

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002449
Centre county:	Monaghan
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kevin Carragher
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Day 1: Philip Daughen
Type of inspection	Announced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
16 June 2015 09:00	16 June 2015 18:00
17 June 2015 09:30	17 June 2015 19:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was an announced inspection completed in response to an application by the provider for registration of the designated centre as required by the Health Act 2007. The designated centre consists of two community houses located in Co. Monaghan and is operated by the Health Service Executive. This was the second inspection of the centre by the Authority. The inspectors found that the provider had demonstrated a responsive approach to regulation. Satisfactory actions were taken by the provider to address and complete areas of non-compliance identified, however further improvements are required in some areas of the service as discussed in the body of this report and associated action plan to bring the designated centre into

compliance with the regulations.

This inspection was facilitated by the person in charge who was present at the opening and closing meeting. As part of the inspection process, inspectors met with residents and staff, reviewed documentation and observed practice. Completed pre-inspection questionnaires issued by the Authority were also reviewed. Whilst feedback was complimentary of staff within the centre and the quality of service provided to residents, some residents expressed concern regarding the availability of meaningful advocacy services for residents with communication deficits. Inspectors found that this area of the service required improvement as discussed in outcome 2. Inspectors found that concerns expressed about unexplained bruising on some residents' skin were satisfactorily addressed as discussed in outcome 6. The absence of toilet facilities for four residents in one of the community houses was reviewed by inspectors on this inspection. The provider acknowledged this finding in the Statement of Purpose document which states the accommodation is not suitable for wheelchair users or residents requiring full-time nursing care.

Inspectors found that staff engaged with residents in a dignified and respectful manner and residents spoken with confirmed their satisfaction and happiness with their home. Non-compliances were identified with nine regulations on this inspection, eight of which is the responsibility of the provider and one is the responsibility of the person in charge. Compliance was found in eleven outcomes. Minor improvements were required in Outcome 1: Residents' Rights and Consultation, Outcome 5: Social Care Needs, Outcome 6: Safe and Suitable Premises, Outcome 14: Governance and Management and Outcome 17: Workforce.

Moderate non - compliance was identified in the following two Outcomes:

Outcome 7: Health and Safety and Risk Management

Outcome 18: Records and documentation

The action plan at the end of this report identifies the required actions the provider/person in charge is required to take to ensure the designated centre is in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors found evidence to support satisfactory resident consultation. Their involvement was encouraged in decisions regarding day to day activities and in choice of outings. There was greater evidence of involvement in one of the two community houses including participation in residents' house meetings. In the second community house, there was evidence that efforts had been made to conduct residents' meetings however based on the needs of the residents, this forum was not effective and a 1:1 methodology was used to involve and encourage residents. Inspectors observed that there was evidence in the personal file of consultation with each resident and/or their representative.

The organisation has policies and procedures in place regarding the management of complaints. The complaints procedure was displayed in accessible format. Inspectors reviewed the complaints log and observed that two areas of dissatisfaction were recorded dated November 2014. No complaints were recorded for 2015. The complainants' satisfaction was recorded in both cases. Contact details for advocacy services were displayed in the designated centre. However, all residents with communication difficulties were not provided with opportunity to become familiar with advocacy services also discussed in outcome 2 which may potentially impact on supports available to them to make a complaint if they wished.

Inspectors observed that residents' rights were respected and staff engaged in a dignified and respectful manner with residents on the days of inspection. Based on the some residents' assessed needs, restrictions were in place to ensure their safety needs were met in one community house. During the last inspection of the designated centre

in June 2014, findings in relation to procedures that impacted on the privacy rights of some residents were the subject of an action plan. Since the last inspection the volume of an alarm to alert staff of access to one resident's room was reduced and a protocol was implemented to advise on appropriate use of a listening device in another resident's bedroom. These actions to mitigate risks to residents identified on assessment were documented in the risk management documentation for the community house and in the individual residents' personal files.

