Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002469
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joseph Ruane
Lead inspector:	Jillian Connolly
Support inspector(s):	Catherine Rose Connolly Gargan;
Type of inspection	Announced
Number of residents on the date of inspection:	5
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:
27 April 2015 10:30	27 April 2015 18:00
28 April 2015 09:30	28 April 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

Inspectors undertook ten inspections in eight centres operated by the Health Service Executive (HSE) through St Peter's Services in Westmeath in 2015, four of which were announced and six unannounced.

These inspections found evidence of poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued immediate actions and warning letters. Regulatory and escalation meetings were also held with the provider

and members of senior management of the Health Service Executive.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to refuse the registration of one of the centres was issued. Following on from this, the provider informed the Chief Inspector of their intention to cease the operation of four houses within the region. The purpose of this was to consolidate the staffing levels in the remaining twelve houses.

HIQA has been informed by the provider that the process for assuming operational and governance responsibility is now complete and the contract has been awarded to another service provider.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection was conducted following on from an application by the registered provider to register the designated centre under the Health Act 2007. The application submitted to the Chief Inspector was to provide services for up to five residents. The centre is a four bedded bungalow which is located in Westmeath and is operated by the Health Service Executive.

A monitoring inspection was conducted in the designated centre in November 2014. At that time there were two community houses inspected as part of one designated centre. Since the inspection, the registered provider informed the Chief Inspector of their intent to operate the community house as one designated centre. There were significant failings of regulation identified in November 2014. This resulted in a warning letter being issued to the registered provider alongside a regulatory meeting being held to inform the provider of the significant risk identified by inspectors.

As part of this inspection, inspectors followed up on matters arising from that inspection. The findings of this inspection, demonstrate that there was an inappropriate and disproportionate response to the failings from the last inspection by the registered provider to ensure that the services provided were safe and effective.

Inspectors met with residents, relatives and staff on inspection. Inspectors also observed practice and reviewed documentation as part of the methodology for gathering evidence. Inspectors found staff to be caring towards residents. However, the findings of this inspection, demonstrated that in the absence of appropriate staffing levels, staff training and support from management, staff did not have the skill set or competency to meet the needs of residents.

Of the eighteen outcomes inspected, compliance was identified in two outcomes, communication and notification of incidents. Moderate non - compliance was identified in five outcomes which are listed below:
Outcome 7: Health and Safety and Risk Management
Outcome 11: Health care needs

Outcome 12: Medication Management
Outcome 13: Statement of Purpose
Outcome 18: Records and Documentation

Major non compliance was identified in the remaining eleven outcomes:
Outcome 1: Residents' Rights, Dignity and Consultation
Outcome 3: Family and Personal Relationships
Outcome 4: Admissions and Contract for the Provision of Services
Outcome 5: Social Care Needs
Outcome 6: Safe and Suitable Services
Outcome 8: Safeguarding and Safety
Outcome 10: General Welfare and Development
Outcome 14: Governance and Management
Outcome 15: Absence of the Person in Charge
Outcome 16: Use of Resources
Outcome 17: Workforce

There were 33 breaches in regulation identified, twenty four of which are the responsibility of the registered provider. Nine of the failings were the responsibility of the person in charge. Governance and Management remained weak and ineffective.

The findings of this inspection are discussed further in the body of this report.

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

Findings:
The designated centre had organisational policies and procedures for the receipt and management of complaints. Staff were aware of the procedure to be followed and there was a register of compliments/complaints maintained in the hallway of the centre. There was one compliment documented and no complaints. However whilst the procedures were in compliance with regulation, inspectors found that the location of the complaints register was inappropriate as it was open and therefore all recorded information could be accessed by anyone entering the premises. Family members stated that whilst they had never had a reason to complain, they were satisfied that they could and there would be no adverse outcome to their relative. There is an independent advocate available for residents if they so wish to avail of the service.

Inspectors were informed that consultation with residents was part of the daily routine. Residents were included in staff meetings within the designated centre, there was no individual or collective residents' meetings. Inspectors found that staff meetings were an inappropriate forum for residents to partake in. From a review of minutes it was found that the agenda consisted of operational issues and issues pertaining to individual resident needs. Therefore it is not appropriate for all residents in the house to be aware of the personal information of individual residents. Family stated that they were consulted with.

The designated centre is a four bedroom house and is the home of five residents. Therefore two of the residents share a room. There is a sitting room and a kitchen/dining room. As three of the residents have their own room, they were

facilitated to undertake personal activities in private. However inspectors found that the privacy of the residents sharing the twin room was compromised due to the absence of personal private space and the layout of the room. The residents sharing the room had an en suite. However inspectors were directed to utilise this en suite for their own personal use whilst on inspection. Inspectors also observed personal information of residents to be stored in an unsecure location.

Inspectors were not assured that the procedures in place to safeguard and respect resident's personal possessions were robust and effective. There were Health Service Executive guidelines in place for the management of personal belongings of residents. However, it was not adhered to. There was no record maintained of residents' own personal belongings. It was stated in the written agreement to be completed on admission of the terms and conditions of residency that this would be maintained. A finding from the last inspection was that there was inappropriate individualised lighting in the twin room. This, as stated in Outcome 6, had been addressed. However on review of resident's personal belongings and finances, inspectors found that the lamp had been purchased from the residents' own personal funds. There was no evidence that the resident had consented to this. This was also in contravention to the policy of the organisation. Inspectors informed management team of this at the close of inspection, who stated that that resident would be reimbursed immediately. There was also a discrepancy identified by inspectors in respect of resident's personal finances. Inspectors found that residents had on occasion borrowed money from each other; however this was not done in consultation with the residents. There was one instance identified by inspectors where money was withdrawn from one resident's account to 'pay back' another resident. The money however had not been logged in the recipients account. The money was found, whilst inspectors were on the premises. However the discrepancy did not demonstrate appropriate and respectful practices in regards to resident's finances.

