

**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-0003999
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	Michael Keating
Support inspector(s):	Finbarr Colfer; John Greaney
Type of inspection	Unannounced
Number of residents on the date of inspection:	80
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 20 October 2015 09:00 To: 20 October 2015 19:00

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

Outcome 06: Safe and suitable premises
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

Prior to this inspection during 2015, HIQA had undertaken eight inspections of these centres and had a series of meetings with the provider to require action to address the serious concerns of HIQA about the safety of residents in these centres, the poor quality of life for residents and the poor governance and oversight of the centres. HIQA had required the provider to undertake immediate actions during previous inspections, had issued the provider with a warning letter and had issued the provider with a notice of improvement which the provider failed to comply with fully.

Following the most recent engagement with the provider, they had submitted to HIQA a programme of actions that they stated had been implemented to address the areas of significant concern. Prior to the court proceedings, HIQA undertook this inspection to confirm whether the actions had been implemented and whether they had been effective in ensuring a safe and good quality of service for residents. This information would inform any decision to proceed with the court action.

Overall, while inspectors found that there had been progress on many of the actions contained in the provider's submission, there continued to be significant concerns in

relation to governance and management in the centres and the impact that this has had on the safety of residents.

Following previous inspections, HIQA had identified residents who were not appropriately supported and who were a risk to the safety of other residents as a result. The provider had informed the Authority of specific measures that had been put in place to manage this risk and reported that the measures were effective in reducing the number of peer to peer assaults in the centre. On this inspection, inspectors found that these measures were being suspended at specific times during the day to facilitate staff breaks and medication rounds. Neither the centre nor campus management had identified this as a risk even though there had been incidents of peer to peer assault during these periods. As a result, residents had been injured, with one resident requiring hospitalisation as a result of injuries.

At the time of the inspection, the provider had not taken any action to address this risk and inspectors issued the provider with a requirement to take immediate action to ensure the safety of all residents. The provider responded before the end of the inspection and inspectors were satisfied that the action taken would reduce the risk to other residents.

While inspectors found that the provider had made progress on implementing other aspects of the plan submitted to HIQA, there continued to be significant levels of non compliance with the requirements of the regulations and National Standards.

Adequate management arrangements were not in place at the time of the inspection. However, the provider told inspectors that there had been a successful recruitment process for a person in charge for each of the centres, and that the new persons in charge would be taking up their positions in late 2015 and early 2016. Inspectors found that the provider had taken action to reduce the number of residents sharing dormitories in St Raphael's Residential Centre, while retaining current staffing levels. The provider had also recruited social care workers to work in Youghal Community Hostels.

In relation to the premises, inspectors found that the premises in St Raphael's Residential Centre and in Youghal Community Hostels were not fit for purpose and did not provide residents with a living environment that met their needs. The provider has committed to moving residents from these centres to more appropriate living arrangements and had undertaken works in St Raphael's Residential Centre in the dormitory sleeping areas to improve privacy and dignity arrangements for residents. These had been found to be majorly non compliant on previous inspections.

While the provider had started to audit incidents and accidents, there was a failure to identify key risks to residents and to use the audits to improve the safety of residents.

Following the inspection, given the continuing risk to the safety of residents and poor governance arrangements, HIQA decided to proceed with the court action to have specific restrictive conditions placed on the registration of the centres. HIQA also

required the provider to have a suitably qualified person from outside of the centres to undertake a review of staffing levels and staffing arrangements to ensure that they met the needs of residents and to undertake an independent investigation of a specific incident in the centre. The provider was required to submit the outcome from these reviews to HIQA and to inform HIQA of actions to be taken to address any areas for improvement that might be identified.

HIQA also required the provider to undertake an audit of their services around specific critical requirements relating to the safety and wellbeing of residents, to develop an action plan in response to any issues identified and to submit both to HIQA.

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 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):

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

Findings:

While residents remained living in inappropriate dormitory style settings, enhanced measures had been implemented to provide improved privacy to residents. Beds had been partitioned separating one bed from another, and privacy curtains were also in place. In addition, numbers of residents within bedrooms had been reduced. Inspectors visited the three units in St Raphael's Residential Centre. Two of the units were operating on the day of inspection, while renovations to the third unit were nearing completion. Inspectors were assured that the three units would be in operation from Tuesday 27 October and this would reduce numbers of residents residing in the other two units.

