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: | Peacehaven Trust |
| Name of provider: | Peacehaven Trust CLG |
| Address of centre: | Wicklow |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 17 September 2020 |
| Centre ID: | OSV-0003690 |
| Fieldwork ID: | MON-0029571 |

## About the designated centre

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

Peacehaven trust provides full-time residential care and support for 17 adults with mild or moderate intellectual disabilities across three locations on the east coast of Co. Wicklow. Each house is close to a variety of local amenities and residents have access to private transport to support them to access their community. Each resident has their own bedroom and has access to communal rooms including a choice of sitting area, kitchens, laundry rooms, gardens, private spaces, adequate storage, waste disposal, and private transport. Care and support is provided for residents as required within the context of a 24/7 service. The staffing team consists of a person in charge, social care workers and relief staff.

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

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| Number of residents on the date of inspection: | 17 |

## 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 |
|---|---|---|---|
| Thursday 17 September 2020 | 09:40hrs to 15:40hrs | Andrew Mooney | Lead |
| Thursday 17 September 2020 | 09:40hrs to 15:40hrs | Ann-Marie O'Neill | Support |

## What residents told us and what inspectors observed

The inspectors had the opportunity to meet with and speak to a number of residents across two of the units within the centre. Residents spoken with said they were very happy in their home and with the support they received from staff.

An inspector observed and spoke with three residents within one of the units within the centre. They appeared very comfortable in the presence of staff and staff were seen engaging with residents in a positive manner throughout the inspection. Residents were seen going about their day without undue restriction and this contributed to a homely atmosphere within the centre.

An inspector met with two residents living in one a second unit within the centre. During the course of their interactions the inspector ensured to maintain physical distancing measures. Some residents initially did not wish to speak to the inspector and this choice was respected by the inspector. However, as time passed they did wish to engage with the inspector. They told the inspector they liked their home and they enjoyed the meals they had. They were observed to be relaxed and enjoying their preferred TV programmes during the course of the inspection. They were also observed talking and engaging in conversations with staff. Staff interactions were pleasant, friendly and supportive.

Another resident in the residential unit also wished to speak to the inspector and demonstrated a good knowledge of public health social distancing measures during the conversation. They told the inspector they liked their home a lot especially after the recent renovations had occurred. They liked their peers and they said the staff were nice and helpful to them. They also spoke about their frustration in relation to the ongoing COVID-19 pandemic and how it had impacted somewhat on them being able to meet their parent.

## Capacity and capability

The centre had been last inspection in March 2020 and high levels of non compliance was identified. The purpose of this inspection was to establish had the centre addressed the concerns raised in March 2020. Overall, improvements were made since the last inspection and a safe service was being delivered. However, the current governance and management arrangements required further improvements to ensure there was effective monitoring and oversight within the centre.

There was a clearly defined management structure in place which identified the lines of authority and accountability within the centre and the centre was managed by

a suitably qualified and experienced person in charge. The person in charge had continued to implement a local auditing system that included monthly audits based upon the regulations. Furthermore, the provider had completed an unannounced inspection of the centre and produced a report on the safety and quality of care and support provided in the centre. However, the report produced required further improvements to ensure a robust assessment of the centre was completed. For instance, very minimal actions were identified within the report and key areas of improvement noted during this inspection were not reflected within its findings. This demonstrated that the provider did not have the capacity to self identify key areas for improvement. Additionally, the registered provider had not ensured that an annual review of quality and care was produced despite this being identified during the last inspection. Furthermore, the cumulative impact of non compliance across the inspection highlighted that the governance and management arrangements in place required further strengthening to ensure the service was effectively monitored.

The provider had ensured that staff had the required competencies to manage and deliver person-centred, effective and safe services to the residents of the centre. Staff were supported and supervised to carry out their duties to protect and promote the care and welfare of residents. There ws a planned and actual roster maintained that reflected the staffing arrangements outlined within the statement of purpose. The provider had ensured all appropriate schedule 2 information was maintained, as per the regulations. During the inspection, inspectors spoke with staff and found them to be knowledgeable and genuinely interested in residents welfare.