There had been improvement in the opportunities residents had to attend activities in the local community since the previous inspection of the designated centre. Records confirmed that there had been an increase in the activities offered and received by residents. Inspectors observed in practice, three residents to be out for the first day of inspection, one resident attending their day service and two residents on an outing. External providers coming to the centre to conduct art sessions were observed, on the second day of inspection. However, on the first day of inspection the remaining two residents were provided with limited opportunity for activity. Staff attempted to support residents however due to the task orientated activities this was for brief periods of time. On the second day of inspection, the external activities provided to residents were individual and lasted approximately twenty minutes per resident. Staffing levels also provided limitations to the activities provided to residents. The standard staffing levels were two staff on duty at all times in the designated centre. An additional twenty hours of staff had been allocated specifically to support residents to partake in activities since the last inspection, however based on the supports required by residents, and factors such as absenteeism, the additional staff were not always utilised for activities. Staff confirmed that this is a challenge. Inspectors reviewed the activity records for one resident and found that in a twenty six day period the external activities were in the main, a walk or a drive. Therefore improvements were required to ensure that the activities were individualised and in line with the interests of the residents. This is

discussed further in Outcome 5.

Judgment:
Non Compliant - Major

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 were organisational polices in place regarding communication with residents. Residents had received assessments of their communication needs by the appropriate Allied Health Professional. There were communication guidelines in place for residents to inform staff of the needs of residents. Staff were observed being aware of both the verbal and non verbal needs of residents.

There was a television and radio in the designated centre, in which residents could access local media. Residents also had technology such as tablets and personalised radios.

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:
Relatives stated that they were very welcome in the designated centre at all times. There was a policy in place for the receipt of visitors. This policy was a general policy for the Health Service Executive and therefore did not address the constraints that the

environment presented with. For example, the absence of an area in which some residents could meet visitors in private. There was a record maintained of all visitors to the designated centre. Families further stated that they were kept informed of the well being of their relative. Inspectors were informed that residents had been referred to a friendship group in order with assisting with developing their relationships outside of their home. There was evidence that residents went to parties and out for dinner in community amenities. However there was an absence of involvement in the local community outside of these activities.

Judgment:
Non Compliant - Major

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:
Residents had a copy of a written agreement between residents and the registered provider. However these contracts were not signed as the person on charge stated that they had just been issued prior to the inspection.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Inspectors confirmed that each resident had an assessment in place, which identified their health and social care needs. Once a need was identified, there was a plan in place which aimed at identifying the actions/interventions required to meet that need. However inspectors determined that a significant improvement was required in order to ensure that the personal plans in place were meaningful, person centred and effective to ensure positive outcomes for residents. For example, there were person centred plans in place which identified the likes and dislikes of residents. From this, goals had been set. However, inspectors found that in the main the goals were short term and did not promote skill building and lifelong learning. Considering the age range of residents, this did not promote a culture of expectation for residents' ability and development. There was also an absence of assessment to ascertain how the goals would be met i.e the resources required and the individuals responsible for ensuring that the resident achieved the goals. Goals documented included, going on a holiday, a trip home, going to the leisure centre, going to the zoo, going to mass and going to a pet farm. Inspectors determined that the absence of assessment also did not facilitate a review of the goals once achieved. The person in charge stated that this was a work in progress which was the rationale for the deficits identified by inspectors. This was further evidenced by an audit completed by the person in charge in March 2015 which identified the actions required however inspectors were not assured that the audit was robust as it did not identify the deficits identified on this inspection, such as the quality of the goals. Due to deficits previously mentioned and an absence of signatures and dates, inspectors determined that additional supports were required to ensure staff were supported to develop the skill set and competency necessary to support residents in meeting their social care needs. This was further evidenced by the activities that were offered to residents. As previously stated there had been improvement in the opportunities residents had to partake in activities, a review was required to ensure that they were meaningful.

There was also an absence of evidence to support that the personal plans of residents had been completed in consultation with a residents' circle of support such as family members and friends, due to an absence of detail as to who was involved in the planning process. In the main, goals were set primarily by the key worker of the resident.

There had been a significant increase in the access residents had to Allied Health Professionals since the last inspection. However, there was an absence of evidence to support that the recommendations of the professionals were implemented in practice.

There was a policy in place regarding the admissions, discharge and temporary absence of a resident for the Health Service Executive. The sample written agreement that inspectors reviewed also stated that if a resident is moving they will be provided with an accessible guide. However neither of the documents were reflective of the designated centre and the actual criteria for discharge.

