warm, clean and bright. There were cards displayed that the resident had received to welcome them to their new home. The resident pointed out a card and flowers they had received from neighbours and they spoke about how they were going to complete a return gesture by making them a shepherds pie.

When asked about how they were settling into their new home the resident stated it was 'freedom'. They spoke about their plans for sorting out their games room with a family member. The resident had a busy, active life.They attended day services across a five day week. They had been attending part of this day service prior to their transition as part of their plan to get familiar with the new service provider and relevant staff.They spoke about activities they liked to do and was heard telling staff what their plans were for the weekend. The resident was very much making relevant decisions and choices in relation to completing activities that were important to them. They enjoyed spending time with family and also going to the gym and their weekend schedule revolved around these important aspects.

The resident was seen to have open and familiar conversations with staff. The resident expressed that they were a little anxious about an upcoming change in the day service timetable. The resident openly discussed this with a staff member and a solution was discussed to try and provide reassurance to the resident around this. Staff were kind, caring and respectful in their interactions with the resident. The atmosphere during this time was calm and relaxed.

On arrival to the second home, the resident was relaxing on their armchair listening

to music on their tablet. They were being supported by two staff at this time.The resident was observed to ask for help from staff, and this request was immediately facilitated. The resident was waiting on a call from the dental hospital to prepare them for an upcoming visit. This call was arrange to provide reassurances to the resident and to also give them a chance to view the dental room remotely before they arrived for their appointment.

Later in the day the resident showed the inspector their bedroom. It had been decorated to the resident's individual taste and meaningful items and pictures were on display. Their home was clean, homely and warm with adequate space for one resident. The resident had also been involved in decorating the house for Halloween and decorations were displayed in all the rooms of the home. The resident spoke about the upcoming dentist appointment. They spoke about family, and told the inspector that they would be visiting a family member when they returned from their holiday.The resident overall appeared relaxed and comfortable in their home.

A staff member showed the inspector the resident's individual timetable that was on display. Each aspect of the day was accounted for using pictures to help with understanding. The resident had different plans for the day which included going for a drive, walk and coffee and then spending some time relaxing at home. The resident tired easily as they had recently recovered from an illness and staff were cognisant that their timetable had plenty of opportunities for the resident to rest.

The following sections of the report will expand on some of the deficits in relation to the oversight of the centre from a governance and management perspective and how this was impacting on aspects of the quality of care being provided to residents.

Capacity and capability

The inspector found that the management systems were not always effective in identifying areas of improvement. Due to the individualised aspect of service delivery, residents enjoyed a good quality of life and were safe. A number of regulations required improvement to ensure high quality service delivery could be maintained at all times.

The centre had a defined management structure in place which consisted of a person in charge who worked on a full-time basis. They were also responsible for another designated centre. They directly reported into the residential manager who was the identified person participating in management. They met on a regular basis with the other persons in charge from within the organisation. These meetings discussed different aspects of service delivery and shared learning ideas were presented to enhance service improvements.

The provider had completed one six monthly unannounced review of the residential services. This had been completed for one home within the designated centre in

May 2021. As the other house was not registered at the time it was not included in this review. This was in line with the requirements of regulation. In addition to this the person in charge had completed an audit which reviewed aspects such as fire, finances, care plans and staff meeting minutes. Again this had been completed for one home. Both these audits were identifying many areas of improvement and had corresponding action plans in place.

On occasions, the audits and reviews were not always effective in highlighting areas of concern or improvement as identified in this inspection. Additional oversight was required to ensure audits and reviews were effective in improving management systems that would lead to consistent safe and good care. For example in the provider audit dated 2021, an action was identified in relation to fire containment and ensuring all fire doors remained closed. Although this had been rectified in the home it was identified in, the second home had similar findings on the inspection day.

There were no staff vacancies on the day of inspection. Staff on duty on the day of inspection were very familiar with each individuals' preferences and needs and were able to discuss same. Continuity of staff was maintained as much as possible. There was an actual and planned roster in place which was overall well maintained. On review of a sample of rosters it was found that there was insufficient staff on duty at times to meet the assessed needs of one the residents.

The training records were reviewed. These records indicated that staff were required to have specific mandatory training completed. Some of this included, safe administration of medication, bespoke positive behaviour support training, safeguarding and epilepsy training. The records reviewed indicated that there were some small gaps in relation to staff receiving the training they required to complete their role effectively.

Regulation 15: Staffing

Although the number of staff employed was sufficient to meet the needs of the residents, the number of staff on duty was not always in line with what was assessed as required. A sample of rosters were reviewed and in a one month period there were five day/evening shifts in one home that had not been covered. There was one staff member on duty at this time who was familiar with the needs of the resident. However, the assessed needs of the resident indicated that two staff members were required to be present.

