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:	Laverna Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	28 March 2024
Centre ID:	OSV-0008603
Fieldwork ID:	MON-0041541

About the designated centre

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

The Laverna Group provides support for a maximum of six adult residents with a disability. The level of dependency of residents are categorised as low to moderate support requirements. These include residents who are very independent and require minimal supports to those who require ongoing support from staff. The designated centre comprises of two houses located in Co. Dublin a short drive apart. Both houses have access to centre vehicles. Residents are supported by a team of social care workers and healthcare assistants, managed by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 28 March 2024	10:00hrs to 16:10hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

As part of a wider service development to streamline and standardise the governance arrangements of the registered provider's Dublin community residential services, the provider submitted several applications to reconfigure a number of designated centres in 2023. This centre comprises two houses that were originally registered under two different designated centres, the Castlefield Group and the Ashington Group. The provider applied to register the new configuration under the Laverna Group designated centre, and registration was granted in September 2023. For the purpose of clarity, this is the first inspection for the Laverna Group designated centre, although both houses were previously operated under different centres.

The inspector visited both houses as part of this inspection, which the person in charge facilitated. The inspector met with three of the five residents who lived in the centre and reviewed their living arrangements, which helped the inspector gather a sense of what it was like to live in the centre. In addition to meeting residents, the inspector completed a walk-around of the premises, spoke with staff, and reviewed documentation in relation to specific aspects of care and support. At the time of the inspection, there were two vacancies as two residents had successfully transitioned to other designated centres that better catered for their changing support needs.

The inspector also reviewed several safeguarding notifications that the person in charge had submitted to the Chief Inspector of Social Services before the inspection. The notifications' trend indicated a change in the needs of one resident living in the centre. This inspection was conducted to review the newly registered centre and follow up on the safeguarding plans implemented in response to the events occurring in one house.

On arrival at the centre, the inspector was met by a relief support worker who was lone working following a sleepover shift. While they explained that they had not been working in the centre frequently lately, they could describe the recent changes in the local management structure. Additionally, they were aware of the enhanced safety measures that had been implemented in relation to one resident and activities that were planned for each of the residents throughout the day.

The inspector met with one resident living in the house as they came downstairs after getting ready for the day. The other two residents had already left for their day service. The resident appeared happy and content as a staff member made them a cup of tea. They sat and spoke with the inspector, and they outlined that they liked their house and were enjoying a day off from day service, which they were going to spend going out with staff.

In addition to registering these two houses together for the first time, the provider also submitted an application in March 2024 to reduce the number of residents living in this house from four to three. A resident of the house recently moved to another

designated centre that better suited their mobility needs, creating a vacancy. Their room was located on the ground floor and accessed through the kitchen, with another entry point from the sitting room. The provider reviewed the living environment and determined that this room would be better utilised as additional communal space for the three remaining residents in the centre. The inspector noticed that the door in the kitchen leading to this room was being kept open, allowing more light and space for the residents. A small office area was set up with a desk placed against the double doors that led into the sitting room. The remaining space was intended for the residents' use, and a couch had already been placed, with plans to install additional amenities.

The inspector met with the two residents living in the second house, which also had a vacancy. This house was more livelier due to the resident demographic and profile. The support needs in this house were also higher, requiring more staff support. The inspector met with one resident in the living room who was completing a complex jigsaw, which was a favourite pastime of the resident. The other resident was sitting in the kitchen with staff; the inspector observed conversations were supported using a communication device.

While being in the house, the inspector could hear loud vocalisations and shouting from one resident; this did not appear to impact the other resident due to their specific communication needs. As this house had one vacancy, the person in charge informed the inspector that the compatibility of residents would be evaluated and considered as a priority before any new admissions in order to ensure a safe and quality service for all residents.

From conversations with residents and staff, observations made while in the centre, photographs and information reviewed during the inspection, it appeared that the residents had good quality lives in accordance with their capacities and interests and were regularly involved in activities that they enjoyed in the community and also in the centre. Residents were supported to take part in a wide range of activities, including attending day services, local beauticians, celebrating milestones and going on holiday. Some residents enjoyed going out for coffee and meals and meeting up with friends. Others liked to spend time in their homes, relaxing, listening to music, making jigsaws and baking.