Judgment:
Non Compliant - Major

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:
The designated centre is a bungalow located in a rural area. The house consists of four bedrooms, one of which is en suite. A communal shower room/toilet, a sitting room, kitchen/dining area and utility room. There was also an external room/toilet which inspectors were informed was utilised for the purposes of activities. External grounds consisted of a front and back garden. The house is located on a hill which provides attractive views of the country side. Inspectors found that the house had been decorated to reflect the individuals who resided there. This included photographs of residents. However inspectors determined that a review was required of the premises as due to the size and layout, it did not provide for the matters as stated in Schedule 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Inspectors determined that there was inadequate communal space for residents. For example, the sitting room measured 13.5 m 2, for five residents. Inspectors did not have the opportunity to observe all residents in the living area at one time however did observe four individuals (inclusive of inspectors) in the room and found it to be crowded. The kitchen/dining room did provide additional seating area, a dining table and kitchen. However this was also the area which was utilised as an office space for staff. The single occupancy rooms were of an adequate size for the residents residing in the rooms, however as stated in Outcome 1, the twin room was not fit for purpose. The room measured 2.7 m 2 in width and 4.6 m2 in length (total 12.4 m 2). Included in this space were two beds, wardrobes, bedside tables and a privacy screen. Due to the location of the wardrobe and the entrance to the en suite it was not possible for one resident to have their bed side locker, beside their bed. A matter arsing from the previous inspection, was that there was inadequate personal lighting in the twin room. As stated in Outcome 1, this had been addressed. There was also inadequate private space, for the residents residing in the twin room. Inspectors were informed that the sitting room was available however observed residents who continuously entered the room for short periods of time throughout the day regardless of the occupancy, which is their right.

This however resulted in no private space for residents sharing a room.

Inspectors observed the external activity room to be multi-purpose and include archived files, fridge/freezer/complimentary therapy table, photocopier and general storage.

Inspectors were not assured that the centre was consistently maintained in a good stated of repair, as whilst the general areas were observed to be clean. The communal bathroom was not observed to be of a suitable standard as the flooring was stained, there was an absence of a toilet seat, and the shower chair was visibly dirty. This is discussed in Outcome 7.

Judgment:
Non Compliant - Major

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:
There were policies and procedures in place regarding health and safety and risk management. There was a risk register in place however inspectors determined that it was not effective and did not adequately identify all hazards within the designated centre. Of the hazards identified, inspectors found that the control measures were not consistently implemented in practice. For example, the risk of staff lone working had not been assessed, which occurred regularly when the second staff was supporting a resident to attend appointments. The risk of staff supporting residents who were not permanent i.e. agency staff had not been assessed, although this occur. Inspectors also found that the control measures identified were not consistently implemented. For example the control measure in place for the risk of injury to driver due to grabbing of the seat belt stated supervision at all times. However this was not a practical measure as, in the main, there were only two staff on duty, therefore one staff would be regularly driving without the support of another staff. A control measure which was identified for the risk of residents being absent without leave was that the front door was to be locked when residents were at home. Inspectors observed the front door to be unlocked. There were residents residing in the centre who were assessed as being absent without leave. A finding on the previous inspection was that a control measure identified for supporting residents who exhibit behaviours that challenge was that all staff would receive appropriate training. However not all staff had received the appropriate training. Inspectors found that this had not been sufficiently addressed on this inspection and there were still staff who had not received the training. There was

also regular utilisation of unfamiliar staff for residents. There was no system in place to ensure that they had received the appropriate training prior to commencing work in the centre.

In addition to the general risk register, there was a system in place in which individuals were risk assessed for particular needs, such as manual handling or risk of being absent without leave. However, the information documented was not always accurate. For example, there was a resident documented as requiring the supports of two staff for all manual handling activities. Following review of this document, Inspectors were concerned as this inferred that other residents were regularly left unsupervised whilst the two staff on duty supported the resident. However, on meeting the resident and discussing their needs with staff it became apparent that only one staff was required.

Inspectors reviewed the systems in place for the management of infection control. This had been a failing identified on the previous inspection. Inspectors were not assured that the failing had been adequately addressed. The provider had stated that an audit had been completed in respect of infection control in the action plan response submitted to the Authority. However there was no evidence of this audit on inspection and deficits in practice were identified by inspectors. There were cleaning schedules in place and in the main inspectors observed communal areas to be clean. However as stated in Outcome 6, the shower chair was visibly dirty and not fit for purpose. Risk of transmission of a communicable infection was a risk within the centre. However inspectors determined that whilst there were policies and procedures to be followed by staff in order to safeguard all residents from cross – contamination, the practice was not in line with same. For example, the appropriate equipment was not available as required and staff were not knowledgeable on the actions to be taken.

Following on from the previous inspection, the registered provider had engaged the services of an external fire consultant to assess the fire management systems in place. Inspectors reviewed the report and found that actions identified by the fire consultant were in keeping with findings of inspectors in relation to all final exits being secured by a key. As staff carry the key on their person, this could result in an unnecessary delay in the event of an emergency or prevent a resident from independently evacuating the building. Inspectors were informed that this was in the process of being addressed. There were procedures in place in respect of fire which informed of the actions to be taken in the event of a fire. Each resident had an emergency evacuation plan which identified that the maximum support required by any resident was one staff. Another community house had also been identified as a place of safety. The fire equipment was serviced at regular intervals and checked regularly by staff. Permanent staff had received location specific training in fire management. Fire systems were also included in the induction of non-permanent staff. However the success of this is reliant on a permanent staff being on duty at all times. There was one instance in the three months reviewed by inspectors where there were no permanent staff supporting residents. A fire drill had been conducted which demonstrated that all residents could be evacuated with the support of two staff within an appropriate time frame.