The freedom of movement of residents varied dependent on the needs of residents and inspectors observed residents to be supported to be active members of the community. For example, some residents were supported to independently go to the local shop and post office to purchase personal items and carry out personal transactions. Another resident attended Bingo in the local towns independently. Some cupboard doors were locked in kitchen units as a control to safeguard residents. The inspectors observed that this action was also documented in the risk register. In addition, access through the front door of the centre was restricted for some residents with increased vulnerability to ensure their safety by reducing their risk of leaving the community house unaccompanied. This control was also assessed and documented in the risk management documentation. Residents who did not pose a risk of leaving the centre unaccompanied were provided with keys for the front door of the community house to facilitate their independence.

Judgment:

Substantially Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a policy in place informing staff on procedures to meet residents' needs; however this document required review as it did not adequately inform the communication needs of residents in the community houses. This finding is addressed in outcome 18. The inspectors found that an assessment of the communication needs of each resident was completed. A personalised communication interpretation aide was developed for each resident that interpreted the meaning of sounds and gestures to assist residents' interaction with others especially persons unfamiliar with residents' communication techniques. Relatives of residents stated in the Authority's pre inspection questionnaires that they felt staff supported their relative to communicate in line with their abilities. The documentation reviewed belonging to residents with compromised or absence of speech evidenced completion of referrals for assessment of support by use

of assistive technology.

As addressed in outcome 1, while an advocate was available to residents, this person was not known to residents and the advocate was not familiar with residents in the centre. This finding could potentially negatively impact on the value of this service to residents.

Residents had access to television, radios and to telephones. Some documentation was in accessible format, for example, the complaints procedure, menus and staffing arrangements. Work was in progress at a regional level with developing accessible format personal planning templates and resident guides for each community house.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was a policy in place which advised on appropriate procedures to support visiting of residents in the designated centre. Residents were supported and empowered with staff assistance to maintain family contacts which included visiting and for some residents staying overnight. Each resident in the designated enjoyed family contact and for most was on a consistent basis. Residents were also observed by inspectors to be encouraged by staff to maintain family contact by telephone.

Each house had a visitors' book which was up to date with a record of visitors and external staff who attended the centre on the days of inspection. There were no restrictions to visitors in the centre unless requested by the resident or supported by risk assessment. Inspectors found clear evidence from review of the personal records of residents, feedback from the Authority's pre-inspection questionnaires and from speaking to residents and staff that family members were actively encouraged and involved in the lives of residents. Inspectors observed family members in the designated centre who were familiar with their surroundings and stated that they were always welcome. From a sample of records reviewed, there was evidence that family members had been involved in the personal plan meetings of residents and were consulted regarding any change in the residents' health or well-being.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The organisation had an admissions policy in place which included the procedures to be followed for transfers, discharge and temporary absence of a resident. This policy document was reviewed on inspection and found to not adequately inform all aspects of these procedures. The policy did not adequately inform the procedures to take should an emergency occur or temporary absence in respect of a holiday, visiting family or an admission to hospital. The policy did not inform the procedure to be taken if a resident was admitted to hospital including the information to be communicated to the acute setting and the support, if any, the resident would receive from the designated centre whilst temporarily absent from same. The admission procedure did not adequately inform residents' choice or transition needs when moving into the centre from care in the family home or another service. This finding is addressed in outcome 18. There were no new residents in transition on the day of inspection in the designated centre.

On the last inspection of the centre in June 2014, not all residents had a written agreement in place of the terms in which the resident shall reside in the centre, the services to be provided, the fees to be charged, including additional charges. The inspectors found that this action was satisfactorily completed on this inspection. Each resident had a contract detailing terms of residency, aspects of care covered as distinct from services not covered by the fee to the resident. Some contracts were signed in agreement by residents.

Judgment:

Compliant

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

Inspectors reviewed a sample of residents' personal files and found that each resident had an assessment completed which identified their health, personal and social care needs. This documentation referenced assessments of emotional well-being, numeracy and literacy, concept of time, nutrition, independence, personal grooming and sharing their environment. Additional assessments of need were completed for some residents with other vulnerabilities informed by use of accredited assessment tools such as manual handling and nutrition needs.

