Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Gweedore Service
Centre ID:	OSV-0005331
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Catherine Glynn
Support inspector(s):	Jillian Connolly
Type of inspection	Unannounced
Number of residents on the date of inspection:	32
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 compliance with National Standards. 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:
17 August 2016 12:30	17 August 2016 21:00
18 August 2016 11:30	18 August 2016 20:00
19 August 2016 11:30	19 August 2016 17:00

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:
An inspection had been conducted in the centre in May 2016. Inspectors identified significant levels of non compliance with the regulations. As a result the Health Information and Quality Authority took the extra ordinary measures of issuing a notice of improvement to the provider prescribing the actions that the provider was required to take to improve the quality and safety of services provided. Furthermore a provider meeting was held in June 2016 in which HIQA informed senior management of their concerns. The purpose of this inspection was to ascertain if the provider had taken the necessary actions.

Description of the service:
The centre consisted of seven houses with a maximum capacity for 32 residents. Residents spoke with inspectors regarding the support they received and care provided. They expressed satisfaction regarding the care received. However, residents spoke about the difficulty in accessing the community or achieving personal goals they had identified. Three of the houses were located beside each other and

the remaining four houses were dispersed throughout the local town. The centre provided services to females over the age of eighteen with a primary diagnosis of intellectual disabilities. This centre was operated by the health service executive.

How we gathered our evidence:
During the inspection, inspectors met with nine residents, and nine staff. The premises and documentation were reviewed. The review of documentation included daily logs, care plans, incident forms, risk assessments, audits, training records, fire drills and personal plans. The inspectors observed practices at the centre and met with nine all of whom were engaging and participating in activities within centres. The inspection took place over three days. During the course of the inspection, the inspectors visited all seven houses.

Overall judgment of our findings:
Inspectors found insufficient changes had been made on foot of the improvement notice to improve the overall quality of life and service provided to residents. The quality of social care assessments was found to be poor and residents had limited opportunities to participate in any meaningful activities or engage with their local community. Some improvement had occurred in healthcare and medication management. However, failings were identified across a number of outcomes.

These failings included, ineffective governance and management systems, including the allocation of a person in charge with sole responsibility for the centre; lack of a meaningful day for residents; lack of assessment regarding residents' needs and supports required; absence of recognition of residents' rights and consultation with residents; safeguarding and safety issues due to a lack of staff training in the management of abuse and regarding behaviour management. The inspectors also found failing in relation to admissions which were inappropriate and an absence of contracts of care, the premises were not fit for purpose, inadequate fire management systems and inadequate health and safety and risk management systems.

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. The improvement notice had identified, to the provider, that failure to implement the outlined actions would result in a number of actions in accordance with the Regulations. The providers' representatives were advised that, HIQA would be further escalating its procedures regarding regulation of the centre, following findings of this inspection.

HIQA could not agree all action plan responses with the provider, where this has occurred these action plan responses will not be published.

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):
No actions were required from the previous inspection.

Findings:
Overall the inspectors found that the provider continued to fail to recognise residents' right to participate in and consent to the care and supports required. Not all aspects of this outcome were reviewed as part of this inspection.

During the course of this inspection, inspectors identified that the operation of the centre was not led by choice, respectful of residents or in consultation with residents but rather was dictated by available resources. For example, residents were being moved between houses without any consultation or involvement in this change to their life.

The inspectors also found that routines and practices within the centre did not promote residents' independence or choice. For example, there as a lack of consultation with residents regarding new admissions that occurred in the centre. Inspectors also found that further changes to residents' homes were outlined in a reconfiguration plan, however this had not been disclosed to residents affected or their representatives. In addition, no assessments regarding the need for change or supports had been completed at the time of inspection. The inspectors were also asked during the course of inspection not to discuss proposed changes in one house, as residents and staff were unaware of proposed changes.

Furthermore, inspectors found that transitions had occurred within the designated centre which were primarily operational in relation to house closures and levels of staffing. From a review of documentation it was evident that this had a negative impact on those residents that were moved. Inspectors found that there where such a move had occurred, there was documentation outlining distress experienced by the residents.

