

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Adults Services Palmerstown Designated Centre 1
Centre ID:	OSV-0003897
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Provider Nominee:	Gerry Mulholland
Lead inspector:	Caroline Vahey
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	2

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
21 June 2016 11:00	21 June 2016 21:00
22 June 2016 09:30	22 June 2016 17:45

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the fourth inspection of the designated centre. This was a 10 outcome inspection, the purpose of which was to monitor ongoing regulatory compliance. The centre was last inspected in July 2014.

How the inspectors gathered evidence

The inspection took place over two days and as part of the inspection, the inspectors spoke to the deputising person in charge and eight staff members in four of the five units which make up the designated centre. The inspectors also met with one resident and spoke to a number of other residents throughout the inspection.

Practice was observed in relation to food and nutrition, choice at mealtimes, the provision of activities and a trial of a night time evacuation of one unit.

Documentation was also reviewed including residents' personal plans, complaints log, financial records, fire safety records, staff training records, staff rosters and policies and procedures. Five units were visited during the inspection.

Description of the service

The centre had a statement of purpose outlining the services and facilities to be provided to meet the needs of the residents. The inspectors found that the service provided was not reflective of the details set out in the statement of purpose, for example, facilities outlined included a home based day service which was not consistently being provided. The statement of purpose also outlined that community amenities are made available and accessible to residents with staff support as per their individual personal plan however, the inspectors found limited access to community facilities and the staff support required to access the community was not consistently provided. There were 19 residents living in the centre on the day of inspection. The centre could accommodate both males and females.

Overall judgment of findings

Major non-compliances were found in four outcomes inspected against including Outcome 1, residents' rights, dignity and consultation, Outcome 5, social care needs, Outcome 14, governance and management and Outcome 17, workforce. Meaningful activities were not provided for residents and social care needs were not met resulting in reduced outcomes for residents. This was directly impacted by the provider's arrangements not to replace unplanned staff absences and in some cases to replace familiar staff with unfamiliar staff. There was limited choice facilitated in how some residents chose to spend their day and in options for food. Residents were provided with limited opportunity to contribute to the planning and running of the centre. One unit did not have appropriate bathroom facilities to ensure the privacy and dignity of residents. The governance and management arrangements did not ensure the effective management of the centre, and the quality and safety of care and support and whether the service provided actually met the needs of the residents was not appropriately monitored.

Good practice was identified in medication management and these systems in place protected residents. In the main healthcare needs were appropriately assessed and met by the care provided however, some improvement was required in food and nutrition.

Improvements were also required in fire precautions including arrangements for the containment of fire and fire safety training. Behaviour support plans required improvement to ensure they guided practice specifically in the use of restraint practices. Safeguarding training had not been provided to some staff. Not all contracts of care were in place in residents' personal plans. Risk management procedures and the follow up to adverse incidences also required improvement. Suitable ventilation was not provided in one unit.

The reasons for these findings are explained under each Outcome in the report and the regulations that are not being met are included in the Action Plan at the end 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):

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

Findings:

Overall the inspectors found that residents' rights were not upheld in relation to residents retaining access to their finances. Residents were not consistently enabled to exercise choice and control over their own lives in particular in relation to activities and food choices. Improvements were also required to ensure residents participated in the planning and organisation of the centre, and in the arrangements for privacy and dignity of residents in one unit.

The actions from the previous inspection were satisfactorily implemented. The living arrangements for a resident had changed since the last inspection and appropriate staffing was available to attend to the resident's personal care needs. Information was available on an external advocacy service and records confirmed the external advocate had attended the centre in the preceding months.

The inspectors reviewed records of financial transactions and the arrangements in place for residents to access their own finances. Each resident had an individual account managed by Stewarts Care. Petty cash was held for each resident at unit level and was topped up at two weeks intervals through the accounts department. However, the inspectors found that this system did not allow residents to freely access their own money. In addition, the inspectors reviewed financial records whereby a resident, having spent a portion of their allocated allowance, was left with a minimal amount of cash for an eight day period. The inspectors also reviewed the arrangement for residents to access larger amount of money should they wish. The system in place was cumbersome and not timely and took approximately two weeks for any money required over the specified allocated amount. In addition, the service arrangement in place only allowed

for a specified amount to be held locally in a unit at any given time. This was discussed with a clinical nurse manager who outlined this was a difficult arrangement to manage particularly during periods of increased spending e.g. seasonal events.