The provider had ensured that staff had the appropriate skills and training to provide support to residents. Training such as safeguarding vulnerable adults, medication, epilepsy, fire prevention and manual handling was provided to staff, which improved outcomes for residents. However, not all staff had completed all pertinent infection control training. The person in charge had good local infection control measures in place but acknowledged that this training remained a priority for completion.

The provider ensured that there was a planned approach to new admissions within the centre. This included new residents having the opportunity to visit the centre prior to admission. The provider also had a clear admissions policy and procedure in place. From a review of documentation the inspector noted that all new admissions to the centre had a signed contact of care and appropriate compatibility assessments were conducted prior to any new admission. These arrangements upheld the rights of all residents.

The inspector completed a review of adverse incidents within the centre since the previous inspection. This review demonstrated that the person in charge had ensured all appropriate incidents were notified to the Office of the Chief Inspector as required by the Regulations.

## Regulation 15: Staffing

There was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times.

Judgment: Compliant

## Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date evidence-based practice. Staff were supervised appropriate to their role.

Judgment: Substantially compliant

## Regulation 23: Governance and management

While improvements were identified during the inspection the cumulative impact of the non compliance identified, demonstrated that the governance and management arrangements within the centre required further enhancement to ensure the centre is effectively monitored.

Judgment: Not compliant

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

The centres admissions process considered the wishes, needs and safety of residents living within the centre.

Judgment: Compliant

## Regulation 31: Notification of incidents

All appropriate notifications had been submitted in line with the Regulations.

Judgment: Compliant

## Quality and safety

There were systems and procedures in place to protect residents and promote their welfare. This inspection noted improvements with safeguarding practices and there were appropriate arrangements in place to protect residents during the COVID-19 pandemic. However, there remained a lack of access to appropriate allied health care professionals and this continued to negatively effect the quality and safety of the centre.

The provider demonstrated their capacity to communicate with residents, their families and visitors to promote and enable safe infection prevention and control practices. The provider had adopted a range of infection prevention and control procedures to protect residents from the risk of acquiring a healthcare associated infection. There were hand washing and hand sanitising facilities available throughout the centre. There were suitable arrangements for clinical waste disposal. The provider had ensured adherence to standard precautions and there were ample supplies of personal protective equipment (PPE). The provider had developed a COVID-19 contingency plan that was in line public health guidance and best practice. During the inspection, the inspectors observed staff engaging in social distancing and wearing appropriate PPE. These arrangements helped protect residents and staff from acquiring or transmitting COVID-19.

The previous inspection in March 2020 found that not all assessments of need were comprehensive in nature, due to a lack of access to appropriate allied health care professionals. Inspectors acknowledge that the provider had recently received approval to engage in clinical governance arrangements for positive behaviour support however, this process was only in the planning stage. Furthermore, residents continued not to have timely access to appropriate allied health care professionals to review there assessed needs. For example residents' assessed as having eating, drinking and swallowing needs did not have timely access to dysphagia assessments, despite changes in their presentation.

Residents received regular and timely review with their General Practitioner (GP) and were supported to attend chiropody, mental health and dental appointments where required, for example. Residents that required supports in relation to epilepsy management received ongoing regular review with their neurology physician as required also.

It was noted some residents' epilepsy care had been reviewed recently following a change in their seizure pattern. In response to this their epilepsy medication had been reviewed and emergency PRN (as required medication) also prescribed for the management of seizures. Staff spoken with demonstrated knowledge of the time-line criteria for administration of PRN emergency medication.

However, on review of some incidents where a resident had experienced a seizure, it was not demonstrated they had received emergency medication in line with the time-line set out in their medication chart. Epilepsy support planning did not set out information relating to residents' seizure presentation, criteria for administration of emergency rescue medication, criteria for when emergency services should be contacted and guidance on how to support the resident following a seizure. Therefore, in order to ensure consistency of epilepsy management for residents, the person in charge was required to ensure clear care planning was in place.