Each resident had a care plan developed to meet their assessed needs regarding their health care. Risk assessments were completed to inform social care needs such as visiting family and accessing the community. Each resident had identified their short and long term goals with support by staff and family, details of which were documented in their personal plan information.

Progress with achieving these goals was reviewed on a monthly basis and informed reviews at 6 months and annually. Multidisciplinary representation by the services involved in some residents' care at annual reviews was not in place on the days of inspection. While acknowledged that sustaining achievements presented challenges for some residents, some resident goals documented were competently maintained as part of their usual routines. This finding required improvement to ensure residents were facilitated to experience and celebrate personal achievements.

During the last inspection in June 2014, inspectors found evidence to support required improvement in access to allied health professionals especially for residents with complex mental and physical health needs. This area was satisfactorily actioned since the last inspection and there was evidence of professional specialist assessment as required on this inspection evidenced in residents' care documentation.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The designated centre consists of two community houses. One house was a two storey house in an urban setting. The other was a bungalow in a rural setting. Each house also had a standalone apartment to the rear for the use of one resident to live in a supported environment.

Both houses were found to have adequate private and communal accommodation to meet the needs of residents. Residents had adequate space for recreational and dining activities. Both houses had adequate kitchen and bathroom facilities to meet the needs of the residents.

All residents had private accommodation in terms of single occupancy bedroom accommodation. Not all residents could lock their bedroom doors if they wished to meet their privacy needs. Residents who could lock their bedroom doors were facilitated to do so by means of a personal key. This finding posed a potential risk to the safety of the resident due to restricted access to staff to assist the resident in an emergency when the key was left in the engaged lock inside the door in the absence of a suitable key-free locking mechanism. This potential risk had not been assessed. This finding is discussed further in outcomes 1 and 7.

There were adequate storage facilities generally throughout both houses and in both supported living units. Both houses were found to be adequately maintained, clean and decorated in a homely fashion. The layout and design of both supported living units accommodating one resident in each were assessed on this inspection. Inspectors found that while these premises met the needs of residents, a settee in one unit was damaged and torn. Both houses and supported living units provided secure, safe external areas for the use of residents. Inspectors found both houses to be adequately lit, heated and ventilated on this inspection.

However, the two storey community house was found to be inaccessible for residents with high mobility needs. This was due to the lack of a lift to access the bedroom and bathroom on first floor level and also the narrow nature of the landing area on first floor level. However, inspectors found that the residents currently occupying the house were able to mobilise independently. Furthermore, the limitations of the particular house in this regard were reflected in the statement of purpose. The lack of this information within the statement of purpose was the subject of an action from the last inspection of the designated centre in June 2014 and was satisfactorily addressed.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The health and safety of residents, staff and visitors was found to be generally promoted in the designated centre. A review of documentation evidenced that the centre had the requisite risk management policy and documentation and that this documentation was centre-specific. There was a risk register that reflected risks present in the centre, demonstrated that risk assessments were being conducted on an ongoing basis and that control measures were being implemented to address these risks. However, potential risk posed by use of keys to lock bedroom doors was not assessed to ensure unrestricted access by staff to residents in the event of an emergency when keys were left in engaged locks inside these doors.

Inspectors found that there appropriate infection control practices in place in the centre. The centre was fitted with appropriate infection control facilities including hand hygiene and laundering facilities for residents' clothing on-site. There was an infection control policy in place in the centre to inform practice in this area.

Inspectors found that the necessary procedures were in place to safeguard against the risk of fire. There was a fire procedure in place for both houses. There was evidence of regular checks and good housekeeping practice with respect to fire safety. The abilities of the residents were considered in the event of an emergency and any staff spoken with were familiar both with the procedure to follow and also the needs of the individual residents in the event of an evacuation been required. All fire equipment was maintained as appropriate and there was evidence of regular fire drills reflecting a number of scenarios at times of the day and night. There was a satisfactory level of detail in the recording of information surrounding these drills. However, inspectors observed that there was no record of a drill being carried out in one house with one staff member to assist residents as one staff member would be present in the house at times, particularly at night. Inspectors also noted fire drill records where challenging behaviour by some residents had been noted during drills but there was no evidence that procedures and/or staffing levels had been reviewed in ensure evacuation of these residents was not compromised in the event of a fire.