The systems in place for recording of financial transactions were complete with all receipts for purchases forwarded to the accounts department. There was a policy in place on residents' possessions and a policy in place of residents' finances.

The inspectors observed meals served to residents in two separate units during the inspection and found that the choice available to residents required improvement. Residents did not contribute to menu choices provided by a central kitchen. While there were two choices provided by a central kitchen, there were not sufficient portions of each choice available to cater for some of the residents. In one unit, residents were respectfully supported by the staff to choose and serve their own meals however, the inspectors found that in this unit, sufficient portions of one choice of meal were not available. An alternative meal choice was prepared for a resident in the unit as per their wishes.

In the second unit the staff informed residents of the choice of meals available, and meals were served by staff. There were limited portions of meal choice available, for example, there were only three portions of one of the two choices provided, to cater for a group of eight residents.

The inspectors found the location of bathroom facilities in one unit to be inappropriate. Residents in one unit had to walk through the main sitting room to access all bathroom facilities and there were no bathroom facilities near bedrooms.

Participation of residents in the planning and running of the centre required improvement. How residents chose to spend their day was in the main dictated by available staffing, which was not consistently adequate. There was a resident council and a resident from this centre represented the campus at these meetings. There inspector also reviewed records of meetings in two units between individual residents, their keyworker and the manager of the unit and areas such a personal planning, holidays and home visits were discussed.

There were policies and procedures for the management of complaints however, the policy was out of date. The policy was available in an accessible format. The procedures in place for complaints were timely and the appeals process was fair and objective. There was a nominated person to deal with complaints. The inspectors reviewed records of complaints in two units. There was one compliant recorded which was in progress in line with the centre procedures on complaints.

Throughout the inspection, staff were observed to be respectful of residents, communicated sensitively with residents and were knowledgeable on residents' needs.

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:

Inspectors found that not all of the actions were completed from the last inspection.

The centre had a policy and procedure for admissions, including transfers and discharges. The centre accepted emergency admissions in line with policy. Inspectors found that written contracts of care were not in place for some residents which was an action from the previous inspection. However, inspectors reviewed the contract which outlined the services to be provided and the fees to be charged.

Not all aspects of this outcome were inspected.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspectors found that while residents' healthcare and personal care needs were maintained by a good standard of care and support, social care needs were not

consistently met. Residents did not have ongoing opportunities to engage in meaningful activities. Improvement was also required in the development of some healthcare plans.

The action from the previous inspection was not satisfactorily implemented. Residents' needs were not consistently met in terms of access to suitable recreation, meaningful activities and community integration. While social care needs were assessed, there was evidence that these identified needs and goals were not being met. The inspectors reviewed records of activities and social outings in three units. In one unit, one activity was recorded for a resident for a seven day period and three activities for this resident for a separate seven day period. For another resident, two activities, of one hour duration were recorded for a seven day period and for a separate week, three activities were recorded. These weeks directly corresponded with reduced staffing levels as outlined under outcome 17. In addition, the inspectors found limited evidence of regular access to the community for residents with most activities campus based. There was evidence of good practice in two units with meaningful activities provided. In one of these units, regular and appropriate staffing levels were available and suitable social care activities were provided in line with residents' assessed needs. In the second unit, meaningful activities were again dependent on staffing levels and when appropriate staffing levels were made available, consistent activities were provided which were focused on activities outside the campus. However, consistent staffing was not provided in this unit resulting in reduced outcomes for residents.

Assessments of need in place for residents also outlined health care needs and personal needs. Residents were involved in the assessment of need process. Multidisciplinary team members had been involved in the assessment of residents' needs, for example, speech and language therapist, clinical nurse specialist in behaviour and psychiatrist.

