

**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 2
Centre ID:	OSV-0003899
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:	30
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 07 June 2016 09:30 To: 07 June 2016 19:25

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 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
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 third inspection of the designated centre. This was a 10 Outcome inspection carried out to monitor ongoing regulatory compliance. The centre had last been inspected in September 2014.

How the inspectors gathered evidence

The inspection took place over one day and as part of that inspection, the inspectors met with the person in charge and the deputy person in charge. The inspectors also spoke to staff members working in three of the five units which make up the designated centre. The inspectors observed practice in relation to food and nutrition and the provision of activities as well as reviewing documentation such as personal plans, complaints log, activity records, staff training records, staff rosters and policies and procedures. Three of the five units were visited during this inspection. The person in charge facilitated this inspection supported by a deputy person in charge and shift leaders within each unit.

Description of the service

The statement of purpose outlined the services to be provided to residents. The inspectors found the service provided was as described in the statement of purpose. The centre comprised of five units, four of which were based on campus and one based in community setting. The centre was close to a local village. Transport was shared with five other designated centres and was made available through a booking system managed locally. The centre provided services to both male and female residents and there were thirty residents living in the centre on the day of inspection.

Overall judgment of findings

Major non-compliances were identified in four outcomes inspected, Outcome 1, residents' rights, dignity and consultation, Outcome 5, social care needs, Outcome 14, governance and management and Outcome 17, workforce. The provider had not put adequate arrangements in place to replace staff in the event of unexpected absences. This impacted on the quality of life for residents in particular in the support available for residents to attend to meaningful activities. There was limited evidence of choice offered to residents in relation to how they wished to spend their day and their preference of food. How residents contributed to the organisation and planning in the centre was not apparent and the rights of some residents had not been considered in the implementation of a restrictive practice. Social care needs of residents were not met. The governance and management arrangements did not ensure the service provided was safe, consistent and effectively monitored in order to ensure the needs of residents were met, resulting in poor outcomes for residents.

Evidence of good practice was identified in areas such as the provision of appropriate and timely healthcare, medication management practices, and admissions procedures. Improvements were also required in residents' communication needs, arrangements for the containment of fire, staff training in safeguarding, behaviour support planning, the use of restrictive practice and supervision of volunteers.

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):

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

Findings:

Overall, inspectors found that residents' rights and dignity were not upheld and that individual residents were not consulted and did not participate in the running of the centre. There was evidence of institutional practice in relation to food choices, the provision of activities and in the implementation of restrictive practice in one unit which impacted on the rights of other residents to access their possessions. Some actions had been implemented from the last inspection.

The previous inspection identified issues with privacy and dignity in shared rooms. The centre had put screens in place in the shared rooms and where this did not work alternative arrangements were made to ensure the residents privacy and dignity. The inspectors reviewed intimate care plans in place for these residents and the guidelines outlined the support required in order to ensure these residents privacy was upheld.

Inspectors found that the resident ability to make choices in their daily lives and activities were limited. In three units of the centre, food was prepared off site and delivered to the centre. The food delivered was not based on residents' preferences but a mixture of dishes which, staff aimed to match the dishes with the residents' preferences as best as possible based on their knowledge of the residents' likes and dislikes. However, there were limited portions of each choice available and staff members told the inspectors that residents' choice could not be facilitated at some mealtimes. Some choice had been facilitated in one unit and an activity staff assigned to the unit had commenced cooking a meal once a week in this unit. In the other two units of the centre, the units had a budget and food was prepared on site for the residents.

Inspectors found that residents had little opportunity to engage in activities that were meaningful and purposeful to them. This was also identified in the previous inspection. On the day of inspection, inspectors observed residents seated in the sitting room or conservatory of two units for prolonged periods of time. The inspectors also reviewed activity logs in personal plans and found no activities recorded for up to 48 hours for some residents. This was reportedly due to availability of staff and is discussed under workforce.

In addition, inspectors found that residents' meetings were not taking place in all the units and how individual residents contributed to the planning and organisation of the centre was not evident. However, this was identified by the centre in a recent audit. There was a monthly service user council meeting being held by the provider and a resident representing the campus residential setting attended.