The inspector reviewed the information and spoke to the person in charge regarding recent safeguarding concerns submitted for the centre. Relationships between some residents had recently broken down due to a recent change in a resident's presentation following a cognitive decline. Several safeguards had been implemented to protect residents, and, importantly, measures had been taken to maintain and repair these relationships. As a result, these types of incidents ceased, and it was apparent that residents, with the support of staff, had resolved the sudden conflict that had arisen.

The findings of this inspection indicated that measures taken to address safeguarding concerns in the centre effectively reduced incidents and supported relationships between residents. The provider was actively responding to issues within the centre with good effect, as the inspector noted that residents changing

needs had been responded to in a timely manner. Some residents required support to manage their behaviours of concern. However, positive behaviour support plans had not been prepared for residents who had assessed behavioural support needs and this required improvement by the provider.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

In general, the management systems in place at the centre ensured that residents received a safe, consistent, and suitable service. Overall, the provider had ensured that the centre was well-resourced. For instance, they increased staffing levels when required in response to any changes in residents' needs. However, the service did not have adequate resources to facilitate timely and appropriate access to positive behaviour support, which is discussed in the quality and safety section of the report.

There had been changes to the local management team since the reconfiguring of the designated centre. A new person in charge was appointed in September 2023. They had worked in the organisation for several years and were known to the residents. They were supported in their role by the staff team and the named person participating in the management of the centre (PPIM). The person in charge spoke of being well-supported since commencing in their role.

The person in charge worked full-time and split their working hours between the two houses that made up this designated centre. They had the qualifications, skills, and experience necessary to manage the designated centre and comply with the mandatory requirements for this post, as detailed in the regulations.

This centre was adequately resourced to ensure the effective delivery of a person-centred, safe service to residents. Due to changes in residents' needs, staffing arrangements increased in one location in September 2023, with the implementation of two waking-night staff alongside one sleepover staff to support one resident. These were filled by relief staff and, in some cases, agency staff. Due to the significant sudden increase in resources these were not always covered by regular staff. However, this requirement for waking night staff had ceased in the previous month with the resident transferring from the centre. Staffing requirements at night were reduced to one sleepover staff, and the need for additional staff in the centre was therefore eliminated.

The staff training records reviewed indicated that staff, including relief staff, had completed mandatory training. The person in charge had systems in place to regularly review training needs, and further training was scheduled as required. Staff had also completed additional training in various aspects of infection

prevention and control, administration of medicines, and human rights.

As stated earlier, one of the aims of this inspection was to review the application to vary the conditions of registration of this service. As part of this process the provider must submit the prescribed information to the Chief Inspector to complete this process. The variation the provider was applying for related to reducing the number of residents in one house and also the change of room use from a bedroom to a communal room. The inspector saw that these changes had been implemented before the variation was granted; however, these changes had positive outcomes for the residents and formed part of safeguarding plans. On review of the floorplans, the provider was required to submit updated floor plans to reflect the correct number of bedrooms in the second house.

Staff had access to training and refresher training in line with the organisation's policy and residents' assessed needs. Staff were in receipt of formal supervision and the person in charge described how staff could meet with them to discuss any issues in between these sessions for informal support and advice. Staff confirmed that the person in charge was freely available to them. Staff meetings were held on a regular basis, and minutes were available of these for absent staff to review and sign off on.

Registration Regulation 8 (1)

The provider had made an application to vary a condition of the registration of this centre. However, it was identified in the course of this inspection that the floor plans submitted to support this application were not accurate.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person was found to be suitably skilled and experienced for the role and possessed relevant qualifications in social care and management. The person in charge demonstrated effective governance, operational management and administration of the centre.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff and appropriate skill mix to meet the needs of residents both day and night. A planned and actual staffing roster was maintained

as required by the regulations. The same team of staff was consistently available to the residents, which helped establish a sense of familiarity. If any resident required individual staff support, it was provided.

The staffing levels expressed in whole-time equivalence (WTE) varied between the two houses that formed the designated centre. This difference was due to the level of individual support that each resident required. The first house had staffing arrangements totalling 3.0 WTE, while the second house had a staffing level of 6.26 WTE. At the time of the inspection, there was only a 0.5 WTE vacancy, which was being managed well through staff taking on extra shifts and relief staff.

The inspector that staff members were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Judgment: Compliant

Regulation 16: Training and staff development

Regular staff meetings were held, and a record was kept of the discussions which included accidents and incidents, risk management and the care and support of residents. A record of attendance at these meetings was maintained, and any staff unable to attend were required to sign the record to say that they had reviewed the minutes. The person in charge informed the inspector that discussions on human rights were incorporated into the supervision sessions with staff to reflect on the online training undertaken by staff.