While these changes improved the environment for residents, the premises continued to be unfit for purpose and the provider had informed the Authority of plans for the closure and transfer of residents to more suitable living environments. It remains the case that this rearranged living environment falls significantly short of what could be called a suitable living environment. Thirty one residents were living in three units on the ground floor of an old inaccessible multi-story building. The transition plan commits to the closure of this premises by March 2017 to ensure that residents individual and collective needs are met in a more suitable, comfortable and homely way.

As has been previously identified within inspection reports, Youghal community hostels remain not fit for purpose. Both hostels were not designed or laid out to meet the individual or collective needs of residents. Many of the residents shared twin rooms and several residents with assessed mobility issues had difficulty using the stairs. The premises were observed to poorly maintained and in need of decor and repair. Damp patches were visible on walls and stained ceiling tiles. While the provider has confirmed their intention to close these units and move residents to more suitable accommodation

a timescale has yet to be agreed for this to happen and would be judged to be an urgent requirement to meet the assessed needs of an ageing population.

Judgment:

Non Compliant - Major

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):

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

Findings:

Inspectors found that the arrangements for the management of behaviour that challenges was inadequate, did not adequately safeguard residents and was impacting on the safety and wellbeing of residents.

As identified on previous inspections most staff had not received training in relation to behaviours that challenge including de-escalation and intervention techniques. Many residents across the centres had support requirements in this regard. Many positive behaviour support plans for these residents referred to the intervention of staff; but staff had not been provided with the skills to implement the plans. Many behavioural support plans were also incomplete. The director of nursing did provide a training plan to indicate that 100 staff would be trained by the end of 2015, with the remainder to be trained in January 2016, in line with the timeline agreed following the last inspection. Once trained, there would need to be a management plan to ensure implementation of the learning so that supports for residents are improved.

An inspector read about a restraint intervention used with a resident in response to a significant behavioural incident. This resident's behavioural support plan did not provide adequate information on the de-escalation or intervention techniques to be used by staff. This resident's file contained a 'comprehensive behaviour assessment' form that was not filled in. The director of nursing was aware of the incident, and stated that she believed the restraint practice to have been carried out in line with best practice. However, apart from speaking with the staff member involved, she had not undertaken a sufficient investigation into the use of this significant, unplanned restraint measure and was not aware of the detail of the incident as recorded in the nursing notes. She

was also unaware of a wound that was reported the following day in the nursing notes that may have been related to the incident of restraint.

One unit within Oakvale residential centre was described as a 'high-support challenging behaviour unit', and the practice of locked doors was a feature in this unit. Staff and the provider were unable to provide evidence to demonstrate that this restrictive practice was appropriate to the needs of each resident and was the least restrictive for the least duration. Inspectors found that while staff told inspectors of various incidents of behaviours that challenge from different residents, the records made reference to infrequent minor incidents of behaviour. For example, one resident had three incidents recorded since November 2014, of which only one could be described as a behaviour that challenges, and none of which provided sufficient evidence to support a decision to retain the resident in a locked environment. In addition many residents had 'comprehensive behaviour assessments' and 'aggression risk assessments' contained within their behavioural support plan folders that were blank. Behaviour support plans were in place however they were not being used consistently

In addition, while behavioural risk assessments were noted as being reviewed quarterly, the date of review was not recorded. As a result the staff nurse in charge of unit(s) could not identify when the last review took place.

Analyses of incidents and accidents were now taking place as part of weekly and monthly management meetings. This analysis provided evidence to inspectors that the frequency of incidences such as peer to peer aggression had reduced significantly in recent months. However, as detailed within Outcome 14, known triggers to escalated behaviours were not used to reduce risk and this was leading to critical incidents which impacted on the safety of residents..

By this inspection, the majority of staff had completed safeguarding vulnerable adults training; the remaining 20 staff members were due to receive training by the end of October 2015.