The community houses were each fitted with a fire alarm system and emergency lighting throughout. The layout of both houses ensured there were adequate escape routes from the building in the event of fire. There was also first-aid fire fighting equipment provided. Fire doors were provided where necessary to contain fire and smoke in the event of same occurring in the designated centre. Inspectors found storage of some combustibles under the stairs in one house that could pose a risk in the event of fire but staff endeavoured to remove same immediately when this was brought to their attention. A number of fire exit doors were locked with a key, particularly at night. Inspectors found that where this was the case, a key was provided directly adjacent to the door in a break glass unit and that this arrangement had been risk assessed and recorded. All staff spoken with had a key on their person in order to open the door. Inspectors found that the manual call points on the fire alarm were found to be activated by a key in one of the houses. Staff members were in possession of this key also and an additional key was accessible underneath each call point. However there

was no evidence that this arrangement had either been certified as a variation from the Irish Standard 3218: 2013 Fire Detection and Alarm Systems for Buildings or that the arrangement had been appropriately risk assessed.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The designated centre has a policy in place titled 'Guidelines on the Protection from Abuse of Vulnerable Adults with a Disability' advising on prevention, detection and response to abuse. The policy was reviewed in response to findings during the last inspection in June 2014 regarding the additional support available to residents in the event of an allegation or suspicion of abuse such as social work or advocacy services. However, as discussed in outcome 2 of this report, advocacy services provision for residents continued to require improvement. Inspectors confirmed that all staff had received training in prevention, detection and response to abuse. Staff spoken with confirmed to inspectors that they were aware of the appropriate action to be taken in the event of an allegation or suspicion of abuse. A regional safe-guarding team had been established but was not implemented at the time of this inspection. This finding is addressed in outcome 18.

Inspectors found that the person in charge was closely monitoring and investigating unexplained resident bruising. A tracking record was introduced to inform monitoring and investigation procedures for residents presenting with repeated unexplained bruising to their skin. There was also evidence of referral and review by of residents with repeated incidents of unexplained bruising to haematology specialist services to identify an underlying physiological aetiology. Staff-resident interactions were observed on the days of inspection and inspectors observed them to be responsive, supportive and caring during the days of inspection. Residents spoken with confirmed that they felt safe in the designated centre and relatives responded in the Authority's pre-inspection questionnaires that they felt their relative was safe and well cared for.

The designated centre has a policy in place informing management of residents'

personal property and possessions, reviewed since the last inspection to include the necessary information to ensure appropriate safeguards were in place. On review of practice inspectors found that all transactions were transparent and supported by signatory records. The person in charge assisted one resident with management of their finances. Inspectors were satisfied that the person in charge had implemented appropriate measures to safeguard the residents' finances in all respects. For example, two signatures were present for all income and expenditure events. Arrangements were in place for secure storage of residents' money. A personal property record was maintained for each resident, but required improvement to include a record date and clarity in the detail of property listed.

Residents in the designated centre had a history of presenting with behaviours that challenge. Inspectors reviewed the positive behaviour support plans and were satisfied that the appropriate assessments had occurred and that the appropriate proactive and reactive strategies were in place. Staff spoken to were also aware of the necessary strategies.