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:
The inspectors found that the registered provider continued to be in non compliance with elements of this outcome as previously identified on the last inspection in May 2016. On foot of an improvement notice issued to the provider, it was outlined by HIQA, that no new admissions would occur without an agreement in writing on admission.

Improvements were required in relation to residents' contract of care. Inspectors found a recently admitted resident had a written agreement. However, this had not been signed on admission and was dated the final day of the inspection. Throughout the inspection, inspectors met with a number of residents who stated that they had not signed an agreement with the provider for the terms in which they would reside in the centre and the care and support that they would receive.

Inspectors were informed by management that alternative living arrangements within and external to the centre were currently being sought for some residents. However, on review of documentation and discussions with residents and staff, it was not clear what information was guiding the decision making process. For example, inspectors were provided with a document that identified residents who would be internally transitioned to other houses within the service. In addition, this document outlined residents who were to be admitted and residents who were proposed to be discharged from the designated centre. However, this plan was not supported by a robust assessment which identified the needs and subsequent supports residents required. Residents were not involved in the decision making process as confirmed by staff.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Following the inspection in May 2016, the provider had agreed to ensure that no resident would be admitted to the centre, without a comprehensive assessment of residents' needs occurring. Furthermore, the provider agreed to ensure that the assessment would identify if the collective needs of all residents could be met prior to admitting a resident. Inspectors identified on this inspection, that two residents had been admitted since the last inspection in the absence of a robust assessment of need.

One of the admissions was an emergency admission and was for one night. It involved a resident staying in the room of another resident who was temporarily absent from the centre. The second admission had occurred two weeks prior to the inspection. Inspectors found that the resident was admitted without a comprehensive assessment of their needs. Inspectors reviewed the resident's personal plan and found it was reflective of their previous residence. Minutes of meetings demonstrated that the decision making process, regarding this move, involved management and was not reflective of the resident's wishes, the needs of the resident or the needs of residents currently residing in the centre at that time.

The provider was required to ensure that following the completion of a comprehensive assessment, a personal plan is developed for each resident within the centre detailing the supports they required to ensure that their assessed needs were met. Inspectors found, from a review of sample of personal plans thatplans, which this had not occurred for all residents. As a result the personal plans did not outline the supports residents required. Inspectors found that this resulted in an absence of a coordinated approach to the care and support provided to residents. For example, inspectors found that closures had occurred of some houses during the summer period in the centre. As a result residents moved to other houses within the centre. This was not supported by an assessment of need. Daily records and discussions with staff demonstrated that this had a significant impact as the arrangements in place did not meet the needs of the residents.

Inspectors also found residents had goals identified which were not being achieved. This was due to a lack of appropriate resources and supports available to ensure that the

goals could be met. Inspectors found from a review of daily logs, residents were unable to complete or participate in social outings or personal goals as identified in personal plans. For example, residents informed inspectors that at weekends choice to attend outings was limited. They had been informed to choose a day as staff were not available on both days.

Residents told inspectors of times in which they could not achieve their personal plans due to staff shortages. However, personal plans did not identify the staffing levels the residents required to ensure that their goals were met. Through speaking with residents and a review of daily records, inspectors identified a correlation between residents' emotional wellbeing and their inability to engage in activities in line with their goals.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
In May 2016 inspectors found that that the premises did not meet the needs of all residents' living in the centre. Failings identified during the last inspection remained. Of the seven houses in the designated centre, one house remained in a state of poor repair. In addition, the stairs were difficult for residents with mobility issues to manage.

Another house was also found to be in a state of poor repair, inspectors observed plaster was missing from around the sitting room window and this prevented a blind being installed at the time of inspection. Furthermore, a bedroom upstairs was found to require painting and required repair to the wall surface.

The inspectors had identified that in another house there was limited communal space due to the needs of residents and equipment required. The records reviewed by inspectors indicated that residents complained repeatedly about the challenges they were experiencing due to the size and layout of some of the premises in the designated centre. The provider had responded by stating that residents would be moved to more suitable housing to reduce the challenges experienced by residents.