Judgment:

Non Compliant - Major

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:

Overall inspectors were not assured that appropriate management systems were in place to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. Residents had been injured because adequate safety and monitoring arrangements were not in place to meet the assessed needs of resident(s) with complex support needs. An immediate action plan was issued to the provider during this inspection to ensure that adequate measures were being taken to mitigate the immediate risk identified.

The governance arrangements were not ensuring that the service was implementing planned staffing arrangements to ensure the safety of residents and the provision of consistent support and care. Residents were not being adequately protected from peer to peer incidents of aggression and this was a recurring finding in inspections of these centres. Inspectors read about three incidents relating to the suspension of one-to-one staffing supports to facilitate staff break times. The most recent incident led to the significant injury and hospitalisation of a resident. Following the inspection, the person in charge submitted a copy of a critical incident investigation report relating to this incident. This report confirmed that conflicting guidelines were provided to staff in relation to supervision levels and also clarified that one-to one supports were suspended each day to accommodate staff lunch breaks. During this period, the resident was accommodated with other residents in a unit, but that unit's staffing was reduced from six to three during this time to accommodate staff lunch breaks, thereby reducing further the level of support for this resident and for others in the unit.

Additionally the report confirmed that an incident review meeting had taken place on the day before the most recent incident which acknowledged that the resident who was placed in the main unit during lunch break was not happy with this situation. The report states that they intended to cease this practice when the 'third unit opened on the ground floor as we would then have the available extra staff'.

The report stated that the provider's response to the immediate action plan issued on the day of inspection was being implemented to mitigate the risk.

While changes had been made to the governance structures, inspectors found that the management structure remained ill-defined. There were a number of local management arrangements in separate centres and units within centres. While these arrangements had the potential to support and enhance local governance, inspectors found that senior staff at times were reluctant to accept responsibility for the delivery of services to residents. For example, in the critical incident referred to above, senior management stated it was the responsibility of the local nurse in charge (including staff nurses and clinical nurse managers) to ensure adequate staffing levels were maintained to prevent such incidents occurring. However, there was no process to ensure that this was being implemented at unit and centre level.

However, while continuing to be majorly non compliant, there were some improvements

in the governance structures since the previous inspection. Interim arrangements were now in place with a person in charge assigned to each of the three separate designated centres, but accountability for delivery of services and implementation of service measures were not in place. The provider informed inspectors that recruitment to appoint a permanent persons in charge to each centre was at an advanced stage. It was also noted that regular formal management meetings were now taking place on a weekly basis and these incorporated analysis of incidents and accidents occurring in the centres, but this information was not being used effectively to ensure the safety and quality of life for residents.

Judgment:

Non Compliant - Major

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:

While there was some improvement in staffing levels across the centres since previous inspections, the skill mix of staff in some centres did not adequately meet the assessed needs of residents. For example, many residents were not availing of any form of day service, and were relying upon the residential staff for daily activation and stimulation. For many residents this was provided for in communal day rooms located within their residential centres. Inspector's observed limited social interaction for many of these residents. Care plans detailed minimal activity, with many residents having little or no opportunity to engage in activity outside of the centres. Those who were leaving the centres availed of a walk on the campus or a drive. In this regard social interaction and activity was insufficient and there was little by way of meaningful activity provided to many residents. Staff were not trained in common social care concepts such as person centred planning or goal setting.

However there was evidence of increased activity and meaningful engagement with residents within Youghal Community Hostels. Social care workers had been employed in this centre and inspectors found evidence that the additional skill mix was now showing signs of enhanced outcomes for residents, as evidenced by discussion with staff and residents and through the development of person centred care plans.

Inspectors were also reassured by the commitment given by the persons in charge and by the director of nursing that staffing support would not be reduced following the transfer of residents across the three units on the ground floor of the the centre with mutli-occupancy rooms. This would mean that staffing levels would be maintained in each unit, while providing care and support to fewer numbers of residents. Inspectors were informed that this reduction in staffing would allow for the development and implementation of appropriate person centred plans for these residents.

As referred to previously, there was a comprehensive training plan for staff to complete mandatory training in areas such as safeguarding vulnerable adults, positive behaviour support and manual handling. While not all staff were trained in some of these areas the director of nursing was confident that timelines agreed following the last inspection would be met.

Judgment:
Non Compliant - Major

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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