There was no relief panel available to cover staff shifts if unexpected absences occurred and the organisation relied on existing staff to cover vacancies. This system was not always effective in ensuring the number of staff was in line with the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training records reviewed indicated that the majority of staff were required to have specific mandatory training completed. Some of this included, safe administration of medication, fire safety training, first aid, safeguarding vulnerable adults and positive behaviour support. The records reviewed indicated that one staff member had not completed first aid training.

The provider had also listed training that was specific for staff to have completed to work in this designated centre, this included specific training in relation to epilepsy. One staff member had not completed this.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems were in place and were identifying some areas of improvements in relation to service provision and ensuring residents were safe. The inspector was not always assured that sufficient oversight was occurring to ensure these systems were effective at all times. Audits were not always driving quality improvement. For example, the audit completed by the person in charge identified that the protocol to direct staff in relation to meeting a health care needed to be reviewed. This review had been completed, however, it had not been identified that staff were not adhering to the relevant steps as directed. Audits and other oversight systems had also failed to address other areas identified on inspection, such as gaps in risk management documentation and formal reviews of restrictive practices.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All notifications were submitted in line with the requirement of the regulation.

Judgment: Compliant

Quality and safety

From what the inspector observed, residents lived in warm, clean and comfortable homes, where they appeared happy and content. The transition of one resident into their new home had been successful. However, improvements were required across some regulations including reviews of restrictive practices, healthcare, and systems to monitor the effectiveness of fire containment.

Residents' healthcare was supported through good access to G.P's (General practitioners) and other specialist clinicians and health care professionals. On review of the one resident's personal file it was found that some referrals to health and social care professionals had occurred in March and April 2021. When the inspector requested an update in relation to the referrals there was no evidence available to indicate if any follow up in relation to waiting times and appointments had been made. In addition to this, as previously mentioned staff were not adhering to a healthcare protocol in line with the residents' specific assessed needs.

The inspector reviewed a resident's support plan relating to their positive behaviour support needs. The resident had a detailed plan in place which guided staff practice. The behaviour support plan detailed environmental accommodations and different approaches staff should use to help support the resident. On the day of inspection the use of the daily schedule was demonstrated to the inspector, this was one of the recommendations in the resident's current plan. In addition, staff were supported by the behaviour support specialist on a monthly basis. A meeting occurred between staff and the behaviour support specialist to discuss the resident's plan and what relevant changes were needed. Debriefs were also occurring following any major incidents to ensure shared learning was available for the team. Although many positive practices were noted in relation to the residents behaviour support plans. Improvements were required in relation to the review process for restrictive practices. There were no formal systems in place to ensure restrictive practices were reviewed on a regular basis.

Both houses were suitable in design and decoration to provide a safe, homely living space for the residents. The homes were clean and in a good state of maintenance, and suitably equipped to control risks associated with fire. The homes were equipped with emergency lighting and fire extinguishing equipment which was regularly serviced and tested. Routine fire drills took place in the house to assure the provider that all residents and staff members could safely and quickly evacuate to a place of safety. All bedrooms and communal areas were equipped with doors which could contain smoke and flame in the event of a fire. However, the containment measures were found not to be effective on the day of inspection. The provider took immediate actions to address this.

Regulation 25: Temporary absence, transition and discharge of residents

The inspector reviewed a sample of transition plans. They were found to be person

centred with the residents' individual preferences and needs put at the forefront of the planning process. For example it was noted on the transition plan that the resident had chosen all the furniture for their new home.

Judgment: Compliant

Regulation 26: Risk management procedures

From the sample reviewed, risks were identified, assessed and control measures implemented as required.The provider was in the process of addressing the risk management systems and some improvements were noted. For example risks and specific incidents were now a standing agenda on staff meetings to evidence shared learning.

However, the inspector found that there was some gaps in the documentation related to the providers risk process. For example a risk assessment in relation to specific behaviour of concern had been updated in relation to a pattern of incidents. Additional control measures had been noted. However, the risk rating was not proportional to the identified risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

From what was reviewed on the inspection day overall, residents were protected through the infection prevention and control policies, procedures and practices in the centre.

The premises was found to be clean throughout and there were cleaning schedules in place to ensure that each area of the centre were cleaned regularly.

There were suitable systems in place for laundry and waste management and there were also systems in place to ensure there were sufficient supplies of PPE available in the centre.

Staff spoken with where able to provide details of the steps that would be taken in the event of a case or suspected case of COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

For the most part, there were suitable arrangements for detecting, and extinguishing fires in the centre. There were adequate means of escape and emergency lighting in place. Fire drills were occurring at regular intervals. The resident that had recently transitioned into the centre had completed a fire drill and had successfully evacuated the building.