Inspectors found that there continued to be a risk for some residents with mobility issues. For example, where residents' bedrooms were upstairs this caused a challenge which was also verbally expressed to inspectors by a resident. In addition, an incident had occurred where a safety issue had been identified regarding access to the steep drive. Inspectors were also advised by staff that some residents had to attend other houses in the designated centre to access a suitable bathroom facility. Furthermore, in another house, inspectors found that a resident had complained about the communal use of an ensuite bathroom within the centre.

Whilst inspectors found evidence of improvements in the centre, such as painting and decoration since the last inspection, work remained outstanding. No log of completed and planned maintenance of work outstanding was available to inspectors for review at the time of inspection.

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:
Based on the findings from the inspection in May 2016 and the requirements of the improvement notice issued on 19 of May 2016, the inspectors found that the provider had failed to complete a comprehensive review of operational, environmental and clinical risks within the centre, a fire management systems review and implementation of findings of this report. Furthermore, of the risks identified, the control measures identified did not reduce the level of risk to residents or had not been implemented in practice. Overall there continued to be an absence of appropriate management practice regarding health and safety in the designated centre.

The inspectors reviewed risk assessments throughout the designated centre and found that the documents were dated 2014. This was also a finding on the previous inspection. The inspectors also found that there had been no review of the risk assessments in personal plans. Where inspectors observed control measures identified in personal plans, they found that some had not been implemented. For example, a hand rail was detailed as being required outside a front door to assist residents with mobility issues. This had not been implemented and therefore the risk had not been mitigated. Another example of poor implementation of control measures related to residents accessing stairs. At the time of inspection in a number of stairwells continued to be a difficult for residents with

mobility issues. The provider had also completed an internal audit identifying the need to review risk assessments on a monthly basis; at the time of inspection this was not being completed. Staff also informed inspectors that they had not received training in the area of risk management.

A comprehensive review of fire management systems had not been completed in the designated centre at the time of inspection as required by the improvement notice issued on the 19 May 2016. While the provider had submitted to HIQA a letter stating an external consultant had been involved in reviewing fire systems post inspection, it did not detail the level of work required or the timeframes in which the works would be completed, as required by the Chief Inspector.

Some improvement regarding fire safety had occurred. Inspectors observed that self closures on doors and fire doors had been installed in some parts of the centre but this was not consistent throughout the houses. However, inspectors observed that fire doors were not closing fully; this had not been identified by management during an internal audit of the centre. Inspectors also observed the use of door wedges which was a failing identified from the previous inspection.

Fire drills were being completed however they did not demonstrate safe and full evacuation with the lowest compliment of staffing. For example, one house required high staffing levels to support residents during the day. The inspectors found simulated night drills were not completed where a reduction in staffing at night was evident. The inspectors reviewed evacuation plans for residents and found that in one house support from staff was identified as a requirement in the event of an evacuation. However, staff had not been allocated to this area of the centre.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:

Overall the inspectors found that there had been improvement in safeguarding residents living at the centre, for example there were measures in place to keep residents safe and protect them from abuse. Inspectors found that improvement was still required with regards to the provision of training to staff regarding managing behaviour that is challenging.

The inspectors found that there were policies and procedures in place to ensure that staff were guided in their practice. For example, policies included safeguarding, behaviours that challenge and behaviour support. The inspectors found that the person in charge was failing to ensure that all staff were trained in relation to safeguarding of residents. The person in charge was unable to provide these records to the inspectors during the course of the inspection regarding staff deployed within the centre. The inspectors found that the provider was not assured that all staff deployed with residents in the designated centre had appropriate training, in line with regulations. At the time of inspection, inspectors found that there were no incidents or allegations of abuse in the designated centre.

While there was evidence of therapeutic intervention where required for residents, inspectors were not assured that all staff deployed within the centre had received training in positive behaviour support at the time of inspection. There were no restrictive practices being used at the time of inspection in the designated centre.

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

Findings:
Overall the inspectors found that residents' healthcare plans were appropriately assessed and their healthcare needs were met and informed by the use of evidence based tools.