The organisation had policies in place to inform support procedures for residents who exhibited behaviours that challenged and the use of restrictive practices. Staff in both community houses had attended PMAV (Professional Management of Aggression and Violence) training and training on positive behavioural support which included de-escalation procedures. The inspectors observed from review of accident and incident records and notifications forwarded to the Authority that some residents engaged in behaviours that challenge including destruction of property. Each resident who presented with challenging behaviour had a positive behavioural support plan developed to inform individual triggers and de-escalation procedures. There were instances where physical and chemical restraint was utilised however inspectors were satisfied that appropriate assessments and protocols were in place with reviews conducted following the implementation of such practice to ensure that it was in line with best practice and that all other strategies are utilised prior. Some environmental restrictions following risk assessment were in place to prevent adverse outcomes for vulnerable residents. A restraint log was maintained referencing all restrictive incidents.

Judgment:
Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed the accident/incident log and confirmed that all incidents as

required by Regulation 31 had been notified to the Chief Inspector. All restrictive practices were notified appropriately. The person in charge demonstrated the appropriate knowledge of their statutory obligation to notify the Chief Inspector.

Judgment:
Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was no policy available to advise on procedures to ensure residents' access to education, training and development to staff in the designated centre. All residents had access to a formal day service which two residents chose not to participate in. These residents were supported to engage in activities of interest to them. There was evidence that the service had supported one resident to trial different day service placements without success. In response a vegetable tunnel was erected to support this resident's interest in gardening. Personal plans reviewed provided satisfactory evidence that residents were supported to access training opportunities. For example, a resident was supported to taking up employment one day per week and an internship. In addition and as discussed in Outcome 1, residents were supported to engage in on-going social activities they enjoyed and engage in new social activities both internal and external to the designated centre.

Judgment:
Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Inspectors found that the healthcare needs of residents were adequately met on this inspection. Assessment of resident needs with concomitant care plans were available as

part of each resident's personal planning documentation. The inspectors observed that all resident needs identified were informed by a care plan. Care plans were updated as required and discussed with the resident and their family by staff as appropriate. Care plan development was the subject of an action plan from the last inspection and was satisfactorily completed on this inspection. A number of residents had a diagnosis of epilepsy. The inspectors observed where their seizure activity and medication to control seizures was closely monitored and managed appropriately. Protocols were in place to advise staff on medication administration in the event of prolonged seizure activity including transfer to hospital. All staff had attended training on Epilepsy Awareness to inform their practice.

From review of residents' documentation, inspectors observed that residents were appropriately referred to and reviewed by relevant medical specialists and allied health professional including occupational therapy and physiotherapy as required. Residents with chronic conditions such as epilepsy attended regular outpatient appointments. Records of referrals, clinical interventions and treatments were maintained in each resident's documentation.

Referral pathways for residents with a nutritional need to a relevant allied health professional to meet that need including modification of food/fluid consistency were not adequate on the last inspection in June 2014. Inspectors found that this action was satisfactorily completed. There was evidence that residents were appropriately reviewed by a dietician and/or a speech and language therapist as required. Recommendations made following assessment were implemented as part of the residents care plan. Menus were in accessible format and dishes prepared were observed to be imaginative and varied. Staff preparing meals demonstrated that they were informed and knowledgeable regarding the dietary needs of residents including those with assessed swallowing difficulties. An accredited tool was used to assess the nutritional status of residents with unintentional weight loss. Residents' body weights were monitored with increased frequency for those at risk of weight loss/gain. However the nutrition policy available to advise staff dated 13 November 2013 was not adequate as it did not advise on some specialised diets for residents in the centre and did not adequately advise of all aspects of nutritional assessment. This finding is addressed in outcome 18.

In response to an action plan from the last inspection, all staff had attended food hygiene training on this inspection. Inspectors observed that residents were provided with opportunity to have snacks and drinks throughout the day outside of their main meals. On inspection of refrigerators, there was evidence that there was sufficient amount of nutritious food and drinks available in the designated centre.

Judgment:
Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

On the last inspection of the centre in June 2014, the designated centre did not have a current policy in place regarding medication management. A draft policy which was under review as a result of findings of inspectors at an organisational level and was found to be satisfactorily implemented on this inspection. However, review of this policy on inspection evidenced improvement required in the information to inform appropriate secure storage and disposal of unused or out of date medications. This finding is addressed in outcome 18. The medication policy was centre-specific to inform practice in respect of staffing arrangements. Separate policy documents were in place to inform medication procedures by nurses and care staff as medications were administered by care staff in one of the two community houses. Nursing and care staff had completed medication management training and competency assessment procedures were in place. The inspector observed medication administration and found it to be safe and in line with best practice procedures.