The person in charge demonstrated that protocols and safety measures were discussed with the staff team during team meetings. There was evidence of reflective practice and on-the-floor mentoring and support. Staff were signing to indicate they had read resident-specific documents and completed training. The person in charge informed the inspector that discussions had taken place to provide resident-specific training for staff following a recent diagnosis.

Staff could also utilise an emergency on-call service if they required support outside of normal working hours.

Judgment: Compliant

Regulation 23: Governance and management

The inspector reviewed the governance and management structures in place and found clear lines of authority and accountability. Management systems ensured that the service provided was appropriate to the residents' needs and was being effectively monitored. The management structure consisted of a person in charge

who was a social care leader and reported to a clinical nurse manager. The person in charge had responsibility for the day-to-day governance and operation of this centre

The provider had systems in place for reviewing the quality and safety of the service, including six monthly provider-led audits and an annual review. The quality and safety department was responsible for the annual review of the service. The inspector was informed that a quality, safety and risk advisor had visited the centre the day before the inspector to conduct this annual review. At the time of the inspection, the centre was not yet due for a six-month announced visit to the centre by the provider; however, the inspector viewed previous visit reports produced when the houses formed part of different designated centres. Improvements identified as a result of those visits had been shared with the previous person in charge, and the provider had plans in place to address any identified areas for improvement.

Any accidents and incidents were reported and recorded appropriately, and again, any required actions were monitored until complete. For example, the inspector reviewed the provider's investigation of a serious event that occurred outside of the designated centre and beyond the control of the service. The inspector found the service had taken appropriate action to provide support to the resident, and the incident was being reviewed by the Senior Incident Management Team (SIMT).

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications were submitted to the Chief Inspector within the required timeframes. A review of the notifications indicated that incidents had been well managed by the person in charge and provider.

Judgment: Compliant

Regulation 34: Complaints procedure

A clear complaints procedure was available to residents and their friends and families, and it was displayed in the designated centre as required by the regulations. Any complaints were recorded and remained open until resolved. The records maintained by the person in charge were detailed and included the steps taken to resolve the issue and the satisfaction of the complainant. The annual centre review process included a review of any complaints received.

The inspector was satisfied that when received, complaints were logged and

managed appropriately in accordance with the centre's complaints policy. The complaints procedure had been discussed with residents at a recent house meeting.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life that met their needs. An efficient personal planning system was in place, and the residents and their families were actively involved in the person-centred planning process. As previously mentioned, improvement was required in ensuring residents who had assessed behavioural support needs had corresponding positive behavioural support plans.

The inspector found that residents were supported and encouraged to engage in activities of their choosing and to have a good quality of life. There was evidence of consultation, and residents had access to healthcare services and opportunities for social engagement.

The registered provider had a risk management policy that met the regulatory requirements. Risk management systems were also in place to ensure that risks were identified, assessed, managed, and reviewed, including a system for responding to emergencies. Each resident had individual risk management plans in place, which identified control measures for staff to follow to minimise the impact of these risks.

The person in charge ensured that assessments of residents' needs were carried out, which informed the development of personal plans. The inspector reviewed a sample of residents' assessments and personal plans. The assessments were current, and the plans, including healthcare support plans, were readily available to guide staff practice. The inspector found that staff were aware of the care plan interventions and were applying them accordingly.

Residents each had a person-centred plan, and goals were set with them at regular intervals in accordance with their preferences and any interests they had. One of the residents, having shown interest in this area, was increasing their skills in technology. These included voice-activated control tools for music and smart devices. The resident who also enjoyed singing and acting expressed interest in having their own living space so they could pursue their interests without interfering with other residents' recreation. The inspector was informed this was actively being explored due to a vacancy in the house, which created the opportunity for additional private or communal space.

Appropriate arrangements were in place to safeguard residents from abuse. For example, staff had received relevant training to support them in the prevention and appropriate response to abuse, and residents had also received education in this

area. The inspector found that any safeguarding concerns had been appropriately managed, and measures were put in place to protect residents from abuse. The provider had implemented safeguarding plans, which minimised the likelihood of further safeguarding incidents occurring, and staff reported that these actions had a positive impact on day-to-day care. These included changing the use of a downstairs bedroom into an additional communal space. Moving the office downstairs also allowed for greater staff presence in communal areas. Residents themselves attended a house meeting in February 2024 to decide upon and discuss rules for shared living. A framed arts and crafts design of these mutually agreed upon house rules with each resident's name was hanging in the kitchen. A photograph of the residents smiling and embracing from the house meeting also accompanied this frame.