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

Findings:
Inspectors met with family members during the course of the inspection, who stated that they felt that their relatives were well cared for and safe. A failing identified on a previous inspection was that whilst there were policies and procedures regarding the safeguarding of vulnerable adults in place, incidents of unexplained bruising had not been investigated in line with the organisation policy. The provided stated in their response to the failing that an investigation was being conducted with immediate effect. This report was submitted to the Chief Inspector. The findings of the investigation substantiated the findings of the Authority. The rationale for the bruising could not be definitely determined however numerous factors inclusive of absence of appropriate assessment and plans of care were contributing factors. The investigation further found as the policies and procedures were not adhered to safeguarding mechanisms had not been implemented, such as comprehensive assessments and plans of care. Inspectors found that the recommendations from the investigation report were in progress, however had not been completed. This included developing a meaningful day for residents, however as evidenced in Outcome 1 and 5, this was yet to be achieved.

The provider further stated in their response to the action plan to this failing that all staff would receive updated training on the policy of the protection of vulnerable adults. The provider stated the rationale for this was to improve the practice of staff and to clearly inform staff of the procedure to be followed in the event that they discover bruising. Inspectors reviewed the training records and found that staff had not received updated training as of the day of inspection. Six staff had read the policy on safeguarding implemented by the Health Service Executive in December 2014. Inspectors determined that this was an inadequate and disproportionate response by the registered provider to the failings identified on the previous inspection and to the recommendations identified in the report commissioned by the provider. In January 2015, it had been identified that not all staff had read and signed the policy however no action had been taken to address this as some staff signatures were omitted as of the day of inspection.

As stated in Outcome 1, inspectors were also not assured that the systems in place to protect residents from financial abuse were robust and implemented in practice. The policy in place regarding the management of resident's personal finances stated that resident's could be managed through the patient's private property account. Resident's also had personal accounts. However inspectors found that the systems in place for the withdrawal of residents' personal monies were not safe and therefore a risk was present. The internal procedure was that two staff would check and sign residents' personal monies as a safeguard. This was not occurring as identified in an internal audit. However inspectors found instances where it was still not occurring post the findings of the audit.

As stated in Outcome 1, external providers had been obtained to provide activities to residents within the designated centre. Inspectors observed residents individually attending the activity without the support of staff in the external room. Inspectors requested to view the Garda vetting form to ensure that all measures had been taken to safeguard residents. Inspectors were informed that this had not been sought.

There had been four breaches of regulation identified regarding the provision of positive behaviour support in November 2014. Inspectors observed that progress had been achieved towards compliance in this area. Staff had read the policy in relation to restrictive interventions as stated in the action plan response. Residents had been referred to and were being assessed by the appropriate Allied Health Professional as of the time of inspection. A review had been conducted of medication prescribed to residents and medication as required in response to behaviour that challenges had been discontinued. Staff had received training in de – escalation and break away techniques, as stated in the action plan. The provider had stated that all staff employed in the designated centre would also receive training in positive behaviour support by January 2015. This has not occurred as of the day of inspection. Inspectors noted that this deficit was preventing the successful implementation of the positive behaviour support plans as staff were not engaging in the process. For example, if a resident engaged in an incident of behaviours that challenge, there was no evidence that staff were implementing the proactive and reactive strategies identified in the support plan.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors confirmed that a record of accident and incidents were maintained in the designated centre. Inspectors found that all notifiable events had been submitted to the Authority as required by Regulation 31 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 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
A finding of the previous inspection was that residents were not supported to access opportunities for education, training and employment. The provider responded by stating that each resident would be reviewed with a particular focus on education, training, skill building and employment and where identified needs are identified the key worker would support residents to access the required supports. This was to be achieved by December 2014. Inspectors found that this action had not been adequately addressed. There was no policy in place specifically pertaining to access to education, training and employment. There were policies in relation to person centred planning and access to friendship groups. Referrals had been sent for residents to avail of the friendship group services. Inspectors found that there was an absence of expectation for residents' ability and potential for lifelong learning. One resident had access to a formal day programme four days a week. There had been attempts to secure a placement for another resident however this had not yet been achieved as of the day of inspection. A report completed by an Allied Health Professional in April 2015 found that one resident needed to be 'empowered' and not 'minded' as there was a 'learned helplessness.' Inspectors found that this was a culture within the organisation which impeded residents' opportunities for autonomy. Immediate attention was required in the area of day care provision outside of the centre for residents.

Judgment:
Non Compliant - Major

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

Findings:
Failings identified in November 2014 pertained to residents' health care needs not being met through evidence based practice and access to Allied Health Professionals. As stated in Outcome 5, there had been a substantial improvement in the access residents had to Allied Health Professionals inclusive of psychiatry, psychology, dietician, occupational therapy, physiotherapy and speech and language therapy. Residents had an assessment in place of their health care needs. Once a need was identified a plan of care was developed to inform of the interventions/supports residents required to meet that health care need. Inspectors confirmed that residents had regular access to their General Practitioner.

Whilst there were plans of care in place improvements were required to ensure that the needs of residents could be met in the centre. For example, residents in the designated centre had a diagnosis of epilepsy. There were instances however where a registered nurse was not on duty. As the policy is that all medications are administered by a registered nurse, this resulted in a registered nurse from another centre attending to administer medication. However there was a significant risk present with this system, as one resident required medication as required in the event of a seizure. It had not been risk assessed if a registered nurse attending from another centre, to administer same was safe, considering the medication must be administered with two minutes of the seizure commencing.