Medications were administered from blister pack systems in the community house where medications were administered by care staff. Comprehensive documentation was completed and updated as required by the person in charge regarding the action and potential adverse reactions for each medication. Care staff did not administer any medications outside those in the blister packs with the exception of basic medication for pain management. A pain assessment tool was in use to assess residents' pain. Medication prescription and administration documentation was revised since the last inspection to include provision of adequate space for insertion of comments. Inspectors observed that medication was stored appropriately and stock was checked appropriately.

Auditing procedures were completed by the person in charge and the pharmacist. Residents had access to the pharmacist if they wished. There was evidence that residents had received assessments to ascertain if they were in a position to self medicate.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

As part of the application to register the designated centre under the Health Act 2007, the provider was required to submit a Statement of Purpose to the Chief Inspector. Inspectors reviewed the Statement of Purpose dated 13 May 2015 and found that it accurately described the service provided and contained the information as required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013,

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was a clear management structure in place. The provider nominee was the regional manager for the service. The provider nominee is supported by a director of nursing and an assistant director of nursing. The person in charge is employed as a Clinical Nurse Manager Grade 2 and has responsibility for the two community houses which form the designated centre. The person in charge reports directly to the director of nursing. The person in charge met with the Director of Nursing formally on a monthly basis at a forum for all persons in charge in the region. The person in charge met with the director of nursing approximately every 8 weeks. Both these meeting forums were informed by an agenda and minuted. There was also evidence that the staff employed to work directly in the community houses met approximately every six weeks as a group with the person in charge.

The person in charge was available throughout the two days to facilitate the inspection. The person in charge has the necessary qualifications and experience to ensure compliance with the legislation and demonstrated adequate knowledge of the operation of the designated centre. The evidence supported her involvement in the governance, operational management and administration of the centre. The person in charge was knowledgeable regarding residents and their assessed needs. Through observation and

speaking to residents, inspectors confirmed that residents were familiar with the person in charge.

Although at an early stage, there was evidence of a system in place to monitor the quality and safety of care and quality of life of residents. There was evidence of audits of medication management practices, infection prevention and control and health and safety. There was also evidence of analysis of some audits completed. Action on deficits was identified but it was not clear if all deficits were addressed as action plans were not developed clearly identifying the action to be taken and to enable tracking to satisfactory completion.

There was evidence that the provider or the director of nursing nominated on behalf on the provider had visited the designated centre regularly in the previous six months and the provider produced a report on the quality and safety of care and support provided in the centre as required by Regulation 23.

Judgment:
Substantially Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were suitable deputising arrangements in place should the person in charge be absent and the Provider was aware of his responsibility to notify the Chief Inspector of the absence. To date the person in charge had not been absent for a period of more than 28 days.

Judgment:
Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The inspectors found that the designated centre was in general adequately resourced to ensure the effective delivery of care and support in accordance with the centre's Statement of Purpose. The layout and design of the centre premises consisting of two community houses met the needs of residents. One of the two community houses in the designated centre is two-story in design and the Statement of Purpose clarifies its unsuitability for wheelchair users or residents who require full-time nursing care. The inspectors found that all residents residing in this house were mobile on the days of inspection.

With respect to laundry facilities, both buildings had been provided with new washing machines recently, one of them was a large industrial type washing machine. The lack of adequate laundry facilities had been identified as an action on the last inspection in June 2014.

Judgment:

Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors reviewed a sample of staffing rosters and confirmed that the staffing levels on the day of inspection were reflective of the rosters. Staff spoken to on the day of inspection stated that they felt that the number of staff on duty was sufficient to meet the needs of the residents. However a review of staffing levels and skill mix was required to ensure residents could be evacuated safely in one of the community house in the absence of evidence that evacuation drills were completed to assess day and night-time conditions. The inspectors found that there was adequate staff available to meet the needs of residents on both days of the inspection.