Residents' health care assessments documented a review of National Screening services that residents required or were eligible to participate in based on their gender, age or medical conditions. On further review however, some residents had not received or participated in the National Screening service. It was outlined to inspectors that some residents had, in the past, expressed apprehension in relation to accessing these services. This was not documented in residents' personal plans however. In addition, support plans were not in place for the purpose of educating and supporting residents' that expressed apprehension in availing of these services.

There was a frequent pattern of behavioural incidents occurring in the centre which had been notified to the Office of the Chief Inspector as peer-to-peer safeguarding incidents. Inspection findings demonstrated behaviour support planning was in place for residents that were assessed as requiring supports in this area however, they were limited in scope. For example, behaviour support plans for residents did not set out examples of triggers which may cause residents to become upset or engage in responsive behaviours or provide adequate detail of proactive or reactive strategy guidelines for staff to implement to ensure effective mitigation and management of behaviours that challenge. In addition, the provider had not made provisions to ensure behaviour support plans were created by an appropriately qualified person in the area of positive behaviour support to ensure they were evidence based, comprehensive and in line with best practice.

While it was demonstrated the person in charge and provider were actively reviewing restrictive practice interventions in the centre, with a view to reducing or eliminating these practices, this process was occurring in the absence of comprehensive behaviour support planning in place to manage and mitigate behavioural risks from presenting in the future. The provider was required to put in place appropriate oversight arrangements for effective positive behaviour support systems to ensure residents' identified behavioural needs were met to a good standard, managed in line with best practice and followed a Human Rights framework.

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Safeguarding plans were developed and safeguards put in place as required. Allegations or suspicions of abuse were reported and escalated in line with requirements of the organisation's and national policy. Staff who spoke with the inspector were knowledgeable in relation to their responsibilities in the event of a suspicion or allegation. Residents also had intimate care plans developed as required which clearly outlined their wishes and

preferences.

The provider had ensured that there were fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire. The cumulative impact of these measures promoted safety within the centre.

## Regulation 27: Protection against infection

There were arrangements in place to protect residents from the risk of acquiring a healthcare associated infection, including hand wash facilities, clinical waste arrangements and laundry facilities. The provider had introduced a range of measures to protect residents and staff from contracting COVID-19.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had ensured that there were fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and appropriate fire evacuation drills were carried out regularly.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Generally residents' health, personal and social care needs are met. However, as residents do not have consistent and timely access to allied health care input, their assessments of need are not comprehensive in nature.

Judgment: Not compliant

## Regulation 6: Health care

Healthcare planning required improvement in relation to epilepsy management to ensure consistency in the implementation of prescribed emergency management interventions.

Improvement was required in relation to educating and supporting residents to avail of National Screening Services. Where residents did not wish to avail of these services their decision was not clearly recorded in their personal plan.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

It was demonstrated there was an ongoing pattern of behavioural incidents in the centre.

While behaviour support plans had been developed, they were limited in scope.

The provider had not ensured behaviour support plans had been developed by an appropriately qualified person in the area of positive behaviour support who could oversee and ensure they were evidence based, comprehensive and in line with best practice.

While it was demonstrated the person in charge and provider were actively reviewing current restrictive practice interventions in the centre, with a view to reducing or eliminating these practices, this process was occurring in the absence of comprehensive behaviour support planning in place to manage and mitigate behavioural risks from presenting in the future.

Judgment: Not compliant

## Regulation 8: Protection

The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse.

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 | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 6: Health care | Not compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Peacehaven Trust OSV-0003690

## Inspection ID: MON-0029571

## Date of inspection: 17/09/2020

**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 |
|---|---|
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>The Person in Charge will ensure that all staff complete all key training in a timely manner to maintain their competency in delivery of safe person centred services. IPC training that was not complete at time of inspection to be completed by 30th October 2020.<br><br>The Provider/CSW will ensure that a training needs analysis is completed annually, that all mandatory training is maintained in date for all staff, each according to its training schedule.<br><br>The Person in Charge will ensure that effective quality supervision continues for each staff member – which reviews the individual training needs of the staff member – along with annual appraisal. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The Provider of Peacehaven Trust (Chair of the Board), along with the Secretary of the Council for Social Witness (CSW) of the Presbyterian Church in Ireland to name the Person Participating in Management, who will fulfil the duties of the Provider, to ensure the all elements of the Statement of Purpose and Function are enacted, audited, | |

reviewed and maintained to a quality standard, in line with all regulations and national standards.