The inspectors reviewed records of risk management plans in the centre relating to nightly checks. This practice was discussed with the person in charge and a staff member in one unit. Residents were checked by night staff at approximately thirty minute intervals throughout the night. While there was a requirement due to some residents' assessed medical needs to maintain frequent checks, this was not consistent throughout this unit. There was no documentary evidence to confirm the decision making mechanism, having regard to the assessed needs of some residents, as to why these frequent checks were taking place. In addition, the inspector found a restrictive practice implemented in one unit had resulted in residents not being able to freely access some of their possessions.

There was a complaints policy in place however it was out of date and required review. There was a nominated person to deal with all complaints. Inspectors reviewed a sample of complaints and found that they were dealt with in an appropriate and timely manner as per the centre policy. A user friendly complaints process was displayed in a prominent place. An external advocacy service was available to the residents and on the day of the inspection an external advocate was visiting one of the units.

The inspectors reviewed records of financial transactions for residents and found a safe system in place for the management of finances. All transactions were recorded and corresponding receipts were available.

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):

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

Findings:

The inspectors found that while some progress in the development of communication plans had taken place since the last inspection further improvement was required.

The action from the previous inspection was not satisfactorily implemented. Communication plans had not been developed for some residents since the last inspection however, this was not consistent throughout the centre. Communication passports were available for some residents and outlined the residents likes and dislikes, receptive and expressive language methods and individual information. Staff members spoken to were knowledgeable on the communication methods of residents in the centre. Communication needs were assessed and where required a speech and language therapist had also completed assessments.

Residents had access to media such as a radio, television and internet access however, the inspectors found the centre was not part of the local community and access to regular community activities was limited.

An up to date policy on communication with residents was available.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspectors found that the admissions and discharge procedure in place was timely and written contracts of care were in place. There was a policy on admissions including transfers, discharges and the temporary absence of residents.

The action from the previous inspection had been implemented and residents had written agreements in place outlining the services to be provided and the fees to be charged.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

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

Findings:

The inspectors found that while some aspects of residents' well being and welfare was maintained, social care needs were not met and the standard of support in terms of social care was not adequate.

One action from the previous inspection had not been satisfactorily implemented. While residents' health, personal, and social care needs had been assessed there was minimal evidence as to how social care needs would be or were being met in the centre. On the day of inspection, the inspectors visited three of the five units of this centre. In two of the units adequate staff numbers were not available in order for some residents to leave the centre and attend to a meaningful activity. The inspectors spoke with staff members in these units who outlined that due to staff shortages activities would be limited and if possible a walk would be facilitated later in the day for residents. In one of these units, three of the seven residents had one planned activity for approximately one hour that day. The inspectors observed that residents in these two units were not engaged in meaningful activities, with significant periods of time whereby residents were seated in chairs in the sitting room or conservatory with no apparent stimulation. The third unit had a dedicated activity staff resulting in more frequent individualised activities for residents. In the two other units, residents attended day services.

Personal plans were developed in areas such as family contact, health care and safety for example, nutritional plans, intimate care plans, epilepsy plans and family support plans.

The inspectors reviewed sample records of activities for two residents, one for the preceding month and one for the preceding two weeks and noted there were numerous occasions where no activity was recorded as haven taken place for up to periods of 48

hours. In addition, the inspectors found that some planned activities were inappropriate, for example, tabletop activities and an activity of relaxing in the chair between the period of breakfast time and lunchtime.

Individual goals had been identified for residents in personal and social care and incorporated short term goals for the upcoming year and long term goals for three years, for example, improving personal independent self help skills, going on holiday, day trips and activities in the community. However, the inspector found that actions had not been consistently developed to meet these goals and the support required was not outlined. Some goals were progressing or had been achieved in recent weeks, for example, a planned day trip had taken place and a resident was being supported to improve personal self help skills.

One action from the previous inspection had been satisfactorily implemented and families had attended reviews of personal plans.

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:

The inspectors found that measures were in place to promote safety however, adequate arrangements were not in place for the containment of fire and fire drills required improvement.

An action from the previous inspection had not been satisfactorily implemented and fire doors in bedrooms were wedged open at night time. The inspectors were informed this was to ensure residents could be appropriately observed during the night and in the event of a fire the staff on duty at night time had responsibility to remove all wedges in order to implement containment measures. This had been an issue from the previous inspection however, the inspectors found the actions the provider outlined they were undertaking were not in place on the day of inspection.

