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:	Fernhill Respite House
Centre ID:	OSV-0003338
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Amanda Doyle Gilmartin
Lead inspector:	Jackie Warren
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 October 2016 10:30	26 October 2016 18:30
27 October 2016 10:00	27 October 2016 15:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was an 18 outcome inspection to monitor compliance with the regulations and standards and to inform a registration decision.

How we gathered our evidence:
As part of the inspection, the inspector observed practices and reviewed documentation such as health and social care files, medication records, staff files and health and safety documentation. The inspector met with all three residents who were using the service at the time of inspection. Residents told the inspector that

they loved coming to the centre and felt safe there. They said that they enjoyed their leisure time and the social interaction with other residents and staff. All residents complimented the staff and said that staff looked after them very well. The inspector also met with four staff members, the person in charge and her line manager. Some residents and their families had returned satisfaction questionnaires to HIQA and these indicated a high level of satisfaction with the service.

Description of the service:
The centre is a single-storey house on the outskirts of a town. The centre provided a respite service to approximately 50 male and female adults with a physical and sensory disability including adults with an acquired brain injury. A maximum of three residents used the service at any time. The service provided to residents was for three-day respite breaks, up to three or four times a year.

Overall judgment of findings:
The inspector found a good level of compliance with the regulations, with seven of the outcomes being found compliant and seven substantially compliant. Three outcomes were moderately non compliant and there was one major non-compliance.

Overall, residents received a good level of health and social care, and stated that they were happy visiting the centre. Although residents took responsibility for their own medication administration, medication management practices were not in keeping with the centre's policy. Improvement was also required to staff recruitment and record keeping.

There were measures in place to safeguard residents, such as, staff were suitably trained and were aware of safeguarding risks and how to address them should any arise. However, improvement to fire safety and risk management was required.

The centre was suitably resourced to meet the needs of residents with suitable staffing levels and transport available to meet these needs. Minor improvement was required to the statement of purpose, health care records, premises, internet access, outcomes of auditing, reviewing of bed rail assessments and the complaints process.

Findings from the inspection are outlined in the body of the report and actions required are found in the action plan at the end.

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:
The inspector found that residents were consulted in how they spent their time in the centre, and had access to a complaints process. However, some improvement was required to the complaints procedure.

Residents told the inspector that when they came to the centre for respite stays, they met with staff to make plans and discuss what they wanted to do during their stay, including personal events, activities and shopping. Residents' activity preferences were recorded on arrival to guide staff, but these were reviewed on a daily basis and could be changed if the residents so wished.

There had been no complaints made in the centre to date, although the person in charge knew the system for the recording and investigation of complaints if required. The complaints process was based on 'your service, your say', details of which were displayed in the centre. This information had also been supplied to each resident as part of an information pack. There was a complaints policy to guide staff. The policy, however, did not clearly explain the appeals process, and did not identify a person, separate from the nominated complaints person, to ensure that all complaints were suitably recorded and resolved as required by the regulations.

Residents had access to other supports, such as advocacy services and a confidential recipient.

Residents told the inspector that they would talk to staff if they had any complaints or worries and they felt that they would be addressed. These residents told the inspector

that they were very satisfied with the service and really enjoyed and looked forward to their respite breaks. At the end of each stay each resident completed a feedback form to record their level of satisfaction with their stay.

The inspector observed that the privacy and dignity of residents was respected. Staff spoke with residents in a caring and respectful manner. All residents had their own bedrooms and could lock their bedroom doors if they wished to. As residents used this service for short respite breaks only, they generally did not choose to personalise their rooms for the duration of their stay. Staff confirmed that residents brought the clothes, toiletries and personal items that they required for the duration of their stay. There was some lockable storage space in all bedrooms.

Intimate personal plan had been developed for residents to ensure that maximum independence was promoted during the delivery of intimate care.

