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:	The Park Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	03 June 2022
Centre ID:	OSV-0004038
Fieldwork ID:	MON-0036168

About the designated centre

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

The Park Group is a community based residential service located in west Dublin. It is comprises three houses, all located in close proximity to each other. The centre provides residential care and support for up to 14 adults with an intellectual disability. Two of the centres provide full time residential care, and the third provides residential care for five nights per week ordinarily, however, this has been extended to seven nights per week during the COVID-19 pandemic. The centre is staffed by social care workers, and has a full time person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 3 June 2022	08:45hrs to 16:00hrs	Sarah Cronin	Lead
Friday 3 June 2022	08:45hrs to 16:00hrs	Michael Keating	Support

What residents told us and what inspectors observed

This unannounced inspection took place following an inspection in January 2022, which found poor levels of compliance with the regulations. The provider was found to be in breach of one of their conditions of registration. A warning meeting took place with the provider following this inspection. The provider had reduced the number of residents in one house's annexes back to a single occupancy in line with the conditions attached to the registration of the designated centre.

Overall, inspectors found that residents they met were happy and well supported in their homes. They appeared to be enjoying a good quality of life. Residents were supported to enjoy activities, such as attending day services, going to a social club, going out for dinner and they were supported to maintain contact with a resident who had recently moved out of the centre. Staff members on duty were very familiar with the residents and their needs and were noted to interact in a respectful and responsive manner with residents. However, inspectors found that further improvements were required in the areas of governance and management, positive behaviour support, premises and infection prevention and control.

The first house is a four bedroomed house with an annex attached. Downstairs comprises a sitting room, a kitchen, a dining room and a small bathroom. Upstairs there is a shared bathroom, three residents' bedrooms and a staff office and sleepover room. This house was in the process of being decorated and there was a painter in the house on the day of the inspection. On arrival, the inspectors met with a resident in the sitting room. The resident told the inspectors they were going to a a social club that morning and out for dinner later in the evening. This resident became upset intermittently during the morning as they were unable to access their bedroom while the painting work was in progress. The staff member on duty was noted to be supportive and responsive towards the resident and fetched their belongings that they requested. Inspectors met with the second resident upstairs who showed them their newly painted bedroom. The resident spoke with one of the inspectors as they ate breakfast and told them they loved living in the house and that all of the residents got along well. The third resident in the house was at home with family. Inspectors met with the resident who now lived in the annex alone. They showed the inspectors their living space which was in the process of being adapted to have a kitchenette for them. The bathroom had been treated for mould and painted. The resident reported that they were much happier having their own space and spoke about their activities and plans for the week.

The second house is a large five bedroomed property which was home to four residents. Downstairs there was one bedroom for a resident, a bathroom which was adapted for the needs of that resident, a sitting room and to the back of the house there was a large kitchen and dining room which was also used as an office. Upstairs, there were five bedrooms. One of these was vacant and another was used as a staff sleepover room. There were two shared bathrooms. There was a large back garden which had a seating area and was well maintained. The inspector had

the opportunity to meet two of the residents living in this house and the other two residents were in their day service. On arrival to the house, the inspector met with a resident in the hallway. They greeted the inspector and told them that they were expecting a visitor whom they had not seen in a number of years and were excited to see them. The resident's visitor arrived and they were supported to have tea and coffee together alone. The second resident was sitting in the sitting room doing a large jigsaw puzzle. The resident told the inspector that they liked living in the house and that the staff were 'nice'. They appeared very comfortable and content.

The third house is a four- bedroomed house which has an annex attached. Downstairs comprises a kitchen and dining room, a sitting room and another quiet room. Upstairs, there are four bedrooms, with one of them used as a staff sleepover room. There is one shared bathroom. Repeated non-compliance had been found in this property due to inadequate bathing facilities being available to the resident living in the annex. The provider has committed to renovation works being completed by December 2022. One of the inspectors met with the resident living in the annex. They spoke to the inspector about their daily life in the centre and said that they were happy living in their flat. The resident asked when their bathroom would be completed and reported that it was taking a long time for this to be actioned.

