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:	Dawn House
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	05 November 2021
Centre ID:	OSV-0002635
Fieldwork ID:	MON-0034315

About the designated centre

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

The provider's statement of purpose details that Dawn House provides full time long-term care to 6 adult residents, both male and female with severe to profound intellectual and physical disabilities and behaviours that challenge. Care is provided to residents who require high support and the staff team comprises of full time nursing staff and support workers. The centre comprises of a single story house on its own grounds located in Co.Wexford. It is accessible to all services and all amenities in the local area. The premises has its own internal gardens and all areas and facilities are easily accessible to the residents

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
Friday 5 November 2021	09:30hrs to 15:30hrs	Sinead Whitely	Lead

What residents told us and what inspectors observed

There were five residents living in the centre on the day of inspection. The inspector had the opportunity to meet with all five residents. Residents used non verbal methods to communicate and the inspector endeavoured to determine residents experience living in the centre through observations, engaging with residents, speaking with staff, and reviewing documentation regarding the care and support provided.

The inspection took place during the COVID-19 pandemic and therefore precautions were taken by the inspector and staff in line with national guidance for residential care facilities. This included social distancing, wearing face masks and regular hand hygiene.

This was a unannounced focused risk inspection to review areas of concern noted during the centres previous inspection. This included a review of residents rights, the use of a shared bedroom and the use of a central kitchen. The inspector found marked improvements since the centres most previous inspection. Overall, the inspector found that actions had been addressed since the previous inspection and the residents in this centre were supported to enjoy a good quality of life which was respectful of their choices and abilities. The inspector found that residents' well-being was maintained by a good standard of evidence-based care and support.

The inspector started the day with a walk around the centre, facilitated by the person in charge. The centre was designed and laid out to meet the needs of the residents. The premises is a single story building which comprises of five single occupancy bedrooms. The centre also had two large living areas, a dining area, a kitchen, laundry facilities, accessible bathrooms and toilets and a staff office. The centre also had a wheelchair accessible garden. Some minor outstanding maintenance issues were noted around the premises, as detailed under regulation17.

The staff team comprised of nursing staff and multi-task workers. Staffing levels in place appeared appropriate to meet the assessed needs of the residents and staff spoken with appeared familiar with the residents needs. Positive and familiar interactions were observed between staff and residents throughout the inspection day. The centre also facilitated nursing student placements.

While COVID-19 continued to impact some residents normal schedules, all residents appeared to continue to enjoy daily individualised activation. All resident had personal activation folders in place. A review of recent activity records maintained by staff found that residents regularly enjoyed day trips, sensory programs, baking, arts and crafts, bingo, and reflexology. One resident was supported by staff to regularly engage in their prescribed physiotherapy program. Activation schedules were available to residents in picture versions.

Residents all had individualised social goals in place and these were integrated into residents daily activities. These included residents improving their hand washing skills, visiting a butterfly farm, developing skills to set the table for dinner and joining local leisure facilities.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered in the centre.

Capacity and capability

This was an unannounced focused risk inspection to review areas of concern noted during the centres previous inspection. This included a review of residents rights, the use of a shared bedroom in the centre, staff training, risk management and the use of a central kitchen. Overall, the inspector found marked improvements since the centres most previous inspection and outstanding actions had been addressed by the provider. The centre had discontinued the use of the central kitchen, staff training and refresher training was all up-to-date, and appropriate risk management systems were in place.

However, it was communicated at the beginning of the inspection day that one resident had moved out of the centre since the most previous inspection. Following discussion with the person in charge and the provider representative, the inspector became aware that this resident had been moved to an unregistered centre. An application to register a new centre where the resident had moved to, had been received from the provider by HIQA, however registration had not yet been granted for this new centre. Therefore the provider was responsible for operating an unregistered centre. The provider had done this while endeavouring to adhere to conditions attached to the registration of Dawn House which stipulated that overall numbers would be reduced in the centre before 31 October 2021 in line with a plan submitted to HIQA. Immediate assurances were sought and received on the day of inspection and the management team confirmed that the resident was safe and well living in the new centre. While the inspector acknowledges that the provider had reduced overall numbers in the centre to 5, the provider had also failed to adhere to conditions attached to registration and to the compliance plan response submitted to HIQA within specified timelines. The new centre was successfully registered as a designated centre a number of days following the inspection.

There was a clear management structure in place and lines of accountability. The person in charge had good management systems in place to ensure day-to-day oversight of the centre's running. The person in charge shared the role with one other designated centre and divided their time evenly. The person in charge was supported in the house by a clinical nurse manager. There were a number of quality assurance audits in place to review the delivery of care and support in the centre. These included reviews of health and safety systems, six-monthly unannounced

provider visits and an annual review for 2020.

There were effective systems to support staff to carry out their duties to the best of their abilities. Staff were in receipt of regular formal supervision every six months with their line managers. The provider had a staff training program, and the inspector found significant training and development levels for staff members. Staff meetings and resident meetings took place on a regular basis.

Regulation 16: Training and staff development

All staff training and refresher training was up-to-date on the day of inspection. This was an area that had been addressed since the centres most previous inspection. Training was provided in areas including fire safety, infection control, food hygiene, children's first, safeguarding, management of behaviours that challenge, manual handling and CPR. All staff experienced regular one to one formal supervisions with their line manager. A clear schedule was in place for this to continue in the year ahead.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place in Dawn House. The centre had a nursing management structure and had a full time person in charge who shared their role with one other designated centre. Management and staff were found to be responsive to the inspection process and knowledgeable regarding the residents individual needs on the day of inspection.