Residents' religious rights were supported if required. The person in charge confirmed that any resident who wished to go to the church or participate in religious events would be supported by staff to do so. As residents lived at home, they took responsibility for their civil rights themselves.

Residents' finances were not managed by staff in the centre, as residents took responsibility for their own money.

Judgment:
Substantially Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were communication systems in place to support residents, although improvement to internet access for residents was required.

At the time of inspection all service users could communicate clearly and staff confirmed that most residents using the service had good communication skills. There were communication plans in place for residents who required further support from staff.

There was information for residents displayed in the centre, including information on an advocacy service, whistle blowing, evacuation procedures and the organisation's

management structure.

All residents had access to televisions, radio, newspapers, postal service and reading material. However, internet access was not available to residents in the centre. The person in charge had identified this as an area for improvement and was investigating the provision of internet access.

Judgment:
Substantially Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Residents who used this service lived at home with their families and used the service for intermittent short respite breaks. Family visits did not usually take place during respite breaks. However, family visits could be facilitated on request, in accordance with centre visitors policy.

While on respite visits, links with the local community were maintained and residents spoke of going out for meals, shopping and going for outings.

Residents said that they were supported to go on outings, attend sporting and entertainment events and dine out in local restaurants. Residents frequently visited the shops and amenities in the town.

Judgment:
Compliant

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:
Since the last inspection the development of service agreements with respite residents had been addressed.

A new service agreement document had been developed and had been agreed with residents. The inspector read a copy of this agreement and found that it was informative and clearly explained the service provided.

There was a policy to guide the admission process, and the person in charge was aware of the importance of suitable assessment for compatibility prior to admission.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that residents' social care was being well supported.

There was an individualised assessment undertaken for each resident and residents had opportunities to pursue activities based on their individual preferences.

All the residents using this service lived at home with their families and came to the centre three to four times a year for three day breaks. Residents told the inspector that they treated these breaks as short holidays, during which they relaxed, enjoyed leisure activities of their preferences and dined out.

Each resident had a personal plan which contained information about residents' health and social care requirements.

Residents using this service at the time of inspection were not involved in a schedule of planned activities, but decided on activities or outings of their choice on admission or on a daily basis. For example, on the day of inspection, residents did activities such as, personal shopping, taking a drive to a scenic area with staff, dining out and relaxing in the house. In addition, there was also a selection of movies and games available for residents' to use.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The design and layout of the centre generally suited the needs of residents. The centre was a single-storey house which was well maintained both internally and externally. The house was clean, warm, well furnished and comfortable. However, there was inadequate wardrobe space in one bedroom and provision of grab rails was required in a bathroom.

There was a variety of communal day space including a large open plan kitchen, dining room and seating area, and an additional sitting room. All bedrooms were for single occupancy and were comfortably furnished. Most residents had adequate personal storage space in their bedrooms and could lock their bedroom doors if they chose to. However, one bedroom did not have any wardrobe, and therefore residents staying in that room did not have anywhere to hang their clothes.

Two bedrooms had en suite toilet and shower facilities. One of these was allocated for use by residents while the other was the staff bedroom and office. There were sufficient additional toilets and showers, including assisted facilities. However, while grab rails were in fitted in some of the bathrooms, they had not been fitted at all sanitary facilities and this had been raised in resident feedback. The person in charge was exploring options to address this.

Call bells were fitted in all bedrooms and bathrooms in the house.

While all the residents using the service at the time of inspection were independently

mobile, there was a ceiling hoist fitted in one of the bedrooms. There was also a free-standing hoist available. These were being serviced annually, and were available for use if required at other times.

The kitchen was well equipped and clean. There was adequate food storage and preparation space, although residents did not prepare meals other that breakfast and snacks in the house.

There were separate office, bedroom, toilet and shower facilities for staff.

Residents had use of a washing machine and clothes dryer with which they could do their own laundry. However, due to the short duration of stays in the service, residents did not normally use these facilities.