There was evidence that residents were involved in the running of the centre and that they had choice and control in their daily lives. Minutes of residents' meetings were viewed by the inspectors and a standing agenda was in place which covered areas such as COVID-19, activities and personal goals, fire, complaints, safeguarding and rights. However, these meetings were only taking place on a monthly basis so it was unclear to inspectors how things such as activities and menu planning were being decided on on a weekly basis. It was evident that residents' rights were considered where any restrictive practice was required. For one resident who had a device for health and safety reasons, a human rights assessment had been carried out to ensure full consideration of the impact of this restriction on that resident.

In summary, from what the residents and staff told us, what the inspectors observed and from a review of documentation, it was evident that some improvements had been made since the last inspection. Inspectors found residents to be happy and comfortable in their homes. There were a number of activities and social outings occurring frequently and there was a friendly and relaxed atmosphere in each house. 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 the service being provided to residents.

Capacity and capability

Inspectors found that some improvements had been made in strengthening the

governance and management arrangements in the centre. These improvements were notable at local management level, with an increased presence of managers in each house on a weekly basis. Regular meetings were taking place between the person in charge and the local management team. However, inspectors were not assured that governance and management arrangements at provider level were adequate to ensure oversight and monitoring of the quality and safety of care of residents.

A review of rosters indicated that the centre was resourced with an adequate number of staff available to meet residents' assessed needs in each house. Documentation in the centre was found to require improvement to ensure that clear, up to date and consistent information was in place to guide and inform staff practices and to ensure that oversight systems such as audits were

Inspectors found that there was a complaints policy in place and an overarching complaints log for the centre. There was evidence that complaints were identified, documented and appropriately managed. Most complaints were resolved locally. A quarterly complaints report was sent to the Health Service Executive by the Service Manager. However, the complaint in relation to the premises issue remained open. This issue is referred to under residents' rights in the findings of this report.

Registration Regulation 8 (1)

The provider had come into compliance with this regulation by moving a resident out of an annex which was registered for one bed only.

Judgment: Compliant

Regulation 15: Staffing

Inspectors found that there was an adequate number of staff available to meet the assessed needs of the residents. The maintenance of rosters had improved since the last inspection, with planned and actual rosters showing full names of all staff on duty.

Judgment: Compliant

Regulation 21: Records

Documentation in the centre required improvement to ensure that staff practices were informed and guided with the most up- to -date information about residents

and their care needs. Throughout the day there were examples of the duplication of information. For example, residents had two documents to be used to transfer important information to hospital with them and the information within these documents did not match. This could lead to out -of -date information being transferred with a resident. Another example was a resident who had guidelines on their file from a speech and language therapist from 2016. Staff were unclear if these guidelines were still required. This issue also arose with positive behaviour support plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that some improvements had been made in strengthening the governance and management arrangements in the centre. Following the last inspection, the provider had committed to establishing a governance and oversight team for the centre, comprising of members of the executive team and the local management team to oversee the implementation of an action plan to address areas of non-compliance and ensure the delivery of a quality person-centred supports to residents. On the day of the inspection, it was reported to the inspectors that the executive team had met on a small number of occasions, but that the local management team were tasked with carrying out improvements required. Therefore, inspectors were not assured that the provider had adequate oversight of the centre to ensure they achieved the required improvements which they had committed to in their compliance plan.

Audits were being completed on areas such as care plans, medication, incidents and accidents, finances and medication. However, it was unclear to inspectors what system was in place to collate these audits and share findings with local management to ensure good monitoring and oversight and continuous quality improvement. One example of this was an audit on a resident's MPARs which identified an area requiring improvement. The person in charge reported that the staff member who found the issue was responsible for rectifying it themselves, but this was not clear in the documentation, nor was it clear how this information was tracked by management to ensure ongoing quality improvement was taking place.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors found that there was a system in place in the centre for oversight of complaints. A record of complaints indicated that residents and families had been supported to make complaints and they were appropriately documented and dealt

with. Concerns were acted upon in a timely, supportive and effective manner.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents were receiving person-centred care and had a good quality of life. They exercised choice and control in their daily lives. Residents told inspectors they were happy with their homes and with the support they received from staff. However, improvements were required in positive behaviour support and protection against infection.

The need for positive behaviour support plans to be updated in line with residents' current presentation and support needs had been identified on the centre's last inspection. This had not been actioned in line with the provider's compliance plan.

