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

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| Name of designated centre: | Ballyduff Park |
| Name of provider: | Health Service Executive |
| Address of centre: | Donegal |
| Type of inspection: | Unannounced |
| Date of inspection: | 05 February 2020 |
| Centre ID: | OSV-0002519 |
| Fieldwork ID: | MON-0023791 |

## About the designated centre

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

The designated centre provides a full time residential service to eight adults with an intellectual disability, both ladies and gentlemen. The centre is a purpose built eight bedroom house located in a small housing estate close to the nearest town. Staffing is provided over 24 hours, and there is a nurse on duty most week days. Residents attend various day services and activities, and there is a vehicle available for their use.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 8 |

## 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 5 February 2020 | 10:00hrs to 18:30hrs | Julie Pryce | Lead |

## What residents told us and what inspectors observed

There were eight residents in the centre on the day of the inspection, and the inspector met all of them. Not all residents wished to speak to the inspector, and this was respected. However the inspector observed residents arriving home in the afternoon and going about their daily activities in a relaxed manner. Interactions between staff and residents were knowledgeable and caring, and residents were seen telling staff things about their day, and asking for help with issues which had arisen.

Residents were observed going about their evening meal, and were involved in meal preparation as they preferred. Some residents showed the inspector their rooms, or had a chat in one of the living rooms. Residents told the inspector that they were happy in their home, and some were proud of their rooms and personal belongings.

Some residents said it was the best house they had ever lived in, and others spoke of some difficulties in their lives, and were able to identify staff who they would go to for a talk or look for assistance.

Residents were continually consulted by the service, and regular residents' meetings which were chaired and documented by residents were held. Consent for interventions and access to residents' personal information had been sought and was documented.

## Capacity and capability

The centre was effectively managed, with a clearly defined management structure in place and explicit lines of accountability and various governance processes in place to ensure the safety and quality of care and support to residents.

The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who was appropriately skilled, experienced and qualified. This person in charge was full time and demonstrated their ability to lead the staff team and to support good practice. They were knowledgeable about the care and support needs of residents.

The provider had put systems in place to ensure the staff team could effectively meet the needs of residents. The number of staff was appropriate to meet the needs of residents. There was a core team of staff on a daily basis in accordance with the needs of residents. Staff were in receipt of regular training including all mandatory training. Staff demonstrated a detailed knowledge of the support needs

of residents, could describe their input into ensuring the wellbeing of residents and were observed to be implementing guidance in personal plans.

A sample of staff files were reviewed, and all the required documentation was in place. Staff were supervised by the person in charge informally on a regular basis, and annual performance discussions were held, with six monthly reviews if required. Therefore there was evidence that the staff team were knowledgeable and competent.

The provider had put systems in place to identify and address areas for improvement. Six monthly unannounced visits had been conducted on behalf of the provider. Actions were monitored and those marked as complete had been implemented within the identified time frames.

A suite of audits had been undertaken, within the areas of quality, clinical and health and safety, and the person in charge undertook a quarterly 'self assessment' of the centre. All actions from these processes were included in the centre's quality improvement plan and were monitored until complete.

Whilst there was evidence of informal communication between staff and management, staff meetings which were intended to be on a quarterly basis were held sporadically, and on average every four months. This key communication strategy therefore, was to infrequent to be effective.

The required notifications to HIQA had not all been made within the required time frame, several had been made retrospectively, and with a significant delay. The person on charge outlined a system to ensure that any further notifications would be made in a timely manner.

The provider had put systems in place to receive and respond to feedback about the service. There was a complaints procedure in place which was clearly available, and any complaints were reviewed and recorded. The records of any complaints or conversations relating to complaints were clearly maintained, and the outcome of any actions taken was recorded.

## Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, and had clear oversight of the centre.

Judgment: Compliant

## Regulation 15: Staffing

There were sufficient staff to meet the needs of residents, and consistency of care and continuity of staff was maintained.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, and were appropriately supervised.

Judgment: Compliant

## Regulation 23: Governance and management

There was a clear management structure in place and robust systems to monitor the quality of care delivered to residents, although formal communication with staff was infrequent.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

There were contracts in place which clearly laid out the services offered to residents and any charges incurred.