Personal plans were developed in health care needs, communication needs and personal care needs however, some health care plans were not developed for assessed healthcare needs, for example, mental health and hypercholesterolaemia. However, there was evidence that these needs were being met, for example, prescribed therapeutic interventions were administered and reviews with the relevant practitioner were facilitated. The plans in place outlined the support required to meet the assessed needs of residents. Personal plans were subject to an annual review or as needs changed and copies of residents' personal plans had been forwarded to residents' families.

Individual goals had been developed in areas such as social care and leisure. The actions required to achieve goals were outlined in plans however, were not consistently implemented. For example, a resident's goal to increase opportunities for activities was recorded as implemented twice since its development in February 2016. Some goals were being implemented, for example, progress for a resident to go on holidays and also to introduce a resident to a new social activity.

The inspectors reviewed documentation pertaining to one planned discharge from the centre, in which the discharge had been discussed with the resident and a planned transition had recently been initiated.

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):

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

Findings:

Inspectors found the issues identified with the design of one of the units in the last inspection was addressed.

The unit was sub-divided into four separate apartments accessed through a shared corridor. The centre had altered the physical design to support accessibility and use for all residents which included the addition of an external access door and the installation of a new bathroom for one apartment. In addition, the centre manager informed inspectors that the two residents sharing one of the apartments at the time of the previous inspection had moved to a new apartment. The apartment in this unit now accommodated one resident.

Inspectors visited each of the five units and found that in one unit, suitable ventilation was not provided, impacting on the comfort of the resident residing in the unit.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

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

Findings:

Overall, inspectors found there to be health and safety systems in place however, improvement was required in the arrangement for the containment of fire, in risk management and the outcomes of adverse incidents to ensure learning.

One action from the previous inspection was implemented and fire exit doors were found to be unobstructed on the day of inspection. Fire exits were checked on a daily basis by staff.

One of the actions from the previous inspection was not satisfactorily implemented. Inspectors reviewed training records and found that there remained gaps in mandatory training in fire safety and management.

Inspectors observed fire doors being wedged open which negated the function of the fire door. Inspectors reviewed certification to show that fire equipment, fire alarm and emergency lighting were all serviced by an external company. The centre had completed regular fire drills and recorded the issues and actions taken to resolve them. The provider had recently initiated a review of night time drills in order to review the supports required to evacuate the centre and the inspectors observed a practice drill being implemented. Personal emergency evacuation plans were in place for each resident and sufficiently guided staff.

The centre had a risk management policy in place which contained the specified risks required by Regulation 26. The centre maintained individual risk assessments for each resident including risk assessments for absconding, slips, trips and falls, challenging behaviour and smoking. Risk assessments identified the control measures in place to minimise potential impact. The inspectors requested risk assessments on environmental risks such as use of oxygen however, these were not made available on the day of inspection. The inspectors were informed at a feedback meeting that these risk assessments were in place however, the inspectors found the staff working in the centre were not aware of these. Each units of the centre conducted monthly health and safety audit.

There was a system in place to review incidents in the centre. Incidents were reviewed by the person in charge and forwarded to the risk manager. The risk manager prepared quarterly reports on identified trends. However, it was not clear how this information was fed back to the unit staff and as such the arrangements in place for learning from adverse events. The person in charge was in the process of developing a new quarterly review of all incidents in the centre in order to inform the development and review of a risk register.

There was a health and safety statement in place and a centre specific procedure in the event of a resident going missing. There were policies and procedures in place relating to health and safety including a waste management policy, infection control policy and a manual handling policy.

Suitable arrangements were in place for the prevention and control of infection. Inspectors found the centre to be clean and reviewed cleaning schedules. The centre had an infection control policy in place. There was ample supply of personal protective

equipment and suitable hand washing facilities throughout the centre. Inspectors observed good food safety practices at mealtimes which included the checking of food temperatures.

Training records were reviewed for eight staff and all staff had received training in manual handling.

The vehicles used to transport residents were not checked as part of this inspection.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Overall the inspectors found residents' were safeguarded however, the use of restrictive procedures was not clearly set out in personal plans in order to ensure a consistent approach. Improvement was also required in mandatory staff training. Appropriate resources were not consistently available to support the needs of residents with challenging behaviour.