The staffing levels for one of the community houses were:

Care Assistant: 8.00 - 20.00 x 7 days per week
Care Assistant: 20.00 - 8.00 x 7 nights per week
Care Assistant: 14.00 - 23.00 x 5 days per week (Monday - Friday) and 10:00hrs - 22:00hrs at weekends

This staffing arrangement ensured residents could attend social activities in the evening. All residents in this house had low dependency needs. The person in charge told inspectors the staffing levels and skill mix were subject to on-going review and monitoring to ensure the needs of residents were met.

The staffing levels for the second community house were:

Staff Nurse: 08:00 - 20.00hrs x 7 days per week
3 x Care Assistants: 08.00 - 20.00 x 7 days per week
Additional Care Assistant staff are rostered to support residents for activities including home visits, hospital appointments and holidays.
Care Assistant: 20.00 - 08.00 x 7 nights per week
Care Assistant: 20.00 - 08.00 x 7 nights per week

These staffing levels reflected the higher support and assistance needs of the residents in the second community house and as observed by inspectors, adequate staff to provide 1:1 activation with and support to the two residents who choose not to attend day services. The person in charge was also based in this community house and had responsibility for the two community houses five days per week.

Inspectors reviewed a sample of training records for staff. Of the records reviewed staff had completed mandatory training requirements in addition to training in areas reflecting the needs of residents.

Inspectors were verbally informed that a new system was being implemented in the designated centre for the formal supervision of staff based on re-structuring within the larger organisation. However, there was adequate evidence to support supervision and competency assessment of staff by the person in charge.

A sample of four staff employment files were reviewed on this inspection. They were found to contain the information as required by Schedule 2 of the regulations in each case. All registered nursing staff were recorded on the active register of nurses in Ireland. There were no volunteers employed in the designated centre.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities)

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

As stated previously, inspectors reviewed a sample of staff files and confirmed that they contained all of the relevant information as required by Schedule 2.

The designated centre maintained a directory of residents which contained the pertinent information as required by Schedule 3 of the regulations and recorded temporary absences by residents as appropriate. Details of fire evacuation drills were not maintained in one community house as discussed in outcome 7.

The records as required by Schedule 4 were maintained in the designated centre, inclusive of all accidents and incidents in the designated centre and a record of all charges to the resident. However as discussed in Outcome 1, records maintained in respect of complaints management required improvement.

Inspectors reviewed the policies and procedures as required by Schedule 5, and identified a number of policy documents that did not inform practice due to the absence of adequate information as discussed throughout this report.

The organisation had an admissions policy in place which included the procedures to be followed for transfers, discharge and temporary absence of a resident. This policy document was reviewed on inspection and found to not adequately inform all aspects of these procedures.

Review of the medication management policy on inspection evidenced improvement required in the information to inform appropriate secure storage and disposal of unused or out of date medications.

The nutrition policy available to advise staff dated 13 November 2013 was not adequate as it did not advise on some specialised diets for residents in the centre and did not adequately advise of all aspects of nutritional assessment.

A policy document advising on residents' access to education and training was not available.

As part of the application to register the designated centre under the Health Act 2007, the provider evidenced to the Chief Inspector that there was adequate insurance in place against accidents or injury to residents.

Residents' personal documentation was protected and securely stored in the designed centre. Records were easily accessible. A policy document was available to inform record keeping and management.

Judgment: Non Compliant - Moderate
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Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002449
Date of Inspection:	16 June 2015
Date of response:	17 September 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all residents with communication difficulties were provided with opportunity to become familiar with advocacy services to assist them in making a complaint if they wished.

1. Action Required:

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:

Individual referrals made for each resident to the advocacy services on the 11/9/15.
This action will be ongoing.