Similar to the findings from the previous inspection in May 2016, the inspectors found that healthcare plans for residents had identified the supports they required, such as psychology, speech and language interventions, physiotherapy and occupational therapy (OT). Inspectors found that where medical treatment was recommended, the required care was facilitated. Residents had access to a general practitioner (GP) of their choice

and were supported to attend when required. Residents' daily records demonstrated that care was provided in line with health care plans.

Inspectors observed that residents were provided with snacks and drinks in a manner that was suitable to their needs. Inspectors spent time with residents while receiving refreshments and observed staff to provide assistance in line with their personal plans. Access to allied health professionals were reflected in personal plans.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
The inspectors found that improvements had been made and overall medication practices in the centre were in line with the requirements of the regulations.

Inspectors found that measures had been put in place to ensure control drugs were managed in line with best practice. A record of the medication stock was kept and signed by nursing staff on a daily basis. Guidance was in place to ensure staff administered this medication at specified times and the maximum dosage was identified.

Inspectors reviewed the prescriptions and administration records and found that they contained all the necessary information in line with the regulations. Protocols were in place for medication that was prescribed as required. Inspectors found that some residents were supported to be independent with their medication management.

During the course of the inspection inspectors observed staff to administer medication and interact with residents in a respectful manner during this interaction.

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:
Based on the findings of the previous inspection in May 2016 and the actions outlined by the Chief Inspector in the improvement notice issued to the provider. The inspectors found that the cumulative evidence and the absence of action from the two previous inspections demonstrated that the provider and person in charge could not ensure effective governance, operational management and administration of the designated centre.

The provider had failed to appoint a person in charge with sole responsibility for the designated centre as required in the improvement notice issued on the 19 of May 2016, following the previous inspection. Staff spoken with were unable to clearly identify the current person in charge.

Inspectors found that there had been several changes in the role of person in charge resulting in a negative impact for residents. For example, a recent change in management arrangements resulted in one person resuming overall responsibility for the centre in addition to two other centres. This had not been effectively communicated with all residents. Residents told the inspectors that they had not been informed of this change. Some residents affected were reliant on support with medication and finance from the person in charge but were at the time of inspection unaware who the person in charge was.

The inspectors also found disparity across the seven houses with regard to personal plans and systems within the houses. Inspectors found that the current management structure failed to identify specific individuals with areas of responsibility for service provision within the designated centre.

Inspectors found that since the last inspection a quality review had been completed in addition to a regulation 23 audit. Inspectors found this was not comprehensive as it failed to include all of the seven houses within the designated centre. The audits focused on completion of tasks, such as documentation completed as opposed to identifying any deficits in documents or the quality of service provision and the impact this had on residents. For example, where staffing allocation was identified, a focus was on number of staff provided as opposed to the relevant skill mix or supports required by residents. Monthly reviews had also been identified in the internal audits but were not completed where reviewed by inspectors, such as fire systems or risk assessments.

Inspectors were informed that an external facilitator had been sourced by the provider to complete a review of staffing support and skill mix in conjunction with assessments of needs and compatibility for residents. This had been identified as a deficit on the two previous inspections and HIQA had been informed that this would commence in June 2016. At the time of inspection inspectors were informed that this had not been completed and had recently commenced. The inspectors were not provided with a timeframe for completion of this action or the implementation of the findings from this review.

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 provider had failed to identify and allocate sufficient staff, with appropriate skills and qualifications to ensure both the health and social care needs of residents were met within the designated centre. This was a repeated failing from the previous inspection and had also been outlined in the improvement notice issued to the provider.

The staffing levels and skill mix had not been identified to ensure the appropriate supports were in place for all residents in the designated centre at the time of inspection. The provider had acknowledged this deficit in audits they had recently completed. The provider had committed in June 2016 that an external review of staffing levels and skill mix would be completed. However, at the time of inspection this had not commenced.

From a review of the rosters, inspectors found, that in one house where three staff were rostered daily (two care staff and one nurse), the nurse was required to attend other houses periodically. This resulted in a reduction in staffing in a house where it had been identified as being required due to an increase in residents' needs and supervision requirements. This had impacted on the supports and care provided to residents as seen in the personal plans reviewed and daily care notes.