Overall, the systems in place to support residents manage their behaviours required improvement. The designated centre currently provides residential support to residents who, at times, may display behaviour of concern. Despite this being a known support need, staff had no up-to-date guidance to ensure consistency for residents. The multidisciplinary support required by residents regarding positive behaviour support had yet to be put in place despite referrals dating from 2021 and 2022 regarding two residents.

Regulation 26: Risk management procedures

There were systems in place for the identification, assessment, management, and ongoing review of risk. The risk register was recently reviewed and updated in March 2023 and reflected risks relevant to the centre.

All incidents were reviewed regularly by the local management team and discussed with staff to ensure learning and improvement in practice. Risks relating to residents' care needs were escalated to the relevant healthcare professionals involved in their care for review. As previously mentioned, serious events were reviewed at a senior level for provider oversight and organisational learning.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal, and social care needs of all residents was completed. Staff spoken with were very familiar with and knowledgeable regarding these assessed support needs. The inspector reviewed a sample of files and noted that a range of assessments had been completed. Care and support plans were in place for all identified issues, including specific healthcare needs. The care plans in the centre were found to be informative and tailored to each resident's individual

needs. There was clear evidence that risk assessments and support care plans were regularly reviewed and updated, especially in response to any changes in the residents' needs. For instance, the centre held regular multidisciplinary team meetings and referrals to address any recent diagnoses. Additionally, consultation with families occurred to determine the best ways to support the residents.

The person in charge and the staff team ensured that any goals set with residents were meaningful to them and recorded progress towards achieving the goals. When residents indicated an interest in a new area, new possibilities were explored with them.

The support needs of residents were being well met, and both long-term conditions and changing needs being responded to appropriately.

Judgment: Compliant

Regulation 7: Positive behavioural support

Minutes from staffing meetings held in January and March 2024 reported that staff had experienced difficulties while working with a resident who displayed behaviours of concern due to the absence of a positive behaviour support plan. The resident was known to display such behaviors while in the community and also in the car due to heightened anxiety. In May 2023, staff also raised concerns about verbal aggression and self-injurious behaviour displayed by another resident. This was a recurring issue observed across inspections, where insufficient resources in the provider's behavioural support and psychology service resulted in inadequate timely support for individuals with behavioural needs.

Judgment: Not compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of its content and knew their responsibilities in relation to safeguarding residents. Staff received up-to-date safeguarding training and could discuss the learning from this training.

A safeguarding log was in place that referenced resident-specific safeguarding reports and plans. Potential vulnerabilities in the centre had been identified and addressed, and control measures had been put in place. There was evidence that some complaints received from residents were processed in line with safeguarding procedures, and the residents were kept informed of the outcomes in writing and through meetings with the person in charge.

Judgment: Compliant

Regulation 9: Residents' rights

The provider ensured that residents were respected and supported in exercising choice and control in their daily lives. Staff had completed training on human rights, and the right to have choice in all aspects of their lives was discussed with residents at a recent house meeting.

During the inspection, the inspector noted that the centre was promoting residents' rights in various ways. One of the ways was by facilitating residents to access their personal information. Typed minutes of discussions regarding individual residents during staff meetings were printed and filed in the residents' personal plans. This way, residents or someone appointed by a resident could review their information at any time, ensuring transparency and accountability in the centre's operations. This practice of providing fair access to their personal information represented the application of human rights training by promoting residents' right to receive information about their own needs, conditions, treatment and care.

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	
Registration Regulation 8 (1)	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Laverna Group - Community Residential Service OSV-0008603

Inspection ID: MON-0041541

Date of inspection: 28/03/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Registration Regulation 8 (1)</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 8 (1):
All sleeping areas are clearly identified within the floor plans located in the Statement of Purpose.</td></tr>
<tr><td>Regulation 7: Positive behavioural support</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Provider has identified the requirement for behavioral support input within the designated centre. The Provider has recruited for behaviour support and the supported individuals identified based on need will be assessed based on priority.</td></tr>
</table>

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
Registration Regulation 8(3)	A registered provider must provide the chief inspector with any additional information the chief inspector reasonably requires in considering the application.	Substantially Compliant	Yellow	16/05/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2024