Proposed Timescale: 30/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Input into residents' personal plans was not multidisciplinary

2. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

Prior to any further personal care plan meetings an invitation will be extended to each discipline. This action will be ongoing.

Proposed Timescale: 15/09/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A settee in one supported living unit was damaged and torn.

3. Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:

New settee ordered and was delivered 16/9/15

Proposed Timescale: 16/09/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Potential risk posed by use of keys to lock bedroom doors was not assessed to ensure unrestricted access by staff to residents in the event of an emergency when keys were left inside these doors in engaged locks.

4. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

Turn key locks to be placed on all bedroom doors in one of the community homes.

Proposed Timescale: 25/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no evidence that the use of key operated manual call points on the fire alarm system had either been certified as a variation from the Irish Standard 3218: 2013 Fire Detection and Alarm Systems for Buildings or that the arrangement had been appropriately risk assessed.

5. Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:

Key operated manual call points on the fire alarm system have been certified and appropriately risk assessed.

Proposed Timescale: 04/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Fire drill records where challenging behaviour by some residents had been noted during drills but there was no evidence that procedures and/or staffing levels had been reviewed in ensure evacuation of these residents was not compromised in the event of a fire.

6. Action Required:

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:

In House Fire Drills are completed on an ongoing basis by staff as part of our overall fire safety training programme. The purpose of completing these fire drills is to allow the clients to become familiar with the sounds & tones of the fire alarm system and to practice the evacuation procedures for the unit.

However, given the nature of residents who reside in our unit, we sometimes are confronted with challenging behaviour during this exercise. Evidence from previous fire drills shows that some clients may become distressed or anxious due to the sounds of the fire alarm and the nature of activity taking place.

In-house procedures have been reviewed following our fire training and at present the procedures are as follows;

The evacuation from our unit takes place on a phased basis such as –

Phase I - Move persons outside the room of origin, to the nearest smoke free area.

Phase II - Move persons horizontally to a neighbouring compartment.

Phase III - Move persons to a final exit and external assembly point.

The first priority is always to move any service user who is in immediate danger to a safe area.

However, for the purpose of a speedy evacuation, the evacuation of residents is carried out in the following order of priorities:

(a) service users requiring only a member of staff to guide or direct them;

(b) service users requiring minimum assistance;

(c) service users who have to be physically moved or carried

Special care is needed in the evacuation of any non-ambulant residents and evacuation sled can be employed to assist with evacuation which is available within the unit.

An evacuation has taken place in each residential unit on the 25.06.15 and 06.07.15.

These will continue to take place on a regular basis.

Proposed Timescale: 06/07/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The system in place to monitor the quality and safety of the service was not robust and required further development.

Action plans were not developed to clearly identify the action to be taken to address deficits found in audits and to enable tracking to satisfactory completion.

7. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

A system has been put in place to monitor the quality and safety of the services. Action plans have now been developed to clearly identify any deficits found in the Audits. This action is ongoing.

Proposed Timescale: 30/09/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A review of staffing levels and skill mix was not completed in one community house to ensure residents could be evacuated safely in one of the community house in the absence of evidence that evacuation drills were completed to assess day and night-time conditions.

8. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

Simulated fire evacuations (representative of day and night time conditions) have been carried out in both residential units on the 25.06.15 and 06.07.15. These will continue to take place on a regular basis.

Proposed Timescale: 06/07/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

A number of policy documents did not inform practice due to the absence of adequate information.

A policy document advising on residents' access to education and training was not available.

All members of a regional safe-guarding team had not been established to support the HSE National Safeguarding policy requirements and as such implementation of the policy into practice was hindered in the absence of clear referral and support pathways.

9. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:

All policies identified, Nutrition, Communication, Challenging behaviour, Education and Training and the Admissions and Discharge inclusive of temporary absence are currently been reviewed.

In the absence of the HSE safeguarding and protection team been established and in consultation with the principal social worker who has responsibility for the over-seeing of these protection teams, A clear referral and support pathway has been identifies and is now operational.

Proposed Timescale: 08/09/2015