Judgment: Compliant

## Regulation 31: Notification of incidents

Not all required notifications had been made to HIQA within the required time frames.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

There was a clear complaints procedure which was available in an accessible version, and residents knew who to approach if they had a complaint.

Judgment: Compliant

## Quality and safety

The provider had put arrangements in place to ensure that residents had support in leading a meaningful life and making choices. However the risk management strategies had not identified and mitigated some risks in the centre.

There was an personal planning system in place which included detailed assessment and regular review. Each resident had a personal plan in place based on a detailed assessment of needs and abilities, including both social and healthcare needs.

There was a section in the personal plans relating to communication, and any communication needs were clearly outlined. Where a resident had specific needs a staff member had been trained in their communication method, and was supporting other staff, and other residents, to communicate with the person involved. Various systems of augmentative communication were in place, and staff were seen to be using them effectively to communicate with residents.

There were sections in the personal plans relating to various areas of support for residents, and both social and healthcare needs were addressed. While much of the information was detailed and offered guidance to staff, and an opportunity to review the effectiveness of support, there was insufficient detail relating to the maximising of the potential of residents. Many of the goals that had been set for residents related to daily activities and ordinary events, and where goals did indicate the need for increased opportunities and experiences, there was insufficient evidence that these had been implemented.

Residents were supported to have positive healthcare outcomes, and had access to members of the multi-disciplinary team as required. Whilst it was clear that heatlhcare was well managed, the documentation did not always provide sufficient guidance for staff in the use of supportive equipment. However, there was evidence that staff were knowledgeable about the healthcare needs of residents, and any changing needs were identified and responded to in a timely way.

Where there were identified restrictions in place, there was clear rationale for the necessity of the practices, ensuring that they were the least restrictive necessary to manage the risk. However, were a strategy had been introduced in relation to safeguarding for a resident, its restrictive nature had not been identified, and it was not documented, recorded and reviewed as a restriction.

While there were structures and processes in place in relation to risk management they were not always effective. There was a global risk assessment and summary in

each resident's personal plan, which detailed any individual risks and management plans. There was also a risk register in place in which any local and environmental risks were recorded. However, there was a practice in place whereby residents did not have access to prescribed emergency medication for significant periods of time, and in particular on outings. Additionally, there were significant periods of time where only one member of staff was on duty, and the risk of unforeseen circumstances which might lead to residents being unsupervised had not been identified or mitigated.

Fire safety practices and equipment were in place to ensure risks relating to fire were mitigated for the most part. Fire safety equipment including fire doors, extinguishers, fire blankets and emergency lighting were in place and were regularly maintained and there were fire doors throughout. There was a personal evacuation plan in place for each resident. While regular fire drills had been undertaken, there had been no fire drill under night time circumstances so that the provider had not demonstrated that residents could be evacuated in the event of an emergency at night.

The premises consisted of a large purpose built eight bedroom house, and although the layout was of an institutional nature, it was clear that residents utilised various areas of the house, including the large entrance which accommodated comfortable furniture enjoyed by some residents. Each resident had their own room and there were various communal areas, including a large garden to the back of the house which was enjoyed by residents.

There were structures and processes in place in relation to the safeguarding of residents. All staff had had appropriate training and demonstrated knowledge of their role in the safeguarding of residents. Where residents had been identified a being at risk, various supports had been implemented, including education, counselling and involvement of appropriate professionals. Interventions were documented, and support was ongoing. It was therefore clear that measures had been taken to ensure that residents were protected from any form of abuse.

There was a contract of care in place for each resident, which clearly outlined the services provided and any charges incurred. These contracts were signed by the resident, the service representative, and also by the person who explained the content to residents who required this support.

There was an ethos in the centre of supporting upholding the rights of residents. Residents were supported in choice making, and were included in decisions about their lives. Regular meetings were held with residents to ensure consultation, some residents took the minutes of these meetings, and others signed them. Residents' dignity was upheld, and all interactions observed between staff and residents were appropriate and caring. However, there was excessive signage throughout the centre which was aimed at informing staff rather that supporting residents. Residents held the keys to their personal rooms and rooms were not entered by staff without their permission. Where activities of residents had caused difficulties in the neighbourhood, these had been managed and residents supported with their

needs.