Inspectors were not in a position to observe a meal time of residents, as due to the needs of residents, the presence of inspectors at this time resulted in a negative outcome for residents. However inspectors did observe that a minimum of two staff were required to support residents at this time. The person in charge was not allocated to work in the centre on the day of the inspection, and was present to facilitate the inspection. Of the two staff on duty, one staff member was absent as they were supporting a resident to attend an appointment. However inspectors observed the person in charge having to support the second staff member at this time. Residents' weight were monitored regularly. Residents had also been referred to the appropriate Allied Health Professional. There had been a system developed which aimed to instruct of the individualised requirements of residents, however on review inspectors found it to be a generic document which did not identify the individual needs of residents. There was no evidence that the food provided was in keeping with the plans of care for residents i.e. high fibre diets/low fat options.

Judgment:
Non Compliant - Moderate

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

Findings:
The centre had policies and procedures in place regarding the medication management process, however it was out of date. Inspectors reviewed a sample of resident's prescription and administration records and confirmed that all of the pertinent information was present. The administration times recorded correlated with the times prescribed. Medication was stored securely and there was a system in place for discarding out of date or unused medication. The centre also had the support of the pharmacist to review the practices in place to ensure that they are safe and in line with best practice.

The centre had a policy in place in which medication was only administered by a registered nurse. This system did result in restrictions for some residents with a diagnosis of epilepsy. Residents were prescribed medication as required in the result of a seizure therefore the resident required the support of a registered nurse at all times.

As stated previously, the designated centre had been required to submit a weekly report to the Chief Inspector from December 2014. The report identified that there had been six medication errors in the designated centre over a six week period. Four of which occurred over a two day period. Inspectors found that whilst the errors were recorded, there was no evidence that adequate control measures or actions had resulted from these errors to reduce the likelihood of a reoccurrence.

Judgment:
Non Compliant - Moderate

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

Findings:
The registered provider submitted a Statement of Purpose to the Chief Inspector as part of the application to register the designated centre under the Health Act 2007. Inspectors reviewed the document and found whilst it contained all of the items as stipulated by Schedule 1 of the regulations, the information contained was not reflective in practice. For example, the objective of the organisation as 'to promote independence whilst enabling individuals to lead lifestyles of their choice promoting dignity, respect and community inclusion.' The findings of this inspection evidence that this does not occur in practice. The document is also reflective of the entire region as opposed to reflective of the actual designated centre i.e. there is a reference to residents residing in other designated centres.

Judgment:
Non Compliant - Moderate

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:
Since the previous inspection there had been a change in the person in charge of the designated centre. The person in charge identified on the application to register and present on the day of inspection had commenced their post on the 29 January 2015. There had been a period of two months in which there had been no person in charge of the designated centre. The person in charge is employed on a full time basis for the designated centre. In the main, they are included in the compliment of staff with twelve hours a week allocated as protected time in which they do not provide direct care to

residents. However this protected time is available for three weeks of a five week period. The person in charge completes rotational day and night rosters, as a result they are employed on night duty as front line staff for two weeks in the five week period. The person in charge has the relevant qualifications and experience to fulfil the statutory requirements of Regulation 14.

The person in charge reports directly to the assistant director of nursing who in turn reports to the regional director of nursing. The regional director supports to the disability manager who in turn reports to the general manager. The general manager is the person nominated on behalf of the provider. Following on from the previous inspection, a working group was established to address the significant failings identified in i inspection of November 2014. However inspectors were not assured that the governance and management structures had been strengthened since the previous inspection, due to the repeated failings of regulations on this inspection and the absence of completion of numerous actions identified by the provider. A review of the minutes of the working group and management meetings identified areas that required addressing. There was an absence of implementation to practice of areas discussed, such as staffing levels, staff supervision, training and staff reviewing polices for safeguarding. There had also been an absence of clinical and environmental audits occurring and a review of the quality and safety of the care provided to residents.

There was a failure to recognise the rights of residents to have opportunity to develop and have the necessary supports to maximize their personal development and quality of life.

There was a failure to recognize the statutory requirement to come in to compliance with the regulations and standards.

Judgment:
Non Compliant - Major

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:
The person in charge had not been absent from the centre for more than 28 days since they commenced their post on 26 January 2015. Therefore no notification was submitted to the Chief Inspector as required by Regulation 32. The organisation has

nominated a member of the management team to deputise in the event of the absence of the person in charge. However inspectors were not assured of the systems in place in the event of the person in charge being absence for less than twenty eight days. Inspectors were informed that the registered nurse on duty is responsible for the day to day operations in this event. However inspectors found evidence that during an absence of the person in charge, a deficit in the roster had not been identified. Therefore there had been no permanent staff on duty for one night.

Judgment:
Non Compliant - Major

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

Findings:
Inspectors were not assured that the designated centre had sufficient resources to meet the needs of residents. Since the previous inspection there had been an additional twenty hours of staff allocated to the designated centre. In the main, this was to facilitate residents with a meaningful day. However as stated in Outcome 5, there was no assessment of the supports residents required to meet their social care needs. Inspectors queried the rationale for the number of additional hours provided. There was no clear rationale provided. Inspectors reviewed minutes of management meetings in which it was requested that an assessment be conducted to ascertain the actual supports residents required. This had not occurred for the designated centre. In February 2015, it was identified at another management meeting that the designated centre was not sufficiently resourced with staff. There was no evidence that action had arisen from same. There was also evidence that the additional staffing hours were, at times, utilise to compensate for staff absenteeism as opposed to supporting residents' meaningful day. There had been an additional staff member placed on night duty following the inspection in November 2014 as a result of an immediate action issued by inspectors.