The actions from the previous inspection had been implemented. The provider had updated the policy on use of residents' finances to include the arrangements where the provider acted as an agent. All residents had individual accounts which were managed by the provider and all transaction records were complete. The use of restrictive procedures was subject to regular review and there was evidence that restrictive procedures were used for the least amount of time necessary. There was also evidence of plans in place to reduce restrictive practices resulting in a discontinuation of practices where deemed appropriate. Risk assessments had been completed for the use of restrictive practices.

There was a policy in place on the use of restrictive procedures including physical and chemical restraint however, the policy did not include the use of environmental restraint. There were a number of environmental restraints in use in this centre, for example,

locking doors and windows.

There was a policy in place on behavioural support and on the provision of personal intimate care. Behaviour support plans were developed outlining the support required to prevent and respond to incidences of challenging behaviour. However, the inspectors found these behaviour support plans did not guide practice, specifically relating to the use of environmental and chemical restraint which formed part of the response to challenging behaviour for some residents. It was not clear in plans at what point these restrictive procedures would be implemented to ensure continuity of approach and to ensure the safety of residents and staff.

The inspectors also found that the appropriate support in terms of consistent and appropriate staffing levels were not provided in line with residents' behaviour support plans. For example, a resident's behaviour support plan outlined recommendations that to prevent incidences of behaviour activation should be maintained however, staff numbers were not always sufficient to allow the resident to leave the unit for activation. In addition, the behaviour support plan outlined unfamiliar staff may lead to an increase in incidences of behaviour, which was evident from review of behaviour records and of the corresponding rosters. Staff training had been provided in behaviour support and in the use of restrictive practice as it pertained to residents.

There was a policy in place on safeguarding however, this policy was out of date. In addition, the inspectors reviewed records of staff training. Three staff in this centre did not have up to date training in safeguarding and there was no record of one staff having received any training. Staff members spoken to were knowledgeable on the types of abuse, the indicators of abuse and the actions to take to respond to suspicions, allegations or disclosures of abuse. There was a designated liaison person to deal with all safeguarding concerns. There were currently no safeguarding concerns in the centre and previous safeguarding concerns had been investigated and followed up appropriately by the provider.

Intimate care plans were developed which guided staff in the support required to meet residents' personal care needs while maintaining privacy. Staff were observed throughout the inspection to treat residents with respect and had a caring approach to residents.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that residents were supported to achieve and enjoy the best possible health. However, some improvements were required regarding food.

Inspectors observed mealtimes in the centre and found that meal times were a positive and social event. The advice of a speech and language therapist and dieticians formed part of personal plans. The inspectors observed these nutritional plans were implemented as required with each resident. However, the food provided was not available in sufficient quantities and there were limited portions of each choice available if all residents preferred one option, as observed on the day of inspection. In the main residents were not supported to prepare their own meals with the exception of one resident, who had a plan in place to learn to prepare a light meal. Staff members outlined how residents in one unit had previously participated in cookery but due to a reduction in activity staff this was no longer facilitated.

Inspectors found residents' health care needs were met. Residents had access to timely and appropriate healthcare professionals such as a general practitioner, speech and language therapist, occupational therapist, chiropodist and psychiatrist. An annual health assessment had been completed. As noted in Outcome 05 inspectors identified some gaps in healthcare plans but staff spoken to were knowledgeable on residents' health care needs and the interventions in place to meet those needs.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

The inspectors found residents were protected by the policies and procedures in place for medication management.

The action from the previous inspection had been satisfactorily implemented and maximum dosages were detailed on PRN (as required) medication prescriptions.

There were policies in place for the ordering, prescribing, storing and administration of medication. The inspectors reviewed medication management practices in one unit of the centre. Medications were securely stored in a locked medication press. Prescription records were complete and contained the required information such as residents' photographs and the name, dose and time of administration of medication. Administration records reviewed were complete and medications had been administered as prescribed to the residents for whom it was prescribed. Medications prescribed were subject to regular review by the prescribing doctor.

There were appropriate procedures in place for the disposal of unused medications. Out of date or unused medications were stored separately and returned to the pharmacy. A record of returned medications was maintained in the centre.