Two of the actions from the previous inspection had been implemented and measures had been put in place to prevent inadvertent injury to a resident. A corresponding risk management plan was in place. Sample training records for six staff were reviewed and all staff had up to date training on fire safety.

The inspector reviewed records of fire drills in one unit since the last inspection in 2014. Fire drills were carried out on a quarterly basis. However, the inspectors found that the procedure in place for the evacuation of residents at night time had not been trialled. There was one staff on duty at night time. The evacuation plan in place required that five floating staff from other centres attend and assist with the evacuation. The day time evacuation plan had been trialled on a number of occasions and drills had been completed in a timely manner. The fire evacuation plan was prominently displayed.

There was suitable fire fighting equipment available in the centre including fire extinguishers, fire blankets and fire alarms. There was adequate means of escape, all exits were clearly marked and unobstructed on the day of inspection. Service records for fire equipment was subsequently reviewed post inspection and the inspectors found that all equipment including fire alarm emergency lighting, fire extinguishers and fire blankets had been serviced within the last year. Personal emergency evacuation plans were in place for residents outlining the support required to assist residents in the event of an evacuation.

There was an up to date policy for risk management. Individual risk assessments had been developed, for example, for falls, choking and challenging behaviours. The system for incident management included reporting the incident to the person in charge on the day of occurrence who attended the centre and reviewed the actions taken to prevent reoccurrence. Additional measures were put in place if required. 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. A risk officer was also available in the service to review identified risks. There was a policy relating to incidents where a resident goes missing.

The centre had policies and procedures relating to health and safety, for example, a food safety policy, waste management policy and a manual handling policy. A monthly health and safety checklist was completed and included areas such as fire safety, use of oxygen, electrical and violence and aggression.

Staff had received training in the moving and handling of residents. Adequate precautions were in place for infection control, for example, hand sanitizers, antibacterial soap and disposable hand towels.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found measures were in place to protect residents being harmed or suffering abuse. However, improvements were required in relation to behavioural support as plans did not reflect current practice, the use of restrictive practice, the follow up to disclosures of abuse and safeguarding training.

There was a safeguarding policy in place however it was out of date and required review. Staff members spoken to were familiar with the types of abuse and reporting mechanisms to report allegations, disclosures or concerns to an identified designated person should an allegation of abuse arise. Of the staffing records reviewed, four staff had up to date training in safeguarding, one staff's training was out of date and no documentary evidence was available to confirm one member of staff had received any training in safeguarding. The inspectors reviewed the follow up actions following a recent allegation of abuse. Measures had been put in place to safeguard residents and some of the follow up actions had been completed. However, documentation was not available on the day of inspection nor in the document submitted post inspection to confirm some actions had taken place as outlined in the provider response to the incident.

The inspectors were informed that at present there were no safeguarding concerns for residents. There was a designated liaison officer to deal with allegations, suspicions or disclosures of abuse.

There was a policy in place for the provision of behavioural support. The inspectors reviewed two behaviour support plans which had been developed following assessment by a psychologist and a clinical nurse specialist. Behaviour support plans outlined the identifying behaviour, strategies to reduce or prevent behaviours and the reactive strategies to support the resident during an incident of challenging behaviour. One behaviour support plan was currently under review by a psychologist. One behaviour support plan was not subject to regular review and the plan was dated as last reviewed in February 2015. In addition the inspectors reviewed corresponding risk assessments but found that some behaviours identified as a risk in these assessments were not identified in the behaviour support plan. The support required to prevent or respond to these behaviours were not detailed in behaviour support plans.

There was a policy in place on the use of restraint including physical, mechanical and chemical restraint however, the policy did not include the use of environmental restraint. Inspectors reviewed restrictive practices in use in the centre and found that some improvements were required. In one unit, staff were knowledgeable on the use of restrictive practices and these practices had been subject to regular three monthly review by a service committee, as outlined in the centre policy. There was evidence also that a review of these practices had resulted in reduction and / or discontinuation of the

practice. However not all restrictions went before the service committee for restraint, for example, an environmental restraint. The inspectors discussed this with staff, however, staff were unsure of the referral system and review system in place for some restrictive practices. Inspectors identified residents wardrobes being locked in response to a behaviour which was not referred to the committee. This restrictive practice had been implemented following a trial of one less restrictive measure in October 2015, however, there was no evidence of the plan in place to reduce this restriction and the reasons for using this restriction were not clearly recorded.