There were suitable arrangements for the disposal of general waste. Refuse bins were stored externally and were emptied by contract with a private company.

Systems had been introduced to reduce the risk of infection in the centre. There was a well equipped cleaning store with a colour coded cleaning system, bed pan steriliser and sluice sink. Hand sanitising gels were provided throughout the building for residents, staff and visitors to use. Bed linen was laundered by private contractor after each respite stay.

Residents had access to the outdoors. There was a paved outdoor garden, which included a smoking area for residents who were smokers.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The inspector found that there were some systems in place to protect the health and safety of residents, visitors and staff. However, improvement was required to evacuation procedures, including fire drills, checking of fire safety equipment and fire safety training. Improvement to the risk management policy was also required.

There was a health and safety statement, a risk management policy and risk register

which identified measures in place to control identified risks. Personal risks specific to each resident were identified and control measures were documented in residents' personal plans. There was a risk management policy which was out of date and is further discussed in outcome 18. The policy did not include guidance on the arrangements for identification, recording, investigation and learning from serious incidents, as required by the regulations. However, the inspector found that serious incidents were being taken seriously and were being reviewed for learning. The specific risks stated in the regulations were included in separate policies.

The inspector reviewed fire safety policies and procedures. There were up-to-date servicing records for all fire fighting equipment, fire alarms and emergency lighting available for review. While there were organisational recommendations for internal fire safety checks, there was no evidence that these were being carried out. The organisation required, for example, that monthly checks of fire fighting equipment and weekly checks of internal fire doors are undertaken, but there were no records to indicate that these were being done. This had also been identified for immediate attention in the provider's unannounced audit, but had not been addressed.

The provider had measures in place to control the spread of fire. The person in charge stated that all internal doors were fire doors and automatic closing mechanisms were fitted on internal doors.

Staff had received fire safety training. Staff who spoke with the inspector were aware of the need to evacuate residents promptly in the event of a fire. However, staff stated that they had received different guidance at different training sessions, and therefore were not sure of the best method to use.

Fire evacuation procedures required improvement. There was a lack of clarity around how residents would best be evacuated from the centre. Although personal emergency evacuation plans had been developed for each resident, some of the information in these plans was not clear and did not sufficiently guide staff. Fire evacuation drills were being carried out monthly. Records of all fire drills were maintained, although these did not accurately reflect times taken to evacuate. In addition, no fire drills had been undertaken during night-time hours, or to simulate night-time circumstances. Therefore, the person in charge and staff did not know of problems that might occur, or how residents might react, during an emergency at night. As this was highlighted on the first day of inspection, the management team carried out an early morning fire drill on the second inspection day. They said that this had been a useful exercise and a source of learning, as it was not completed in a timely manner. In addition, there was no plan to ensure that agency staff were included in evacuation drills.

Residents who spoke with the inspector knew what to do in the event of hearing the fire alarm. The procedures to be followed in the event of fire were displayed.

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

Findings:
There were measures in place to protect residents from being harmed or abused. There was a safeguarding policy and all staff had received training in safeguarding. At times the service used some agency staff if required. The management team confirmed that there was a service level agreement in place between the organisation and the agency, part of which required that all agency staff had received safeguarding training. The person in charge confirmed that she had received training in relation to adult protection and she was knowledgeable regarding her responsibilities in this area. No allegations or suspicions of abuse had occurred in the centre to date.

There was a low level of behaviour management issues occurring in the centre. The service had access to a psychology team, who provided support to staff and residents if required. However, where such behaviour had been identified, although verbal advice had been supplied by the psychology team, a written behaviour support plan had not been developed to guide and support staff. There was also a policy on responding to behaviours that challenge to guide staff.

There were no residents using bed rails as a form of physical restraint, although bed rails were used for safety by a small number of residents. These residents used bed rails when at home and wished to continue using them while availing of respite breaks. This practice was introduced following an individualised assessment by an occupational therapist whose report confirmed the suitability and safety of such usage. However, these assessments had not been reviewed annually to ensure that the guidance remained appropriate and current.