Medication management audits were completed on a monthly basis and included areas such as medication labelling, storage, administration, medication errors and training. Prompt action had been taken to rectify an issue identified on a recent audit.

The centre availed of the services of a community pharmacy.

Judgment:
Compliant

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The inspectors found the management systems in place did not ensure appropriate support and care was consistently provided to meet the needs of the residents and a number of non compliances were identified during the inspection. Effective monitoring was not in place to review the quality of care and support and the experience of residents. Improvement was required in the unannounced visits carried out by the provider and in staff meetings in one unit. The arrangement for the person in charge to manage two designated centres was found not to be appropriate and could not ensure the effective governance and operational management of the centre.

The provider had not consistently provided sufficient resources to meet the needs of the residents impacting on social care needs of residents and appropriate behaviour support. Safeguarding training and fire safety training had not been provided as required. In addition, the provider did not have arrangements in place for the containment of fire.

Six monthly unannounced visits had been carried out by appointed personnel on behalf of the provider and consisted of an audit of defined areas. However, the inspector found these audits to be basic, whereby only one unit of the five units was visited at the six monthly intervals. In addition, the audits did not consider the actual quality and safety of the support provided, for example, social care needs were not reviewed to determine if these were achieved, the provision of meaningful activities were not discussed and staffing levels required to meet the residents' needs were not considered. Actions had been developed to issues identified during audits.

There was an annual review of the quality and safety of care and support and residents and families had contributed to this review.

The person in charge was employed on a full time basis and managed two designated centre comprising of ten units. The inspectors found the person in charge was not in attendance in some units on a consistent basis and the inspectors were not assured these arrangements could ensure the effective governance and management of the centre. Three of the five units had clinical nurse managers assigned. Staff meetings were not consistently facilitated. Records were reviewed in one unit whereby there were no recorded meetings since May 2013 and the manager outlined while quarterly staff meeting were required, sufficient staffing levels were not available to facilitate this. In the absence of regular staff meetings and the lack of attendance of the person in charge in this unit it was unclear how issues which resulted in reduced outcomes for residents were addressed or actioned appropriately.

The staff reported to the manager of the unit or where there was no manager, the person in charge. The person in charge reported to the adult service manager who in turn reported to the provider nominee. The adult services manager facilitated group meeting with persons in charge within this service on a monthly basis. Informal meetings with the adult service manager and the person in charge occurred as the need arose and minutes were maintained.

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:

Overall inspectors found there were insufficient staff on duty to meet the assessed needs of residents and improvements were required in personnel files.

The actions from the previous inspection had not been satisfactorily implemented. Inspectors found that the provider had recruited three temporary staff to ensure consistency of staff in the centre over the holiday period to ensure continuity of care. This had been an action from the previous inspection. However inspectors found that there was still a lack of consistency in staff due to full time staff moving on an ad hoc basis to other units and the low levels of staff. Gaps in mandatory training had not been addressed since the last inspection and inspectors found not all staff had received training in safeguarding and fire safety.

On the first day of inspection, inspectors found two of the five units were understaffed due to unplanned leave, with no replacement staff being organised. There was a staff rota in place and a planned and actual rota was maintained. Inspectors also reviewed rosters and found that staffing levels in some of the units were below the planned staffing complement on several occasions. For example, staffing levels in one unit were below the levels identified as required by the provider, for 14 days of 21 days. This resulted in reduced outcomes for residents specifically in relation to social care needs. In another unit, staffing levels and regular familiar staff were not consistently maintained resulting in increased incidences of challenging behaviour and predisposing a resident to known triggers to behaviour. Staffing levels in a third unit were maintained to an appropriate level. The remaining two units in terms of staffing were not reviewed as part of this inspection.

Inspectors reviewed staff files and some improvements were required as not all the information required under Schedule 2 were recorded in the files. Inspectors found files missing two references and evidence of photo identification, while other files contained all the information required.

The centre was in the process of rolling out formal staff supervision and some supervision sessions had taken place.

There were no volunteers in the centre.

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:

Caroline Vahey
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 report¹

Centre name:	Adults Services Palmerstown Designated Centre 1
Centre ID:	OSV-0003897
Date of Inspection:	21 June 2016
Date of response:	21 July 2016

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:

The participation of residents in the planning and running of the centre required improvement.