However, on arrival to one of the homes the automatic closures on doors had been disconnected. Initially when whey were reconnected by a staff member, the doors failed to close .This issue had been identified by the person in charge two days prior to the inspection and had been placed on the maintenance log. The provider took immediate action on the day of inspection and the door closures were fixed and all doors closed appropriately.

In addition to this one fire door was wedged open. The wedge was immediately removed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The residents had an assessment of need and personal plan in place. Prior to admission to the designated centre an assessment was completed which reviewed the residents individual needs around health, personal and social care needs.

These documents were identifying the residents' wishes, preferences and goals. As both residents were recent admissions into the designated centre, staff were exploring different options in regards to residents specific preferences around social care goals and needs.

Observations on the day of inspection indicated that residents were actively engaging in different aspects of their personal plan such as attending a gym or preparing for different appointments.

Judgment: Compliant

Regulation 6: Health care

Overall, residents were able to access appropriate healthcare. Nurses were available if needed for any immediate medical needs that presented. The residents were facilitated to attend a range of health and social care professionals to ensure healthcare needs were being met. Residents were appropriately prepared to attend upcoming medical appointments, for example information and visual supports were

being used to support a resident in accessing an upcoming dental appointment.

However, there were no systems in place to ensure that some referrals to health care professionals were being appropriately followed up. For example a resident was unable to attend a scheduled appointment for a diabetic eye clinic in March 2021. There was no evidence available on the day of inspection to indicate if another appointment was rescheduled or if the resident was on the waiting list for the same.

Additionally, a health care protocol was not been adhered to and there were limited oversight systems in place to ensure staff were following it as directed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector noted good evidence based practice in relation to supporting resident specific needs in relation to behaviour. Behaviour support plans were comprehensive and reviewed on a regular basis by a suitably qualified person. Additional referrals to health and social care professionals were occurring as needs emerged. Staff were suitably supported and trained. Evidence reviewed on the day indicated that all efforts were been made to identify the cause of any challenging behaviours that were occurring and supports were being put in place as required.

Minimal restrictive practices were in place. Evidence reviewed in relation to the use of restrictive practice indicated that it was only used when all other strategies had failed. Staff had requested that this restrictive practice was reviewed and efforts had been made to contact the relevant professionals in relation to this. However, there were no formal systems in place to ensure that restrictive practices were reviewed on a regular basis. This needed to be addressed in ensure restrictive practices were following the most relevant evidence based practices and national policy.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Both were single occupancy homes. Where required intimate care plans were in place. Staff had completed training in relation to safeguarding vulnerable people.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Delta Hazel OSV-0007990

Inspection ID: MON-0032565

Date of inspection: 13/10/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment is ongoing. A risk assessment has been completed in consultation with behavior therapist in relation to staffing requirements. Organizational policy has been updated to reflect this. Timeline: Completed	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff will continue to receive training in line with requirements specific to the residents living in the designated centre. Staff member without epilepsy training completed on 11.11.21. Timeline: Completed	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Audit systems have been adjusted as a response to the HIQA inspection of Delta Hazel. Specifically, the audit has been adjusted to identify that risk assessments have been reviewed and updated. Audits have been adjusted to ensure the specific healthcare needs of the resident are being met and recorded accurately.

Timeline: Completed

Quarterly meetings involving the relevant professionals have commenced to ensure all restrictive practices are reviewed regularly. These meetings will occur at the end of January, April, July and October or sooner if required. First review meeting held on 18th October.

Timeline: Completed

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All risks have been reviewed and all risk ratings will be proportional to the identified risk. This will occur regularly in line with review of incidents and any amendments to risk assessments as a result.

Timeline: Completed

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Meeting held with all staff on 15.10.21 to enforce the no wedging door policy in delta centre and for staff to ensure any issues with fire doors and equipment is reported to line manger immediately.

Timeline: Completed

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Outstanding referral has been followed up by staff team.

Timeline: Completed

The care plan is now being followed by all staff. Discussion held with staff to ensure all staff follow diabetic care plan in place for resident. All staff will be completing mandatory training in diabetes in 21.1.22.

Timeline: Training has been booked for 21.1.22.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Quarterly meetings involving the relevant professionals have commenced to ensure all restrictive practices are reviewed regularly. These meetings will occur at the end of January, April, July and October or sooner if required. First review meeting held on 18th October.

Timeline: Completed

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.	Substantially Compliant	Yellow	18/10/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	11/11/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	18/10/2021

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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	22/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/10/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	21/01/2022
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	22/11/2021
Regulation 07(4)	The registered	Substantially	Yellow	18/10/2021

	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.	Compliant		