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:

The inspector found residents were supported to achieve and maintain good health.

Residents healthcare needs were met in line with the details set out in personal plans. Residents had access to timely and appropriate healthcare professionals such as a general practitioner, speech and language therapist, occupational therapist, chiroprapist and psychiatrist. Assessments had been completed by health care professional and recommendations formed part of personal plans, for example, cardiac care plans, and epilepsy plans. Staff were knowledgeable on residents' health care needs and the intervention and support to meet those needs and plans were fully implemented in practice. For example, ongoing monitoring requirements, follow up appointments and preventative interventions. An annual health assessment had been completed by a nurse.

The advice of a speech and language therapist formed part of nutritional plans where required.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall the inspectors found the policy and procedures in place for medication management protected residents.

There was a policy medication management including ordering, prescribing, storing and administration of medication. The inspector reviewed the procedures in place in one unit in the centre. Medication stock audits were completed on a monthly basis. While a comprehensive medication management audit was available in the centre, this audit had not been completed in this unit.

Medications were securely stored in a locked press. The inspectors reviewed a sample of medication prescription and administration records. Prescription records were complete and included residents' details, general practitioner details and the name, dosage and route of medications. PRN (as required) medications prescribed outlined the indications for use and maximum dosages were documented for all these medications. Where required, PRN (as required) medication protocols had been developed and guided staff practice. Suitable arrangements were in place for the disposal of medications and storage facilities for medications requiring disposal were available separate from regular medications. A record was maintained of all medications disposed of.

Medications were supplied by a community pharmacy service in monitored dosage systems. Medications not suitable for monitored dosage systems were stored in original packaging.

Medication management plans were developed outlining the support residents required to manage their medication.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspectors found the quality of care and the experience of residents were not monitored on a consistent basis. The management systems in place did not ensure the delivery of a safe and quality service and a number of non compliances were identified during the inspection. Improvement was also required in the provider's unannounced visits to the centre to ensure all areas of the centre were visited and to ensure the review considered the standards of care and support within the centre.

The action from the previous inspection had not been satisfactorily implemented. The management systems in place did not ensure the service provided was safe, appropriate to residents needs or consistent. Issues were identified with the arrangements for the containment of fire, fire doors were wedged open and the provider had failed to ensure that the actions outlined from the previous inspection were implemented. In addition, safeguarding training was not provided to some staff. Non compliances were identified in the provision of meaningful activities for residents and arrangements to meet the social care needs of residents. This was further impacted by ongoing staffing issues in which staffing levels were not consistently provided to the required levels resulting in negative impact for residents.

Six monthly unannounced visits had been completed in 2015 with a recent unannounced visit awaiting completion of documentation. An audit was completed during these unannounced visits however, the inspectors found that only one unit of the five units in the centre were audited on each visit. In addition, the contents of the audits were basic, and did not consider some aspects of quality and safety. For example, the plans in place to meet the assessed needs of residents, whether these plans were implemented and the actual staffing levels made available to meet these needs were not reviewed. In addition, actions were not developed for some identified issues.

An annual review of the quality and safety had been completed and the views of residents and families formed part of this review.

There was a clearly defined management system in place. Staff reported to a manager in each unit, who in turn reported to person in charge. In the absence of the person in charge a clinical nurse manager was also available. The person in charge reported to the adult service manager who in turn reported to the provider nominee. The person in charge was a qualified nurse and was in post in this centre for approximately one year. The person in charge was in attendance in the centre on a regular basis. The inspectors found the person in charge was knowledgeable of residents' needs.

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:

The inspectors found there were not appropriate numbers of staff to meet the assessed needs of residents and to ensure continuity of care. In addition, improvement was required in supervision of volunteers.

One action from the previous inspection had been satisfactorily implemented and rosters consistently recorded the names of staff on duty.

Most staff deployed to the centre had the appropriate skills and qualifications however, the inspectors found that appropriate numbers of staff to meet the needs of residents were not available at all times. On the day of inspection two of the five units were short staffed. There were no arrangements in place to replace these staff resulting in negative impacts for residents in accessing meaningful activities. For example, in these two units staffing levels should have been four staff per unit however, only three staff were on duty due to unplanned leave. The inspectors discussed this with the person in charge who outlined that staff are not replaced due to unplanned leave as per the service directive. In addition, the inspectors spoke with a clinical nurse manager of one unit, in which residents with significant behavioural needs were supported. The required staffing levels were four staff on day duty however, on one recent occasion, two experienced staff were on duty, with one additional staff deployed with no experience of working with these residents.