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:

In order to ensure that the Service Users are involved in running the centre and make choices, the Person In Charge will ensure there are weekly Service User meetings and monthly keyworker meetings to review activities and choices available in each living area.

Each living area will submit to the Person In Charge, on a weekly basis the plan of activities for approval, to ensure activities are met and meaningful. There will be a weekly review and monitoring of activities in each area by the Person In Charge .

The Person in Charge is not included in the WTE of the designated centre and works fulltime in this role. Four hours protected time will be assigned to reviewing weekly activities.

An Implementation Team has been established comprising of Senior Management, to support the Person In Charge and the Deputy Person In Charge who are both supernumery.

There will be a review to ensure the goals developed in the PATH process with individuals are documented and implemented through the Personal Support Plan by the Person In Charge.

The Person In Charge will support the representative from the Service Users Council to visit the living areas to seek any issues the residents wish to raise.

Proposed Timescale: 14/10/2016

Theme: Individualised Supports and Care

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

The arrangements in place for residents to access bathroom facilities in one unit in order to ensure privacy and dignity was maintained were not adequate.

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:

The Person In Charge has contacted the Technical Services Manager to provide a re-design to accommodate residents with easy access to the toilet and bathroom facilities. Funding will be applied for to the HSE.

Proposed Timescale: 16/09/2016

Theme: Individualised Supports and Care

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

Residents' choices in relation to activities and food were not consistently facilitated.

3. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

A review of daily activities and tasks has been undertaken in the living areas to ensure routines and tasks do not interfere with resident's opportunity for activities. Non-essential tasks have been reassigned to waking night staff.

The Quality Steering Group Audit Committee will prioritise a meaningful activities audit in the Designated Centre, an action plan will be developed by August 2016. Social goals will be reviewed and developed for residents in line with their preferences.

A weekly review of meaningful recreation, activities and food choices will be undertaken by the Person In Charge to ensure individual needs of residents are met in line with their goals. This will be achieved through weekly Service User meetings and monthly keyworker meetings which are held to review choices in activities and meals available in each living area.

Three WTE staff have been recruited in this designated centre.

The Person In Charge will ensure that staff understand the process of availability of choice of meals, options and goods from the catering department and ensure cooking/baking facilities with resident involvement is supported in each living area. The Catering Manager will review options in relation to food and meal provision and how to provide adequate choice in each house. A procedure will be developed in relation to food and meal provision.

Proposed Timescale: 14/10/2016

Theme: Individualised Supports and Care

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

Residents were not facilitated to access their own money in a timely manner. Residents did not consistently have sufficient funds or access to their own money in order to facilitate purchases for personal use or social occasions.

4. 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:

The procedure in place for facilitating residents' purchases for personal use or social occasions will be reviewed and guidelines for staff to manage residents funds will be developed . Service User personal funds requests will be facilitated immediately on the day through the accounts department.

Proposed Timescale: 31/08/2016

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:

Some residents did not have a signed contract for the services provided.

5. 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:

Contracts of care have been sent to all residents' next of kin for signing. Where the contract of care is not signed, it has been resent to the next of kin. All the signed contracts of care are filed on the individual residents file and all residents have their own copy of the easy to read version.

Proposed Timescale: 30/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Social care needs of residents were not met on a consistent basis. Adequate arrangements were not in place to meet residents' social care needs. In addition, some identified social care goals were not consistently implemented.

6. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

The Quality Steering Group Audit Committee will prioritise a meaningful activities audit for the Designated Centre, an action plan will be developed by August 2016.

The Quality Steering Group Audit Committee will prioritise a meaningful activities audit in the Designated Centre, an action plan will be developed by August 2016 and social goals will be reviewed and developed for residents in line with their preferences.

The Person In Charge will review all Personal Support Plans to ensure that residents goals are developed and supported through to implementation. A review of meaningful activities will be undertaken by the Person In Charge on a weekly basis to ensure individual needs of residents are met in line with their social goals .

Three WTE staff have been recruited in this designated centre.

There will be a review by the Person In Charge to ensure the goals developed in the PATH process with individuals are documented and implemented through the Personal Support Plan.