Inspectors met with staff and observed their practice with residents. Staff spoke kindly and respectfully about residents. Inspectors were informed by residents that staff were kind and complimentary of care received. Notwithstanding this, the inspectors found that there was insufficient staffing employed throughout the designated centre from observation, discussion with residents and staff and from a review of personal plans.

Inspectors found that staff members had not received formal supervision at the time of the inspection. The inspectors found that this had an impact on practice and accountability in the centre. Inspectors found staff were not consistently supported or guided in their daily practice. For example, inspectors found that some staff in the centre did not report to the person in charge. Some staff identified a different management structure that had not direct remit for the centre or residents.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Glynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005331
Date of Inspection:	17 August 2016
Date of response:	28 November 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 provider is failing to ensure that the residents have freedom to exercise choice and freedom in their daily lives. For example, ability to attend a social outing on a day of their choosing.

1. Action Required:

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

Under Regulation 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:
To ensure each person has the freedom to exercise choice in their daily lives, the volunteer centre and Social Worker has been contacted and a meeting will be arranged to organise additional resources to support residents in their choice of social activities and enhance their independence. Staffing review has been completed and data is currently being compiled and sent to independent auditor.
Resident weekly meetings are held and recorded where by the resident voices their choices, wishes, concerns or familiar communication partner can aid the resident to voice exercise choice and control in their daily lives. New PIC's attend these meetings to ensure compliance in this area.
Annual (or as necessary) yearly reviews are held where by the resident's yearly goals, are discussed recorded and actioned. New PIC's attend annual reviews and ensures any recommendations, actions are completed.
Each resident is asked on a monthly basis what they would like to do for the coming month; monthly goals are compiled from this meeting and actioned. PIC's check to ensure compliance.
The resident or representative/family member will be involved in any transition planning that involves them or any changes within their home. PIC will ensure that each person will be involved and no admissions or changes to their home will take place without the proper consultation.
Update weekly house meetings being held in each service as from oct 2016.
Annual reviews- Gweedore = 12 of 14 complete, remaining 2 dates set for Nov.25th2016
Glendalough = 7 of 11 complete, dates for remaining by Dec 6th 2016
All families are invited to annual reviews and family review forms sent to families.

Proposed Timescale: 31/12/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider is failing to ensure that each resident participates in and consents, with supports where necessary to decisions about his or her own care and support. For example, residents involvement in transitions planning in the centre.

2. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
Resident weekly meetings are held and recorded where by the resident voices their choices, wishes, concerns or familiar communication partner can aid the resident to

voice exercise choice and control in their daily lives. New PIC's attend these meetings to ensure compliance in this area.
Annual (or as necessary) yearly reviews are held where by the resident's yearly goals, are discussed recorded and actioned. Individuals will invite people to their reviews. New PIC's attend annual reviews and ensures recommendations and actions are completed.
Each resident is asked on a monthly basis what they would like to do for the coming month, monthly goals are compiled from this meeting and actioned. PIC's check to ensure compliance.
Resident will be involved in any transition planning that involves them or any changes within their home. PIC will ensure that each person will be involved and no admissions or changes to their home will take place without the proper consultation. Each resident has an easy ready complaints policy. Complaints officer contact details are on display in each house. Complaints can be addressed at a local level in each house where staff can resolve a complaint locally. Each resident has an easy read charter of human rights.
Staff are being trained in safe medication administration to eliminate a resource led service.

Easy read complaint notice on display in each house. Complaints officer for Glendalough being changed to B Timony. Each person has an easy read complaints policy.

Proposed Timescale: 30/09/2016

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:
Written agreements were not signed.

3. 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:
The PIC will ensure each person has a new individualised contract of Care. All contracts of care will be signed by residents or representative. Compatibility assessments will be completed and evaluated to ensure individuals choices and preferences are captured and acted on. This will result in changes occurring within the designated centre.
Will be reissued when new charges are calculated for each person Feb.3rd 2017

Proposed Timescale: 03/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were admitted in the absence of appropriate criteria.

4. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
Should any admissions occur a comprehensive assessment of need will be completed prior to admission to the centre. Consultation with all residents involved regarding changes in their home will be completed. All admissions will be line with the centres statement of purpose. All residents will be involved in any transition planning that involves them or any changes within their home. PIC will ensure that each person will be involved and no admissions or changes to their home will take place without the proper consultation. Transition plans and compatibility assessments will be carried out prior to any admissions or transfers, discharges. Contract of care will be signed by individuals or their representative / family
Two new admissions - nursing assessment updated
New contracts of care for update Jan 2017

Proposed Timescale: 29/11/2016

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 did not receive a comprehensive assessment of needs prior to admission.

5. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The PIC will ensure all documentation including a comprehensive assessment of health, personal and social care needs are completed prior to admission to the centre. All residents in the centre will have their assessment of needs reviewed and updated by Nov 29th 2016

Proposed Timescale: 29/11/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assessments were not comprehensively reviewed following a change in need.

6. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
PIC will ensure a comprehensive assessment will be completed for the each resident following any change in need. This will be reflected and actioned upon within the personal support plan. The assessment and personal support plan will be reviewed annually or sooner if necessary.
Each person within the centre has an assessment of need and each assessment will be updated by year end or sooner if required.

Proposed Timescale: 16/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge is failing to outline the supports required to maximise the residents' personal development in accordance with his or her wishes.

7. 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:
A comprehensive needs assessment of the health, personal and social care needs and development of the residents personal support plan will occur within the 28 day timeframe. The resident/family or representative/ persons circle of support will be actively involved in developing their person centred plan prior to and on admission and to be completed no later than 28 after admission.
Pic will hold a review post admission of the person no later than 8 weeks after admission. Complete post admission meeting held 21/9/16

Proposed Timescale: 06/12/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider was failing to ensure there were a sufficient number of baths, showers and toilets to meet the needs of residents.

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:
Approval has been sought from the Estates Department to have a spec completed on the premises to address the issue of sufficient number of baths, showers and toilets to meet the residents needs
Meeting held with Voluntary Housing Association on Nov16th 2016, specifications of the upgrades required to the buildings were given to the association by the HSE. OT recommendations were also outlined on the specifications. The Voluntary association will cost and plan works required. To ensure that there are sufficient numbers of baths, showers and toilet to meet the needs of the residents. One resident was discharged to more suitable accessible accommodation to meet their needs. All residents have access to toilet and showering facilities.

Proposed Timescale: 16/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The houses were not meeting the needs of all residents residing in them.

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

Please state the actions you have taken or are planning to take:
More suitable accommodation is being sourced for the changing needs of individuals. Approval has been sought from the Estates Department to undertake specification of the premises to improve accessibility within the houses. Specifications will be forwarded onto relevant agencies. All individuals have been referred to Co Council housing list. Meeting held with Voluntary Housing Association on Nov16th 2016, specifications of the upgrades required to the buildings were given to the association by the HSE. OT recommendations were also outlined on the specifications. The Voluntary association will cost and plan works required.

Proposed Timescale: 16/06/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the centre were not in good repair.

10. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The PIC will ensure that the weekly maintenance lists are maintained and cleaning records are completed, this will be maintained by audit and observation by the PIC. A cleaning schedule for rooms is in operation.
Resident's bedroom that required painting has been completed. Sitting room window of one house that required plaster repair has been completed. Gutters and windows have been cleaned.
Painting of houses has been completed.
A once off cleaning for Glendalough Services will be completed on November30th

Proposed Timescale: 23/11/2016

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:
As outlined in the body of the report, the risk management systems in place required further improvement in the designated centre.

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

Please state the actions you have taken or are planning to take:
"The Health Information Quality Authority could not agree a satisfactory action plan response with the Provider relation to this action"

Proposed Timescale:

Theme: Effective Services

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

The provider had not demonstrated effectiveness of fire drills with the lowest compliment of staffing in the designated centre.

12. 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:
Yearly deep-sleep fire drill simulations will be scheduled. Monthly fire drills are ongoing and reports on same are submitted to PIC on a monthly basis. Fire drills will be carried out with the lowest compliment of staff. Learning from fire drills is documented and shared with all staff within the centre.