The provider had suitable arrangements in place to ensure that residents were protected from all forms of abuse. Safeguarding concerns were appropriately documented, reported and investigated in line with national policy. Discussions around different aspects of safeguarding took place at staff and resident meetings. Intimate and personal care plans were found to be clear and respect residents' right to privacy and dignity.

The premises within the centre were found to vary in quality on the last inspection and was found to be non- compliant due to a number of maintenance issues and the inadequate bathing and showering facilities in the annex of one house. Inspectors found that significant maintenance work had been carried out on some of the premises since the last inspection. The person in charge had better oversight of maintenance issues through the use of a centre based log. Maintenance walkabouts were taking place in addition to audits in infection prevention and control (IPC) to ensure that the person in charge was supported to self-identify and document all areas requiring improvement. However, it remained the case that the bathing facilities in one of the houses was not adequate to meet the resident's needs. This was a long standing issue which the provider has given assurances to the Chief Inspector that this work would be completed by November 2022.

The provider had a risk management policy in place which met regulatory requirements. There were clear systems in place to identify, assess and mitigate risks for residents and within the centre. Inspectors found that there were appropriate control measures in place to mitigate against risks. The provider ensured that there were systems in place for the oversight of risk and that risks were regularly reviewed. Arrangements were in place for the identification, recording, investigation of and learning from incidents or adverse events involving residents in the centre.

Inspectors found that progress had been made in infection prevention and control

(IPC) since the last inspection. However, further improvements were required to ensure that residents were protected from health- care-acquired infections and that where infections were presented that they were managed appropriately. . From speaking with staff, it was evident that they were aware of standard- based and transmission- based precautions and they were kept informed of up to date guidance. However, there remained issues with contingency planning, laundry and waste management and cleaning and disinfection which posed IPC risks to residents.

Regulation 17: Premises

Inspectors noted significant improvements were being made in all of the premises. This was particularly notable in the first house visited by inspectors. Damp and mould had been removed and the entire premises was in the process of being re-painted. There were plans to replace two kitchens in the centre and to renovate an annex. Residents' bedrooms were decorated in line with their preferences and some areas of the houses had photographs of residents enjoying activities together. The provider was found to be self-identifying issues throughout the houses and putting action plans in place. However, it remained the case that the bathing facilities in one of the houses was not adequate to meet the resident's needs. The provider has given assurances to the Chief Inspector that this work would be completed by November 2022.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place which met regulatory requirements. There were clear systems in place to identify, assess and mitigate risks, both for residents and within the centre. Inspectors found that there were appropriate control measures in place to mitigate against risks. The provider ensured that there were systems in place for the oversight of risk and that risks were regularly reviewed. Arrangements were in place for the identification, recording, investigation of and learning from incidents or adverse events involving residents in the centre.

Judgment: Compliant

Regulation 27: Protection against infection

Since the last inspection, the Clinical Nurse Specialist in Infection Prevention and Control had carried out an audit in each house and quality improvement plans were developed to improve IPC practices in place. There was better oversight of maintenance issues which impacted upon IPC. Following two outbreaks, there was evidence that staff were afforded an opportunity with management to debrief and to identify any learning from these outbreaks. There was an enhanced cleaning schedule in place which included equipment within the houses. However, there were a number of areas identified on the day of the inspection which required attention. In one of the houses which had an outbreak of COVID-19 in March, the inspector found there to be a number of bags of clinical waste stored in the shed of the back garden. These bags were next to water soluble bags and supplies of aprons. Cleaning equipment was not regularly cleaned and disinfected after each use. For example, the inspector found a mop sitting in a dirty bucket and staff reported that they cleaned the mop "when it needed it". Laundry management in one of the houses meant that all of the household laundry was done together. This posed a risk of cross contamination. While the provider had drawn up contingency plans and isolation plans, these did not provide sufficient detail on individualised information relating to each resident or have adequate information on escalation procedures and staffing arrangements. It was unclear what enhanced environmental cleaning was required in the event of a suspected outbreak.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The need for positive behaviour support plans to be updated in line with residents' current presentation and support needs had been identified on the centre's last inspection. This had not been actioned in line with the provider's compliance plan submitted to the Chief Inspector. Of the care plans reviewed by inspectors, two residents were identified by the provider as having mental health and behaviour support needs. For these residents, there were risk assessments in place and behaviour support was documented as a priority element of care which staff were required to be aware of. In spite of this, behaviour support plans had been drawn up in 2016 and 2017 and were therefore inappropriate to guide staff practice as they did not reflect each of the residents' current presentation and support needs. One residents was prescribed PRN medication as a reactive strategy. There was no PRN protocol in place to ensure consistency among staff. This issue had been identified for another resident on the last inspection and actioned but was not completed for the second resident.