Proposed Timescale: 14/10/2016

Theme: Effective Services

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

Some healthcare plans were not developed for identified healthcare needs.

7. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Person in Charge will audit all residents' healthcare assessments and ensure where appropriate residents needs are identified and reviewed as necessary.

Proposed Timescale: 30/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

One unit in the centre did not have suitable ventilation.

8. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

Trial of alternative measures are currently being undertaken by staff team with support of psychologist due to behaviours of concern. The Person In Charge has reviewed ventilation with the Technical Services Manager to provide a re-design of windows to accommodate suitable ventilation.

Proposed Timescale: 31/10/2016

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 system for review of adverse events required review. Evidence of learning from adverse events was not apparent at unit level.

9. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

A Risk Management Policy which outlines the process for the management of risk including risk escalation is available in each house. The system for the management of risk escalation will be documented and the process will be available in the local risk register in each house. A procedure for analysing incidents will be implemented and training will be provided by the Risk Manager to all staff.

A post incident analysis will be carried out with the staff on the day of any incident. The Person In Charge will hold monthly staff house meetings to ensure there is learning from incidents.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

Staff were not aware of the risk management procedures in place in relation to environmental risks.

10. 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:

Person In Charge to address environmental risks through local house meetings, area meetings and also individual supervision. Training will be provided by the Risk Manager to all staff.

Proposed Timescale: 31/10/2016

Theme: Effective Services

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

Fire doors were wedged open.

11. Action Required:

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

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

A funding request to fit magnetic restrictors to fire doors has been submitted to the HSE on two occasions and will be re-submitted. All fire doors will not be wedged open. This will be monitored through regular supervision and fire drills.

Proposed Timescale: 31/08/2016

Theme: Effective Services

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

Not all staff had up to date training in fire safety and management.

12. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

All staff will be facilitated to attend fire safety training and refresher training following a Training Gap Analysis. The staff identified at the time of inspection as requiring up to date fire safety training have identified a date for training with the education and training department and will complete the training.

Proposed Timescale: 30/09/2016

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:

Behaviour support plans did not guide practice specifically relating to the use of chemical and environmental restraint.

13. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

A review of policy and procedures pertaining to responding to behaviours of concern and restrictive practices has taken place. The policy sets out guidelines for staff relating to proactive strategies, practices which are considered restrictive, and practices which are prohibited in the organisation, policy will be ratified by 31/08/16.

The Person In Charge, Psychology team and Clinical Nurse Specialist (Behaviour) will review all residents Behaviour Support Plans to ensure they contain support measures to respond to behaviours that challenge, to be completed by 31/10/16.

A full review of restrictive practices across the Designated Centre will be undertaken by the Person In Charge to ensure restrictive practices are appropriate and ensuring the use of least restrictive practice methods and that these restrictive practice methods are documented, to be completed by 13/09/16.

Proposed Timescale: 30/10/2016

Theme: Safe Services

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

Some staff did not have up to date training in safeguarding. One staff had not received training in safeguarding.

14. 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:

All staff will be facilitated to attend training and refresher training following a Training Gap Analysis. The staff identified at the time of inspection as requiring up to date safeguarding training has identified a date for training with the education and training department and will complete the training by 30/09/2016.

Proposed Timescale: 30/09/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Food provided was not available in sufficient quantities

15. 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:

The Person In Charge will ensure that staff understand the process of availability of choice of meals, options and goods from catering and ensure cooking/baking facilities with resident involvement is supported in each living area. The Catering Manager will review options in relation to food and meal provision and how to provide adequate choice in each house. A procedure will be developed in relation to food and meal provision.

Proposed Timescale: 14/10/2016

Theme: Health and Development

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

Residents were not supported to prepare their own meals.

16. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

The Person In Charge will ensure that staff understand the process of availability of choice of meals, options and goods from catering and ensure cooking/baking facilities with resident involvement is supported in each living area. The Catering Manager will review options in relation to food and meal provision and how to provide adequate choice in each house.

Person In Charge will review residents' participation in meal preparation. Where suitable residents are now engaged in preparing meals or alternatives such as baking.