The inspectors reviewed sample rosters for the centre. Planned and actual rosters were maintained. The inspectors found from review of actual hours worked that staffing levels were not maintained to the required levels across the centre at all times. The person in charge had recently implemented a system of annual leave planning with the aim to minimise disruptions during periods of staff planned leave.

There was one volunteer employed in the centre and appropriate vetting had been completed. However, documentary evidence was not available to confirm that the

volunteer had received appropriate training or supervision.

The inspectors reviewed staff training records. Mandatory training had been provided to staff in manual handling, fire safety and behaviour support. Some improvement was required in the provision of training in safeguarding. Additional training had also been facilitated for staff, for example, in hand hygiene, communication with residents and intimate care in order for staff to deliver care and support reflective of residents' needs.

Training in supervision was currently being rolled out to managers of units in the centre with a plan for training to be completed for all managers by September 2016. Supervision was planned to take place on a quarterly basis thereafter.

There were effective recruitment procedures in place that included checking and recording of required information. The inspectors reviewed a sample of four staff files and all the requirements of Schedule 2 of the Regulations had been met. Relevant members of staff had up to date registration with the relevant professional body as required for their role.

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 2
Centre ID:	OSV-0003899
Date of Inspection:	07 June 2016
Date of response:	13 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 is failing to comply with a regulatory requirement in the following respect:

Residents were not facilitated to make choices on their daily lives and activities were limited.

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) (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:

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

Each living area will submit weekly to the Person In Charge, the plan of daily 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 .

1.5 WTE staff have been recruited in this designated centre.

The Person in Charge and Deputy are 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 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 and will visit the living areas to seek any issues the residents' wish to raise.

The Person In Charge will ensure that residents and staff understand the process of availability of choice of meals, options and goods from catering and ensure cooking/baking facilities with resident involvement are supported in each area. The catering manager has undertaken to review and audit across the Designated Centre.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

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

Residents were not involved in the planning and organisation of the centre.

2. 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 residents are involved in the running centre and make choices, the Person In Charge will ensure there are weekly residents meetings and monthly keyworker meetings to review activities and choices available in each living area. There will be a weekly review and monitoring of activities in each area by the Person In Charge.

The Person in Charge and Deputy are not included in the WTE of the designated centre and work fulltime in these roles. 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.

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 will visit the living areas to seek any issues the residents wish to raise.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

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

The practice of residents being checked regularly throughout the night required review with regard to the assessed needs of residents and their right to privacy.

3. 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:

An audit of needs and Residents Risk Assessment has been undertaken across the designated centre to ensure that the frequency and requirement of night time checks are consistent with the residents need for supervision. Following audit, the requirements for each person will be advised to night staff and recorded in the Residents Personal Support Plan. The practice will be monitored by the Assistant Director of Nursing (Nights).

Proposed Timescale: 02/08/2016

Theme: Individualised Supports and Care

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

Residents did not have free access to some of their possessions due to the implementation of an environmental restrictive practice.

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:

A full review of restrictive practices across the Designated Centre will be undertaken to ensure restrictive practices are appropriate and ensuring the use of least restrictive practice methods and that these restrictive practice methods are documented. The environmental restrictive practice present on the day has been removed and all residents are facilitated to access their own possessions. The policy on restrictive practices has been revised to fully consider environmental factors.

Proposed Timescale: 30/08/2016

Theme: Individualised Supports and Care

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

Meaningful recreation and activities were not consistently provided for residents.

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:

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.

A review of meaningful recreation and activities will be undertaken by the Person In Charge to ensure individual needs of residents are met in line with their goals at weekly service user meetings. Each living area will submit weekly to the Person In Charge, the plan of daily activities for approval to ensure activities are met and meaningful. These will be reviewed and monitored on a weekly basis by the Person In Charge .

1.5 WTE staff have been recruited for this designated centre.

The Quality Steering Committee Audit Group will prioritise meaningful recreation and an activities audit with action plan will be completed in July 2016.