Judgment: Not compliant

Regulation 8: Protection

Inspectors found that there were suitable arrangements in place to ensure that residents were safeguarded from all forms of abuse. There were a number of policies and procedures guiding practice in relation to safeguarding, the provision of personal and intimate care and protecting residents' finances and personal possessions. Safeguarding was an agenda item on meetings with staff and residents. There was evidence that residents were supported to voice concerns and complaints and that these complaints were listened to. Inspectors viewed documentation relating to a recent safeguarding incident and found that this was appropriately documented, reported and investigated in line with national policy. Finances were checked each day and regularly audited. Intimate care competency assessments were carried out with residents to inform detailed personal care plans which respected each residents' right to privacy, dignity and bodily integrity.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents were involved in the running of the centre and that they exercised choice and control in their daily lives, particularly in relation to social past times. Residents had access to advocacy services and for some residents, there were human rights assessments in place to ensure residents' rights were considered where there were restrictive practices in use. House meetings were taking place and included agenda items such as safeguarding, IPC, fire and menu planning. However, these were happening once a month on average which meant that it was unclear how menus were planned and activities planned each week. There was a continued negative impact on a resident's right to privacy and access to appropriate bathing and showering facilities in their home. This was a finding on a number of inspections since 2016.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for The Park Group - Community Residential Service OSV-0004038

Inspection ID: MON-0036168

Date of inspection: 03/06/2022

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Residents personal plans will be reviewed by person in charge and any out of date documentation will be archived this piece of work has been completed by the person in charge. The person in charge will ensure that each resident has one hospital communication passport document in use and that any duplicate is archived. The person in charge will review each hospital communication passport to ensure information is correct and up to date. Residents who have an identified support need for behavioral support will have a clear support plan within their care plan.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has established a governance and oversight team for the centre comprising of members of the Executive Team and local Management Team to oversee the implementation of an action plan to address areas of non-compliance and ensure delivery of quality person-centered supports to residents this meeting will take place in September 2022. The auditing systems currently undertaken by the person in charge will be overseen and reviewed by the person participating in management during monthly supervision meetings. Oversight of audits will be included in the nominee provider audit. The provider is reviewing the care plan audit in place within the designated centre to improve oversight.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
This work is a funded plan.
The plan has been drafted by the Director of Logistics for works to complete an extension to the identified annex which will provide a suitable bathroom for the resident, since the last inspection,
• Planning permission has been sought and granted for the building works
• The E tendering process has completed
• The work is due for completion November 2022

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The registered provider will arrange for a suitable company to remove the clinical waste stored in the shed. The person in charge has removed the PPE from the shed.
The centre's laundry management plan has been reviewed by the person in charge and clinical nurse specialist in IPC.
The person in charge has implemented a cleaning schedule for cleaning equipment in use in the centre.
The person in charge has reviewed the centre's contingency plan to include enhanced cleaning requirements in the event of an outbreak, escalation procedures and staffing arrangements.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has scheduled reviews of the behavioural support plans by the MDT.

The residents PRN medication was reviewed by the psychiatrist and the medication discontinued.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC has compiled a weekly menu planning record template and a visual prompt which will promote and record resident's choice around their menu.

The PIC has reviewed documentation around quality of life activities engaged in by the resident in the care plan to ensure how choice is promoted is captured.

A plan has been drafted by the Director of Logistics for works to complete an extension to the identified annex which will provide a suitable bathroom for the resident.

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(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/11/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	07/09/2022
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	30/09/2022
Regulation 27	The registered provider shall	Not Compliant	Orange	30/09/2022

	ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	07/09/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	07/07/2022
Regulation 09(3)	The registered	Substantially	Yellow	07/07/2022

	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.	Compliant		