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:
There are two staff in the designated centre both at day and at night. There are nine permanent staff on the roster for the designated centre. There was an increase of one staff at night since November 2014. As stated previously, there has been an additional twenty hours per week allocated to support residents with a meaningful day, this post was filled by relief/agency staff. The registered provider was required to report to the Chief Inspector the level of staff absenteeism and the arrangements in place to address same. The reports demonstrated that there were numerous occasions in which the centre was under resourced.

Inspectors observed staff engaging with residents and found that whilst staff engaged with residents in a dignified and respectful manner, the evidence of this inspection demonstrates that there is a culture of caring as opposed to empowerment. Inspectors determined that staff required additional supports and training to ensure that residents' needs are appropriately met. Following on from the previous inspection, the registered provider had committed to providing training to staff. Below is a table which identifies the training stated by the provider and the number of staff which completed same:
Documentation and Record Keeping - 0
Assessment, Care Planning, Implementation and Training - 1
Management of Complaints - 1
CPI - 5
Role of the Key worker - 0
Training in Risk Management - 0
Infection Prevention and Control - 2
Hand Hygiene - 2
Policy of the Protection of Vulnerable Adults - 0
Positive Behaviour Support - 1
Medication Management Policy - 0

Based on the deficits identified on this inspection, inspectors determined that staff required additional support to have the skill set and competency to ensure positive outcomes for residents.

There was also an absence of staff supervision to adequately ensure that the training needs of staff were identified.

Judgment:
Non Compliant - Major

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) Regulations 2013.

Theme:
Use of Information

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

Findings:
Inspectors reviewed the records maintained in respect of staff as required by Schedule 2 of the regulations. There was an absence of evidence of the person's identity maintained in the sample of files reviewed.

There was a directory of residents maintained as required by Schedule 3 and records pertaining to the care provided to residents were maintained. However inspectors noted an absence of dates and signatures throughout reducing the transparency and accountability of the documentation. Inspectors confirmed as stated in Outcome 7, that all emergency equipment was maintained within the centre. However they were not maintained in the centre as required by Schedule 4.

There was also an absence of the policy in relation to Education, Training and Employment as stated in Outcome 10. Inspectors also found that the medication management policy was out of date as it was developed in 2010. The policies in relation to visitors and the admission, transfer and discharge of residents were also not reflective of the designated centre. The infection control policy was not implemented in practice.

Judgment:
Non Compliant - Moderate

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:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002469
Date of Inspection:	27 April 2015
Date of response:	9 June 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:
There was an absence of evidence to support that residents are consulted and participate in the running of the designated centre.

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

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
The person in charge will have monthly meetings with the residents in the designated centre. These meetings will be facilitated by staff in the designated centre on the first Monday of every month. Records of meetings will be maintained in the designated centre. Family members will be invited to attend and participate in the residents meetings. A policy will be developed on residents meetings.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The privacy and dignity of residents were not respected. For example: -
- twin room was not fit for purpose
- inspectors were directed to utilise the en suite of residents
- personal documentation of residents was stored in an un secure location
- personal information was discussed in front of all residents

2. Action Required:
Under Regulation 09 (3) you are required to: 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.

Please state the actions you have taken or are planning to take:
1. The Regional Director of Nursing met with HSE Estates at the designated centre on 22/06/15

I. Extend and convert one bedroom to living room space
II. Provision of additional 2 bedrooms with en suite bathrooms to eliminate sharing of bedrooms
III. Extension of utility area to accommodate office space
IV. Provision of storage area
V. Provision of car park to front of the house
VI. Review corridor widths

2. All staff have been informed by the Regional Director of Nursing to use the main bathroom in the hallway and refrain from entering the bedroom of the 2 females residing there to use en suite.

3. All files are stored in a lockable filing cabinet.

4. Handover will be conducted in the utility room with immediate effect.

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The systems in place for the safeguarding of residents' personal possessions were not robust.

3. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
1. All staff will be made aware of the HSE Guideline on the management of personal belongings of residents by the person in charge, staff will sign that they have read and are aware of the policy. 25/06/15

2. The existing storage place for residents belongings will be made secure. 30/06/15

3. A record will be maintained of all residents personal belongings. 25/06/15

4. All residents are supported to manage their financial affairs in accordance with RID018 Financial Management for Residents

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that activities offered to residents were in line with their interest and abilities.

4. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. Each resident will be facilitated by their keyworker to develop a meaningful activity plan including activities in accordance with their interests. 31/07/15

2. Staff will be supported by a CNS in therapeutic activities to develop an individual plan for each resident. 31/08/2015

Proposed Timescale: 31/08/2015

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

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate day care provision.

5. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. Discussions are taking place to source a day service location for residents in line with their interests and abilities. 31/08/15

2. There is a plan in place to develop Day Services for residents residing in the designated centre in line with their interests and abilities. A venue is currently being sourced. Outreach activities will be facilitated in the day service. 30/06/15

3. An additional support staff has been assigned to the centre to support residents to access day services

Proposed Timescale: 31/08/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that residents were encouraged to be active members of the community.

6. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
1. Person in charge will develop links with the community.
2. Residents are supported to attend religious ceremonies each weekend.

Proposed Timescale: 31/07/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The written agreements had not been signed.

7. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
1. The contact of care will be reviewed to include criteria for discharge. 05/06/15
2. The contact of care will be reviewed each resident in accessible format and where residents lack capacity will be discussed with residents families to receive consent. 30/06/15

Proposed Timescale: 30/06/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The personal plans of residents were completed by one member of staff.

8. 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:
1. Three monthly reviews will be completed for all residents in the designated centre which will include individuals nominated by the resident and their representatives and members of the Multi Disciplinary Team. 31/07/15

2. Training will be provided for staff to develop personal plans for residents. 30/09/15

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not outline the supports residents required.

9. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
1. All PCPs will be reviewed at PCP meetings and developed no later than 28 days following admission. 31/07/15

2. Person Centred Planning for nurses has been scheduled for 11th & 12th August 2015. 31/08/15

Proposed Timescale: 31/08/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The twin room in the designated centre is not fit for purpose. There is inadequate communal space.

10. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:
The Regional Director of Nursing met with Estates in the Designated Centre on 22/06/15 to address deficits identified in the inspection. A review was conducted of the existing plans for the house. The plans have been amended to provide for the following:-
I. Extend and convert one bedroom to living room space
II. Provision of additional 2 bedrooms with ensuite bathrooms to eliminate sharing of bedrooms
III. Extension of utility area to accommodate office space
IV. Provision of storage area
V. Provision of car park to front of the house
VI. Review corridor widths

This process has commenced of revising the plans. When finalised a costed funded plan will be forwarded to the authority.

Proposed Timescale: 31/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathroom was not clean.

11. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
1. Bathroom was cleaned with immediate effect. Completed
2. New shower chair has been purchased. Completed
3. Staining on floor will be addressed immediately. Completed
4. Toilet seat has been replaced. Completed
5. Cleaning Schedule to be reviewed

Proposed Timescale: 30/06/2016

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:
The systems in place for the management of risk were inadequate and were not implemented in practice.

12. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
The person in charge will review risk assessments and control measures in the following:-
Lone Worker
Agency Staff
Injury to driver
Residents absent without leave

A missing persons drill will be undertaken and audited quarterly

An emergency response plan will be developed in the designated centre

All individual manual handling risk assessments in the designated centre will be reviewed every 3 months or sooner if required.

(1) A procedure for the management of safety in the designated centre has been implemented.

(2) Risk Manager has completed an audit of the risk register in the designated centre.

Proposed Timescale: 14/08/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures in place for the safeguarding of residents were not implemented in practice.

13. Action Required:
Under Regulation 27 you are required to: 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.

Please state the actions you have taken or are planning to take:
1. An audit will be completed in Infection Control in the designated centre

2. Infection Control nurse will visit the designated centre to review practices and provide guidance to staff on the procedures to be followed to safeguard residents from cross contamination.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The final exits were key operated which could result in unnecessary delay in the event if an emergency.

14. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
The Fire Exit door lock will be replaced by a thumb lock.

Proposed Timescale: 31/08/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of review to identify the rationale for a resident's behaviour.

15. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
A review of the residents behaviour support plan will be undertaken by staff trained in behaviour support.

Proposed Timescale: 22/07/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate safeguards in place to protect residents.

16. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
1. Training in abuse has been scheduled. All staff in the designated centre will receive training in the protection of vulnerable adults. 06/07/2015

2. The person in charge will action the recommendations from the investigation report 19/06/15.

3. Training has been scheduled on the Protection of Vulnerable Adults by an External provider. 06/07/15

4. Desktop review will be completed into the incident and the learning outcomes will be communicated to all staff, the policy Financial Management for Residences on two staff signing off on financial transactions. 30/06/15

5. The person in charge will obtain garda vetting for all external staff supporting residents eg Art Therapist, Reflexologist, Day Support Staff ect. 31/08/15

All therapists providing services to residents in the designated centre will submit Garda Vetting forms. In the interim, a self declaration form will be completed and supervision from staff employed in the designated centre will be provided in the interim period.

Proposed Timescale: 31/08/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received updated training as stated in the action plan response by the provider from the inspection in November 2014.

17. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Training in abuse has been scheduled. All staff in the designated centre will receive training in the protection of vulnerable adults.

Proposed Timescale: 06/07/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Activities that residents engaged in did not promote skill development or lifelong learning.

18. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
1. A policy will be devised on opportunities for education, training and employment for residents. 31/07/15

2. All residents will be supported to access opportunities for education and training. 31/07/15

3. Arrangements have been put in place for an external employment manager to attend discussions with management. 11/06/15

Proposed Timescale: 31/07/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents with a diagnosis of epilepsy were at risk if a registered nurse was not present.

19. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
1. All staff will receive training in Epilepsy management and the administration of Buccal Medazallam.

2. Medication presses will be ordered to facilitate the storage of Buccal Medazallam.
3. A register will be maintained in all centres of persons trained in the administration of Buccal Medazallam

Proposed Timescale: 31/07/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the food provided to residents was consisted with their individual dietary needs.

20. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
Dietician will visit the designated entre to review the diet of each resident and provide site specific training to staff in the implementation and use of the MUST Nutrition Screening Tool.

Proposed Timescale: 30/06/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of learning from medication errors which posed a risk to safe medication management practices.

21. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
1. The medication management policy will be finalised by the Project Officer in the NMPDU.

2. A Desktop Review has been conducted on all medication incidents recommendations will be communicated back to staff.

3. Flow Chart has been drawn up on medication events and what to do in the event of medication errors.

Proposed Timescale: 30/06/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of Purpose was not specific to the designated centre and the findings of this inspection did not support the objectives as stated in the document submitted to the Chief Inspector.

22. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:
The Statement of Purpose and Function will be reviewed to be reflective of the individual designated centre.

Proposed Timescale: 30/06/2015

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 findings of this inspection evidence that the management systems in place were inadequate to ensure that the services were safe and effective.

23. 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:
1. A review of the governance structure and staffing levels of the designated centre is currently being undertaken. 30/06/15

2. Policy for staff clinical supervision will be implemented in the designated centre. All staff will receive clinical supervision every 8 weeks with their line manager. 31/07/15

3. All outstanding training from action plan to be provided. 31/08/2015

4. 1 Staff nurse post has been approved for replacement and will be recruited through the National Recruitment Service. 30/09/2015

5. An Agency has been sourced to actively seek staff on short term contracts. 30/06/15

6. All unscheduled annual leave or time in lieu has been suspended until further notice in the designated centre. 31/05/2015

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The findings of this inspection evidence that staff require additional support to ensure that the support to residents is appropriate.

24. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Performance management policy will be developed for the designated centre. Training supervision on structured feedback from staff has been developed. The Local manager

will implement a process for support relating to training supervision and structured feedback for staff. The Local manager will maintain records of supervision of staff. The Person in Charge will ensure that there is a register of training for staff in their area of responsibility. Supervision of staff will be carried out every 8 weeks.

Proposed Timescale: 30/09/2015

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Chief Inspector did not receive notification of when there was no person in charge in the designated centre.

25. Action Required:
Under Regulation 32 (1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

Please state the actions you have taken or are planning to take:
All notifications in relation to absence of person in charge will be submitted within the timeframes (copy of notification form attached).

A deputy person in charge will submit all information required by HIQA.

A person in charge will on in the designated centre be indicated on the roster.

Proposed Timescale: 14/08/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre was not sufficiently resourced to meet the needs of residents.

26. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
Two external persons have been sourced to review the dependency levels of residents in the designated centre. A report will be completed and the recommendations from

same will be utilised to guide resource planning.

An additional healthcare assistant has been employed in the designated centre for 32 hours per week. Two regular agency nurses have also been employed in the designated centre.

Proposed Timescale: 31/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence supported that there was insufficient staff in the designated centre. Staff also required support to develop the skill necessary to ensure residents were supported engage in meaningful and purposeful activity.

27. 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:
A review will be undertaken of the governance structure of the designated centre.

The review identified the requirements for a Deputy Person in Charge in the designated centre. A Deputy Person in Charge is currently being sourced.

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the regular use of unfamiliar staff residents were not consistently provided with continuity of care.

28. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
1. A business cases for replacement staff nurse has been approved nationally. 30/06/15

2. All outstanding training from action plan to be provided. 31/07/15

3. A Business case for a health care assistant has been approved nationally. 30/09/15

4. An Agency has been sourced to actively seek staff on short term contracts. 31/08/15

5. All unscheduled annual leave or time in lieu has been suspended until further notice in the designated centre. 30/09/15

6. One full time healthcare assistant has been transferred to the designated centre 32 hours per week. 30/06/15

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have appropriate training.

29. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Guidelines for the provision of statutory and mandatory training has been developed. The Person in charge will maintain a register of training of staff in their area of responsibility, monitor and facilitate attendance of training.

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of staff supervision.

30. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Person in charge and deputy person in charge has been assigned to the designated centre.

The rosters have been reviewed and a regular staff member will be rostered with agency staff as far as practicably possible

Training supervision on structured feedback from staff has been developed. The Local manager will implement a process for support relating to training supervision and structured feedback for staff. The Local manager will maintain records of supervision of staff. The Person in Charge will ensure that there is a register of training for staff in their area of responsibility. Supervision of staff will be carried out every 8 weeks.

Proposed Timescale: 30/08/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all policy as required by Schedule 5 were maintained in the designated centre. Other polices were out of date or not implemented in practice.

31. 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:
1. A Policy will be developed on education and training and employment in the designated centre
2. The medication management policies will be finalised.
3. The policy on admissions transfer and discharge of residents has been developed
4. The infection control policy will be implemented in practice.

Proposed Timescale: 31/08/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of proof of identify for staff in staff records.

32. Action Required:
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:
The schedule for all personnel files within the service were being reviewed by ID residential management to ensure photo ID etc were all present and correct. All files for this designated centre have now been reviewed (one is complete and returned to the location, ten remain with information outstanding and letters have been issued to these staff requesting official photo ID be returned to ID management as a matter of urgency). It is anticipated that all files will be available at the designated centre no later than Monday 24th August.

Proposed Timescale: 24/08/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to an absence of dates and signatures the records as required by Schedule 3 were not consistently retained.

33. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
The directory of residents will be updated to include dates and required by schedule 3. The assessment in the directory of residents have been updated and dated.

Proposed Timescale: 30/06/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records in respect of fire records were not maintained in the designated centre.

34. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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 fire records will be maintained in the designated centre by the person in charge.

Proposed Timescale: 30/06/2016