Yearly deep sleep completed in 3 houses.

Proposed Timescale: 29/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not ensured that fires could be contained in the designated centre.

13. 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:
"The Health Information Quality Authority could not agree a satisfactory action plan response with the Provider relation to this action"

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure a review, completed by a competent person, of the fire management systems was undertaken that included the environmental, clinical and operational factors.

14. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
Fire assessments by external consultant completed between June and September 2016

consisting of works to be completed with a timeframe of same. PICS have developed action plans for same; controls are implemented as identified on risk assessment. Emergency lighting and fire doors upgraded in Gweedore Services as of 9/11/16. A schedule of works for further houses will be forwarded by external consultant within a year of initial risk assessment.

Proposed Timescale: 30/09/2017

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:
Staff had not received training in the management of behaviours that challenge as identified by the provider.

Staff had also not received training in positive behaviour support.

15. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
"The Health Information Quality Authority could not agree a satisfactory action plan response with the Provider relation to this action"

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge was unable to provide record of safeguarding training for staff deployed in the centre at the time of inspection. It was therefore unclear if all staff had appropriate training.

16. 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:
Safe guarding training is ongoing, with dates scheduled and staff attendance mandatory. 86% of staff has completed safeguarding training and a schedule in place for remainder of staff. 100% of staff will have completed training by Dec 15th

Training record held locally and updated as of Nov 23rd

Proposed Timescale: 15/12/2016

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 provider failed to appoint a person in charge that had sole responsibility for the centre.

17. Action Required:
Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

Please state the actions you have taken or are planning to take:
From September 10th 2016 a new management structure was commenced within the designated centre. This designated centre was divided into three separate areas and two PICS' were put in place to over see and govern the designated centre.

Proposed Timescale: 10/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management structures did not identify the individuals responsible for all areas of service provision.

18. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
From September 10th 2016 a new management structure was commenced within the designated centre. This designated centre was divided into three separate areas and two PICS' were put in place to over see and govern the designated centre. A clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. All staff is aware of the new management structure. Roles and responsibilities have been discussed with staff through management supervision framework agreement. Schedule in place for the completion of same.

Proposed Timescale: 10/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place to ensure the quality and safety of care provided to residents were not effective.

19. 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:
Two PICS' have been identified to govern the designated centres and to ensure quality and safety of care provided to the residents are of a high standard. Audit schedule has been developed by PIC's. A named nurse and key worker system is in place within the designated centres. A draft Team Leader and Key Worker Guideline has been circulated to staff for feedback and comments; the Policy, Procedure and Guideline Group will review this document following this. Training will be sourced on Key worker and Team Leader roles for staff.
Dementia training has been provided for staff within the designated centres. September 10th 52% staff have completed this training and are awaiting further dates for remainder of staff.
PCP training commenced 7/11/16, 15/11/16.
Dementia training scheduled for January 9th +23rd 2017.

Proposed Timescale: 31/01/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not provided with appropriate training to meet the changing needs of residents.

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

Please state the actions you have taken or are planning to take:
A schedule of training is active for staff. This schedule is updated regularly as new training becomes available. A training record for all staff is available in each centre.

Training schedule updated weekly. Behaviours that challenge scheduled 23rd/24th Nov 2016. Person Centred Planning training commenced 7/11/16, 15/11/16. Safe guarding 15th Dec 2016. Dementia training scheduled for January 9th +23rd 2017. Manual handling Dec 1st, 8th and 13th 2016. Disability awareness 24 Nov 2016. Diabetes training 23rd Jan 2017.

Proposed Timescale: 28/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

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

Please state the actions you have taken or are planning to take:
New PIC will commence staff supervision meetings. These are held and recorded by PIC on a 3 monthly basis with all staff in the designated centres. PIC and staff will have record of same. PIC's will carry out regular announced and unannounced visits to the designated centres. Supervision agreements are ongoing with staff within the designated centres.

Gweedore = 7 of 10 complete
Glendalough= 4 of 14 complete
All staff will have supervision meetings completed by: 16th December 2016

Proposed Timescale: 16/12/2016