Proposed Timescale: 30/09/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Communication plans were not in place for some residents.

6. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

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

A review of Communication needs has been undertaken across the Designated Centre. A plan has been developed to ensure Personal Support Plan indicators are updated and individual. Where identified as required, a communication plan/passport will be developed. A pilot total Communication environment will be undertaken in this centre.

Proposed Timescale: 31/10/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents social care needs were not met through personal planning or through implementation of meaningful activities.

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:

A review of meaningful recreation and activities will be undertaken by the Person In Charge to ensure individual needs of residents are met in line with their goals. These will be reviewed on a weekly basis to ensure planning and implementation. Staff have been assigned to support these goals. 1.5 WTE staff have been recruited for this designated centre.

The Quality Steering Committee Audit Group will prioritise meaningful recreation and an activities audit with action plan will be completed in July 2016.

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.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The actions and supports required to meet identified personal and social goals were not identified in personal plans.

8. 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:

The Person In Charge will review all personal support plans to ensure that individual goals are developed and supported through implementation. Staff have been assigned to support these goals.

Proposed Timescale: 30/09/2016

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 procedure in place for the evacuation of residents from one unit at night time had not been trialled to ensure it was effective.

9. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

Night time fire evacuations have been undertaken and reviewed for effectiveness in all living areas. A schedule is in place for regular drills for day and night.

Proposed Timescale: 12/07/2016

Theme: Effective Services

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

Adequate arrangements were not in place for the containment of fire as some fire doors were wedged open.

10. 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 practice will be monitored and recorded during regular supervision and fire drills.

Proposed Timescale: 31/08/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The use of a restrictive practice had not been reviewed by the service committee as per the centre policy. The rationale for use of this practice was not clearly identified and there was no plan in place to reduce this restrictive practice.

The centre policy on restrictive practice did not include the environmental restraint and required review in order to guide practice.

11. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

A full review of restrictive practices across the Designated Centre was undertaken to ensure restrictive practices are appropriate and ensuring the use of least restrictive practice methods and that these restrictive practice methods are documented. The policy on restrictive practices has been revised to fully consider environmental factors.

Proposed Timescale: 30/08/2016

Theme: Safe Services

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

A behaviour support plan did not outline the support measures in place to respond to some behaviours that challenge.

12. 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:

The Person In Charge, Psychology team and Clinical Nurse Specialist (Behaviour) will review all behaviour support plans to ensure they contain support measures to respond to behaviours that challenge.

Proposed Timescale: 30/09/2016

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 training or refresher training in safeguarding

13. 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 in safeguarding of residents following a Gap analysis.

Proposed Timescale: 30/09/2016

Theme: Safe Services

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

A follow up action as per the provider's recommendations, follow a safeguarding concern, had not been completed

14. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

All actions have been completed as per provider's recommendations.

Proposed Timescale: 12/07/2016

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:

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

Actions had not been developed for some issues identified during unannounced visits by the provider.

15. 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

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 particularly in relation to residents' rights, dignity and consultation, workforce and fire precautions indicated the management systems in place did not ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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

Proposed Timescale: 31/08/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Continuity of care and support was not maintained for residents as unplanned staff absences were not replaced.

17. 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:

A relief panel is available in this Designated Centre with persons who are familiar and have the skills to meet service users' needs. There is a recruitment process for three WTE staff to complete this panel. 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.

Unplanned absences are reviewed at handover with the Programme Manager to ensure safe levels of care.

Proposed Timescale: 30/09/2016

Theme: Responsive Workforce

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

The numbers of staff on duty were not appropriate at times to meet the needs of residents. On occasions, staff did not have the experience required to meet the needs of residents.

18. 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. 1.5 WTE Staff have been allocated to support social activities.

A relief panel is available in this Designated Centre with persons who are familiar and have the skills to meet service users' needs. There is a recruitment process for three WTE staff to complete this panel. 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: 30/09/2016

Theme: Responsive Workforce

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

Documentary evidence was not available to confirm volunteers had received appropriate training or supervision.

19. Action Required:

Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

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

The volunteer is a full time manager and member of staff who has completed all induction and core competency requirements, including safeguarding and protection and is fully Garda vetted. The staff member has a long standing friendship with the service user.

Proposed Timescale: 12/07/2016