Judgment:
Substantially Compliant

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge was aware of the legal requirement to notify HIQA regarding incidents and accidents. All required incidents had been notified to HIQA.

Judgment:
Compliant

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
As residents lived at home with their families, education and training was not planned or organised by the designated centre, but residents organised any such events independently or with support from their families.

Judgment:
Compliant

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 that residents' health care needs were well met and they had access to healthcare services if required during their respite stays. There was, however, some improvement required to assessment of a care intervention in a file viewed during the inspection.

Due to the short and intermittent nature of residents' stays in this centre, healthcare referrals were generally arranged and managed at home by residents and their families. However, if any appointment was due during a respite stay, staff confirmed that residents would be supported to attend.

Each resident had a personal plan which outlined the services and supports required to achieve a good quality of healthcare. These plans were developed by residents' key workers and were updated at the start of each stay to reflect any necessary changes in care. The plans viewed contained information around residents' healthcare needs, assessments, medical histories and healthcare supports required from staff.

However, some improvement was required to ensure that guidance was up-to-date and comprehensive. A dietary care plan for a resident contained guidance based on an assessment carried out over three years earlier, and which the resident chose not to adhere to. The assessment had not been reviewed annually or more frequently if required, to establish if the resident's needs had changed. Therefore, it was not possible to establish whether or not the resident was receiving the most appropriate care intervention.

Due to the short duration and intermittent nature of residents' respite stays, weight monitoring was not undertaken in the centre. However, any identified dietary requirements were recorded in residents' plans to ensure continuity of care. As residents ate out during respite breaks, staff in the centre were not involved in providing meals for residents. Breakfast and snacks were available in the centre and during the inspection residents were served a morning snack of tea, coffee, fresh scones, butter and jam which they enjoyed.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The inspector found that while medication management practices were generally safe, some improvement was required to the recording of administration of medication, and use of prescriptions.

All residents took responsibility for the administration of their own medication while they were at home and continued to be responsible for this during their respite stays. Each resident brought his or her supply of medication to the centre at the start of each respite stay and took it home again when leaving. Each resident had a lockable drawer in the bedroom for secure storage of medication. The centre did not have any involvement in the receipt of residents' medication from the pharmacy as this was managed from home.

On reviewing medication prescribing and administration charts, the inspector found that the medication management process was not being managed in accordance with the centre's policy. The policy stated that each medication taken by residents was to be recorded on the administration sheets, but in practice, this was not being done. Staff recorded the time when residents had taken their medications, but did not record the medication actually taken. In addition, the policy also required that an up to date prescription for each resident be retained in the centre, but this was not the case in a sample of resident's files viewed.

All staff had attended training in safe administration of medication. There was a medication policy available to guide staff.

At the time of inspection, there were no residents who required their medication to be administered crushed or who were using medication requiring strict controls. In addition, none of the residents used medication as required (PRN) or night sedation.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose described the services provided in the designated centre and

met the majority of the requirements of the regulations. However, some of the information in the statement of purpose required review. For example, the statement did not clearly describe the services which were provided by the registered provider to meet the specific needs the centre was intended to meet. Information regarding admissions also required some further development.

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

Findings:
The provider had established a clear management structure and systems had commenced to review and improve the quality of service. However, improvement to auditing was required.

Since the last inspection there had been a change in management structure with the creation of the post of a person in charge assigned exclusively to this centre. The new person in charge had recently taken up post. The person in charge was appropriately skilled and demonstrated the necessary experience to manage the designated centre. She was knowledgeable about the requirements of the regulations, and had a good overview of the health and support needs of residents. She was clear about her role and responsibilities and knew the management and reporting structure in place in the organisation.

There were arrangements to cover the absence of the person in charge and there was an out of hours contact arrangement in place to support staff.