The Provider/Secretary (CSW) will review with the Person in Charge the company structure – with a view to arranging the service in the best possible format for governance and continuous development of the service.

The PPIM/Provider will ensure that they monitor the service announced and unannounced) against all regulations, furnishing six monthly and annual reports.

The PPIM will ensure that all HPSC/HSE and DOH advice is communicated in a timely manner and appropriately risk assessed.

The Provider and Person in Charge will ensure effective communication with all stakeholders in Peacehaven Trust, in an open manner seeking regular feedback from residents and their representatives.

The provider will seek to partner with other organisations and persons of expertise to ensure innovative development of the service – to uphold individual resident rights and their autonomy.

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|---|---|
| Regulation 5: Individual assessment and personal plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge will ensure that each resident has an effective holistic assessment of needs, which with the resident is written accurately across their personal care plans, health plans, medication plans and person centred plan – with identified actions and time lines (when appropriate). This will support and inform the resident daily living. The PIC will ensure along with the staff team, that actions are completed, and the residents wishes are recorded and notified to the relevant outside agency when appropriate.

Multi-disciplinary support is sought from GP, and other professionals in accordance to assessed need, and the consent of the resident concerned. HPSC, HSE and DOH advice is incorporated into the relevant plans. Where, as has been experienced, timely access to SALT, Dementia Screening and Psychology has not occurred due to lack of community service provision, the Provider will engage with the HSE to register this deficit and seek provision of same in line with the regulations.

Individual Assessment is completed prior to admission, and then on an on-going basis as the needs, wishes and goals of the resident evolves.

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|---|---|
| Regulation 6: Health care | Not Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in Charge will ensure that each resident has an effective holistic health assessment, which with the resident is written accurately across their health plans & diet/Menu plans, end of life plans and medication plans – with identified actions and time lines (when appropriate). This will support and inform the resident daily living. The PIC will ensure along with the staff team, that actions are completed, and the residents wishes are recorded and notified to the relevant outside agency when appropriate.

Multi-disciplinary support is sought from GP, and other professionals in accordance to assessed need, and the consent of the resident concerned. HPSC, HSE and DOH advice is incorporated into the relevant plans, including detail of National Screening services. Where as has been experienced, timely access to SALT, and Dementia Screening has not occurred due to lack of community services, the Provider will engage with the HSE to register this deficit and seek provision of same in line with the regulations.

Individual Assessment is completed prior to admission, and then on an on-going basis as the needs, wishes and goals of the resident evolves.

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| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Lack of MDT as identified in the previous inspection report is being address by the HSE and the Provider by provision of an external psychology service to support staff to develop MDT diagnosis of need, improved behaviour support plans, and regular monitoring of progress of such supports.
The Person in Charge will ensure residents have positive staff support to engage with MDT or if they do not consent are supported with their decision.

The Person in Charge will ensure that management of any rights restrictions are conducted with care and compassion – that with MDT input such restrictions are monitored and evaluated in line with guidance and regulation.

## 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 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 | 30/10/2020 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 31/12/2020 |
| Regulation 23(1)(d) | The registered provider shall ensure that there is an annual review of the quality and | Not Compliant | Orange | 31/12/2020 |

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| | safety of care and support in the designated centre and that such care and support is in accordance with standards. | | | |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis. | Not Compliant | Orange | 30/11/2020 |
| 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 | 30/11/2020 |
| 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 | 30/11/2020 |
| Regulation 7(5)(a) | The person in | Not Compliant | Orange | 30/11/2020 |

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| | charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour. | | | |