Overall, while some issues were identified with the process of managing risk in the centre, each resident was supported to have a good quality of life, and were supported to make individual choices.

## Regulation 10: Communication

Residents were supported in communication so that their voices were heard and represented in the service.

Judgment: Compliant

## Regulation 17: Premises

Premises were adequately laid out and equipped to meet the needs of residents.

Judgment: Compliant

## Regulation 26: Risk management procedures

There was a risk register in place including risk ratings, and a detailed risk assessment for each risk identified. There was a risk management policy in place which included all the requirements or the regulations. However not all risks had been identified, and a significant risk to residents had not been mitigated.

Judgment: Not compliant

## Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and evidence that residents could be evacuated quickly in the event of an emergency under normal circumstances. However there was insufficient evidence that residents could be evacuated in the event of an emergency at night.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident based on detailed assessments, which had been regularly reviewed. However there was insufficient detail to ensure that the potential of each resident was maximised, and not all healthcare plans included sufficient detail to guide practice.

Judgment: Substantially compliant

## Regulation 6: Health care

Healthcare and health promotion were well managed.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Not all restrictive practices had been identified and recorded.

Judgment: Substantially compliant

## Regulation 8: Protection

There were systems in place to ensure that residents were protected from all forms of abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents rights were upheld for the most part, however there was institutional type signage throughout the centre which was not for the benefit of residents.

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 - 2015 as amended and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 31: Notification of incidents | Substantially compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Ballyduff Park OSV-0002519

## Inspection ID: MON-0023791

## Date of inspection: 05/02/2020

**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 |
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| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>In order to ensure that this centre comes into compliance with Regulation 23 Governance and management the following will be undertaken:<br><br>The schedule of staff meetings has been updated to ensure that there will be staff governance meetings held at a minimum of every 2 months | |
| Regulation 31: Notification of incidents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>In order to ensure that this centre comes into compliance with Regulation 31 Notification of incidents the following will be undertaken:<br><br>The PIC will ensure that all notifications are submitted to the regulator within the required timeframe. | |
| Regulation 26: Risk management | Not Compliant |

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| procedures | |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>1. The PIC to review the risk assessment for Buccal Midazolam, the process of reviewing this risk has commenced 2. There is a protocol in place for each resident in relation to the administration of Buccal midazolam 3. The PIC to update the risk assessment and protocol on lone workers, especially those working night duty, the process for reviewing risk assessment has commenced. | |
| Regulation 28: Fire precautions | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>A Night time fire evacuation drill was completed on 04/03/2020 with minimal staffing and full occupancy | |
| Regulation 5: Individual assessment and personal plan | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>In order to ensure that this centre comes into compliance with Regulation 5 Individual assessment and personal plans the following will be undertaken:<br><br>1. The Person in Charge has completed a review of all residents Person Centred Plans<br>2. All Person Centred Plans will be updated in consultation with residents to ensure goals are meaningful and developmental. | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>In order to ensure that this centre comes into compliance with Regulation 7 Positive | |

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| behavioral support the following has been undertaken:<br><br>A Restrictive practice protocol has been developed for a resident who offers their phone to staff at night. |

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| Regulation 9: Residents' rights | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 9: Residents' rights:<br>In order to ensure that this centre comes into compliance with Regulation 9 Residents Rights the following will be undertaken:<br><br>1. A review of pictorial signage in the centre has been undertaken and a number of pictorial signs have been removed.<br>2. The fire officer has visited the centre on 10/03/2020 to give advice in relation to signage on fire doors. Once advice is received this will actioned accordingly. |

## 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 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | Substantially Compliant | Yellow | 01/03/2020 |
| 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 | Not Compliant | Orange | 30/04/2020 |

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| | emergencies. | | | |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 04/03/2020 |
| 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. | Substantially Compliant | Yellow | 01/03/2020 |
| Regulation 05(2) | The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 30/04/2020 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures | Substantially Compliant | Yellow | 01/03/2020 |

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| | are applied in accordance with national policy and evidence based practice. | | | |
| Regulation 09(3) | The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | Substantially Compliant | Yellow | 30/03/2020 |