The person in charge was well supported by the organisational structure. There was a respite co-ordinator, part of whose role was to assist the person in charge in the management of the centre, including the supervision of staff. The person in charge told the inspector that she worked closely with her line manager, who frequently called to the centre and knew the residents well.

A representative of the provider had carried out two comprehensive unannounced audits of compliance with the regulations and had identified some areas for improvement. However, some issues identified in the most recent audit had not yet been addressed and some of these issues, such as internal fire safety checks and documentation had been identified again in the course of this inspection. Although recommendations were recorded in the audit there were no time frames identified for completion of some of the works required.

The provider's representative had also carried out an annual review and report on the quality and safety of the service.

Judgment:
Substantially Compliant

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The person in charge and management team were aware of the requirement to notify HIQA of the absence of the person in charge. There were suitable arrangements to cover the absence of the person in charge during any such absence.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre was adequately resourced to ensure delivery of care and support in accordance with the statement of purpose.

The building was well maintained and suitably equipped. There were sufficient vehicles available to transport residents to any activities or outings that they wished to attend.

The inspector found that the centre was suitably staffed and there were sufficient staff available to care for and support residents.

Judgment:
Compliant

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 inspector found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents at the time of inspection. Staff had received a range of training appropriate to their roles. However, staff recruitment and supervision required improvement.

Staffing levels were based on the needs of residents and were determined by reviews of residents' care needs. There were normally two staff on duty during the day and two at night, but this arrangement could be adjusted if required. There was a planned roster prepared and maintained on the computerised system, but this was not being updated promptly to reflect the actual roster. Staff accompanied residents when they wanted to do things in the local community such as going shopping or for coffee, visiting the hairdresser, or to attend social events. The inspector observed staff interacting with residents in a respectful and friendly manner. Residents' were clearly comfortable in the company of staff and they told the inspector that staff cared for and supported them very well.

The inspector reviewed a sample of staff recruitment files and found that most of the required information was present. While Garda vetting was present on the files viewed,

there was no photographic identification and there were some unexplained gaps in employment histories in some of the files viewed. A member of the management team stated that the photographic identifications were retained in another office, but she gave an assurance that they were in place for all staff. There was no evidence in the centre of Garda vetting having been received in respect of agency staff working in the centre. However, a member of the management team confirmed that there was a service level agreement in place between the organisation and the agency, part of which required that all agency staff had received Garda vetting.

The person in charge confirmed, and training records indicated, that staff had received training in fire safety, safeguarding and manual handling. In addition, staff had received other training relevant to their roles, such as training in medication management and report writing.

All staff had not received suitable supervision. The inspector found that there was no formal process in place for supervision of staff. The person in charge had delegated the responsibility for staff supervision to another staff member, who performed this task informally. There was no evidence in the centre of how supervision was being implemented to improve the quality of service provided.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The inspector found that the records required by the regulations were maintained in the centre, although the level of detail in some of the documentation required improvement.

During the course of the inspection a range of documents, such as medical records, operational policies, the residents' guide, staff recruitment files and health social care documentation were found to be kept in the centre. Although the required

documentation was made available to the inspector during the inspection, some of this information was not well recorded and did not include sufficient detail. For example, there was inadequate information recorded in incident sheets, some of the fire drills were not recorded accurately and some guidance in personal evacuation plans was unclear. The recording of care information had also been identified as an area for improvement in the provider's six-monthly audit.

The policies required by schedule five of the regulations were available and were readily accessible to staff. The inspector viewed the risk management policy which was developed in 2011 and had not been reviewed as required by the regulations.

The inspector viewed the directory of residents and found that it contained most of the required information. However, details of the person or organisation responsible for the admission of each resident to the centre had not been recorded.

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:

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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-0003338
Date of Inspection:	26 and 27 October 2016
Date of response:	20 December 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 complaints policy did not clearly explain the appeals process.

1. Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an

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

appeals procedure.