Proposed Timescale: 14/10/2016

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 arrangement in place for the person in charge to manage two designated centres did not ensure the effective governance and management of the centre.

17. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The Clinical Nurse Managers and line managers in the centre will be responsible to the Person In Charge and Deputy Person In Charge for ensuring care is provided which ensures the residents rights, dignity and consultation in a safe manner.

The Person In Charge will hold staff house meetings in the Designated Centre to ensure governance and that the quality and safety of care of residents is being met. A schedule of staff meetings with agendas and minutes for the year will be maintained for each staff meeting by 31/07/16.

The Person In Charge will meet weekly with the Programme Manager on a formal basis to ensure there are systems in place to ensure the service provided to residents is safe, appropriate to residents needs, consistent and effectively monitored. This will be completed by the 09/07/16.

The Programme Manager continues to be available at daily handover for review of needs each day across Designated Centres.

The Staff Supervision Policy will be implemented for all staff by the Person In Charge by 31/10/16.

Proposed Timescale: 31/10/2016

Theme: Leadership, Governance and Management

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

A number of non compliances identified during the inspection specifically in relation to residents' rights, dignity and consultation, staffing levels, fire precautions and social care needs of residents, indicated the management systems in place did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

18. 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:

The Clinical Nurse Managers and line managers in the centre will be responsible to the Person In Charge and Deputy Person In Charge for ensuring care is provided which ensures the residents rights, dignity and consultation in a safe manner. The Person In Charge will hold staff house meetings in the Designated Centre to ensure governance and that the quality and safety of care of residents is being met. A schedule of staff meetings for the year will be developed by 31/07/16.

The Person In Charge will meet weekly with the Programme Manager on a formal basis to ensure there are systems in place to ensure the service provided to residents is safe, appropriate to residents' needs, consistent and effectively monitored. This will be completed by the 09/07/16.

The Programme Manager continues to be available at daily handover for review of needs each day across Designated Centres.

The Staff Supervision Policy will be implemented for all staff by the Person In Charge by 31/10/16.

Proposed Timescale: 31/10/2016

Theme: Leadership, Governance and Management

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

Unannounced visits by the provider did not review some aspects of the quality and safety of care and support particularly in relation to staffing levels and meeting the assessed needs of residents.

19. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The provider will continue to carry out unannounced visits to the Designated centre every six months. The visits will continue to be documented but will include a more comprehensive report on the safety and quality of care and support in the centre. The Provider will put a plan in place to address any concerns that are identified.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Appropriate numbers of staff were not available at all times to meet the assessed needs of residents.

20. 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:

The Provider has reviewed the staffing levels and skill mix in the Designated Centre to ascertain the required levels to meet the needs highlighted in the report. Three WTE staff have been recruited for the Designated Centre.

A relief panel is available in this Designated Centre with persons who are familiar and have the skills to meet service users' needs. A holiday relief panel which was recruited earlier in the year has also commenced since this report.

Sick leave is managed in this centre in line with the Attendance policy to promote full attendance.

A comprehensive audit of sick leave in the Designated Centre will be undertaken and appropriate action will be implemented where required. A full relief panel is now available and instances of sick leave will be managed within that panel.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

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

Continuity of care was not maintained for residents in accordance with their personal plans and behaviour support needs.

21. 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:

The Provider has reviewed the staffing levels and skill mix in the Designated Centre to ascertain the required levels to meet the needs highlighted in the report. Three WTE staff have been recruited for the Designated Centre.

A relief panel is available in this Designated Centre with persons who are familiar and have the skills to meet residents' needs. The induction procedure for relief staff will be reviewed in each living area. A holiday relief panel which was recruited earlier in the year has also commenced since this report.

Sick leave is managed in this centre in line with the Attendance policy to promote full attendance.

A comprehensive audit of sick leave in the Designated Centre will be undertaken and appropriate action will be implemented where required. A full relief panel is now available and instances of sick leave will be managed within that panel.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

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

Information and documents as required by Schedule 2 of the Regulations was not complete for some staff.

22. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Documents missing on the day of inspection are now in each staff members HR file.

Proposed Timescale: 22/06/2016