There was evidence that the service provided was regularly monitored and reviewed by the management team. Regular thematic unannounced audits were completed by other persons in charge working with the provider. These included reviews of residents activation, fire safety, infection control, restrictive practices, food, and residents meetings. The provider representative and senior management team were completing six monthly audits and annual reviews of the care and support provided.

While the inspector acknowledges that the provider had successfully reduced overall numbers in the centre to 5, the provider had also failed to adhere to conditions attached to registration and to adhere to the compliance plan response submitted to HIQA within specified timelines. The provider was also responsible for operating an unregistered centre and moving a resident from Dawn House there in the days prior to the inspection.

Judgment: Not compliant

Quality and safety

It was evident that the quality of life for residents and their overall safety of care was prioritised in a person centred manner in the centre. There was a focus on residents choices and preferences and personal goals were promoted and encouraged. Residents were supported to engage in a variety of person centred activities daily. Actions from the centres previous inspection had been addressed by the provider this included discontinuing the use of shared bedrooms in the centre and discontinuing the use of a central kitchen.

The inspector reviewed documentation pertinent to the residents care to determine the quality and safety of the service provided. This included a review of residents activation records, meal plans, risk management documentation, and transfer and discharge records. In general, documentation was well maintained and reflected that safe care and support was provided to the residents.

The registered provider had ensured that the premises was designed and laid out to meet the needs of the residents, however some minor improvements were required to ensure that the premises was maintained in a suitable state of repair. This included some chipped paintwork and scratched/worn flooring in the centre.

Residents all had individualised risk management documentation in place, individual social goals and personalised safeguarding plans which appeared to guide the care and support provided to them. Documentation was regularly reviewed and updated to reflect residents most current needs.

Regulation 17: Premises

The centre was designed and laid out to meet the needs of the residents. The premises is a single story building which comprises of five single bedrooms. The centre also had two large living areas, a dining area, a kitchen, laundry facilities, accessible bathrooms and toilets, a staff office and a wheelchair accessible garden.

A number of areas were noted around the centre which required minor improvements. These included outstanding chipped paintwork and scratched and chipped flooring. The person in charge communicated that a request had been submitted to the service maintenance department to address these issues.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Marked improvements were noted the area of food and nutrition since the centres most previous inspection. The centre had discontinued the use of a central kitchen and fresh home-cooked meals were now being made within the centres kitchen. Mealtimes appeared to be a pleasant experience in the centre.

Staff spoken with appeared knowledgeable regarding residents dietary preferences and needs. Staff members also communicated that the change to cooking meals in the centre had meant that residents preferences and choice could now be facilitated easier. Meal plans were discussed weekly with residents at weekly meetings where choice was offered to residents for the week ahead. A review of recent meals plans found that residents were in receipt of a choice of varied nutritious meals. Some residents had been supported to be involved in cooking some meals. Some residents presented with swallowing risks and had individualised swallow care plans in place.

Some residents were enjoying regular trips to the local supermarket to buy groceries with support from staff and this was part of their regular activation schedule. Two residents had goals in place to develop their skills in the area of picking out and paying for groceries in their local shop.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

One resident had recently moved out of Dawn House to another centre. This had been part of the providers plan to reduce overall numbers in the centre. The residents move from Dawn House appeared to promote a smooth transition to their new home.

A transitional plan had been developed for the resident prior to the move. This had included the resident visiting the new centre, discussions with the resident and their family, assessments of need, and care planning. The resident had also been involved in decorating their new home and had the opportunity to meet with the residents they would be living with prior to the move. Staff familiar with the resident were working with them in their new home. The resident had enjoyed a "goodbye" party in the centre prior to the move to their new home.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had implemented a system for the assessment, management and ongoing review of actual and potential risks in the designated centre. Actions regarding risk management had been addressed since the centres most previous inspection. All residents had individualised proactive risk management plans in place. These considered issues including safeguarding, residents transport, fire safety, COVID-19 and residents wellbeing. The centre had a risk register maintained which detailed all actual and potential risks in the centre.

Individual risks posed to residents were regularly assessed, including skin integrity risks and manual handling risks. Rationale for the use of restrictive practices in the centre was clearly identified in corresponding risk assessments.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded in the centre. A review of training records found that all staff had up-to-date safeguarding training. Potential safeguarding risks in the centre had been assessed and mitigated where possible. All residents had personalised intimate care plans in place. All residents had individual safeguarding plans in place which detailed specific measures to promote their safety. All residents financial decision making capacity had been assessed. There were no open safeguarding concerns on the day of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

The resident rights appeared to be respected and residents appeared to have choice and control in their daily lives. Residents meetings were held weekly where residents were consulted about the service provided. Topics including meal planning and activation were discussed with residents for the week ahead. Complaints procedures were also discussed and the inspector noted the complaints procedure and the details of the designated complaints officer, prominently displayed in the centre.

There was no longer a shared bedroom in use in the centre on the day of inspection. This was an action that had been addressed since the centres previous inspection. This had resulted in one resident moving to an unregistered centre as detailed under regulation 23.

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	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dawn House OSV-0002635

Inspection ID: MON-0034315

Date of inspection: 05/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All regulatory responsibilities were met and deficits in compliance addressed immediately by the provider nominee. Assurances given to the Chief Inspector and Chief Officer that no further use of an unregistered centre would occur.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: PIC sourced private quotation for new flooring throughout Dawn House, funding approved, same scheduled to be completed by 31/03/22. Quotations submitted to ADON for both internal and external painting of Dawn House for escalation for funding to be approved. Same has since been approved, awaiting works to commence.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/06/2022
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	30/11/2021