Please state the actions you have taken or are planning to take:
Complaints Appeals Process was emailed to Inspector on 28.10.2016 policy update drafted with planned limitation sign off and implementation 31.01.2017

Proposed Timescale: 31/01/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not identify a person, separate from the nominated complaints person, to ensure that all complaints were suitably recorded and resolved as required by the regulations.

2. Action Required:
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

Please state the actions you have taken or are planning to take:
The plan is to amend the complaints policy to include a separate nominated complaints person to ensure that all complaints are suitably recorded and resolved as required by the regulations.
Proposed Timescale: Completed 31.012017

Proposed Timescale: 31/01/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Internet access was not available to residents in the centre.

3. 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 plan was activated on the 25.7.2016 and is ongoing. The HSE IT Dept confirmed networking of the facility including staff email on 21.11.2016 however, installation of wifi for service users is not finalised as yet. The plan is that service users will have

access to wifi in the future. IT Services have contacted the National ICT Dept. and are seeking guidance in how they can provide this service, for our site.

Proposed Timescale: 31/03/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Grab rails had not been fitted at all sanitary facilities and this had been raised in resident feedback.

One bedroom did not have any wardrobe, and residents staying in that room did not have anywhere to hang their clothes.

4. 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:
Plan is to fit grab rails in both bathrooms as soon as possible. OT visited the house on 08.12.2016 and awaiting report to forward to maintenance Dept to install grab rails in bathroom 2 planned completion date 31.01.2017. Maintenance Manager visited the house on 28.11.2016 to access works required to bathroom no 1 to include grab rails also. Plan is for works to bathroom no 1 to be completed by 31.03.2016.
Bedroom provided with wardrobe in this bedroom for client's to hang their clothes.

Proposed Timescale: 31/03/2017

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 risk management policy did not include guidance on the arrangements for identification, recording, investigation and learning from serious incidents, as required by the regulations.

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

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

Risk management policy will be amended to include guidance arrangements for the identification, recording, investigation and learning from serious incidents, as required by the regulation.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were organisational recommendations for internal fire safety checks, there was no evidence that these were being carried out.

6. Action Required:
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
Organisational recommendations for internal fire safety checks commenced on a weekly basis on 9.11.2016 and records are being maintained to indicate that these checks are being carried out. Person in charge will audit every quarter.

Proposed Timescale: 30/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff had received differing guidance at different training sessions, and were not sure of the best evacuation methods to use.

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

Please state the actions you have taken or are planning to take:
Clarification on evacuation method will be provided to the staff team regarding the quickest, most efficient and safest method of evacuating each client as per individual evacuation plan in accordance with the regulations. This was added to our staff team meeting agenda and discussed on 5.12.2016. Repeat on site fire training will be arranged to provide clear guidance.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of clarity around how residents would be evacuated from the centre in the event of fire. Information in personal evacuation plans was not clear and did not guide staff.

8. 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:
Commencing on 21.11.2016 the staff team will be aware of the quickest, most efficient and safest method of evacuating each client as per personal evacuation plan in accordance with the regulations. Information in personal evacuation plans will be clear to guide staff up to including 31.12.2016 and thereafter personal plans will be completed on admission to respite in 2017.
Proposed Timescale: Commenced 21.11.2016

Proposed Timescale: 21/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of some fire drills did not accurately reflect times taken to evacuate residents.
No fire drills had been undertaken during night-time hours, or to simulate night-time circumstances.
There was no plan to ensure that agency staff were included in evacuation drills.

9. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Records of all future fire drills will now include the time taken to evacuate residents.
Fire drills will be undertaken to simulate night time circumstances bi annually.
Agency staff will be included in future fire drills and training. Person in charge will audit on a quarterly basis.

Proposed Timescale: 31/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Assessments for the use of bed rails had not been reviewed annually to ensure that the guidance remained appropriate and current.

10. 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:
An up to date assessment for the use of bed rails where identified will be requested prior to admission to ensure that the guidance remains appropriate and current. Communication issued to referrers and the team to include review assessment as part of application. Implemented with effect from 23.11.2016.

Proposed Timescale: 23/11/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A written behaviour support plan had not been developed to guide and support staff in behaviour management interventions.

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

Please state the actions you have taken or are planning to take:
A written behaviour support plan to guide and support staff in behaviour management interventions will be requested prior to admission to ensure staff have up to date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour. Communication issued to referrers and the team to include a behaviour management plan if the need is identified at application stage.

Proposed Timescale: 23/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A dietary assessment, carried out over three years earlier, had not been reviewed

annually or more frequently if required, to establish if the resident's needs had changed. Therefore, it was not possible to establish whether or not the resident was receiving the most appropriate care intervention.

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

Please state the actions you have taken or are planning to take:
A written dietary assessment will be requested prior to admission to establish if the client's needs have changed and to ensure that the most appropriate care intervention provided in accordance with the regulation. Communication issued to referrers and the team to include dietary assessment as part of the application on admission.

Proposed Timescale: 21/11/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The medication management process was not being implemented in accordance with the centre's policy.

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

Please state the actions you have taken or are planning to take:
Medication management process will be reviewed and implemented in accordance with house policy. This was included on our team meeting agenda and discussed on the 5.12.2016.

Proposed Timescale: 31/01/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the information in the statement of purpose required review.

14. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose will be reviewed to include the detail required by the regulations.

Proposed Timescale: 28/02/2017

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:
Some issues identified in the unannounced audit had not been addressed and there were no time frames identified for completion of some of the required works.

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 nominee will carry out unannounced audit as set out in the regulation and identify specific timeframes for completion of work identified in future unannounced audits. The person in charge will carry out spot checks audits once every quarter

Proposed Timescale: 31/03/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some unexplained gaps in employment histories in some staff recruitment files.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has sought clarity on unexplained gaps in employment histories from the Human Resources Dept. The plan is that this information will be available on staff files from 31.01.2017.

Proposed Timescale: 31/01/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no formal process in place for supervision of staff. There was no evidence of how performance management was being implemented to improve the quality of service provided.

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

Please state the actions you have taken or are planning to take:
Person in charge requested Line Manager to implement formal process for supervision and performance management of health care assistants to evidence and improve the quality of service provided. This will include individual supervision meeting and records for each staff member. Person in charge will audit this every quarter. Personal Development Plans for each staff member was made available to the Inspector. Performance appraisal record on file for each staff member. Feedback provided by client's and family is given to staff by their Line Manager and Person in Charge.
Proposed Timescale: Commenced 15.12.2016

Proposed Timescale: 15/12/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy which was developed in 2011 and had not been reviewed as required by the regulations.

18. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The risk management policy will be reviewed as required by the regulations.
A draft review of the policy will be completed by 28.02.2017. Management commits to reviewing this policy at intervals not exceeding three years as set out in the regulations. Additional new polices may be developed and implemented as required going forward.

Proposed Timescale: 28.02.2017 (3 years 25.10.2019).

Proposed Timescale: 28/02/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not include details of the person or organisation responsible for the admission of each resident to the centre.

19. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The directory of residents will be amended to include details of the person responsible for the admission of each resident to the centre. The Person in charge communicated the importance of this detail to the Line Manager and the health care assistants at our staff team meeting on 5.12.2016. The directory of residence is being updated on admission and completed for each client up to the 31.12.2016. This plan will be replicated for 2017 with target of 12 directory of residence to be completed each calendar month.

Proposed Timescale: 05/12/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the documentation and records required by the regulations was not well recorded and did not include sufficient detail.

20. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

The person in charge instructed the respite team of the need to record clear, concise and factual detail in all documentation and records as required by the regulations to be implemented with effect from 05.12.2016 as discussed at staff team meeting. This will be audited by the person in charge every quarter.
Proposed Timescale: 31/01/2017