Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Rosses View
Centre ID:	OSV-0003368
Centre county:	Sligo
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Health Service Executive
Provider Nominee:	Bernadette Donaghy
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	33
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 1 day(s).

The inspection took place over the following dates and times

From:	To:
06 June 2017 09:40	06 June 2017 17:45

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection
Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by the 13th June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential

Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

The inspectors met with four residents, three staff members, four clinical nurse managers and the person in charge during the inspection process. Although the inspector met with a number of residents, some residents did not communicate with the inspector. A number of practices and documents were reviewed as part of this inspection including seven residents' files, three staff files, one volunteer's file, risk assessments, risk registers, protocols, improvement plans, staff rosters and staff training records.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and is part of a campus setting, located close to Sligo town. The centre comprised of six units providing residential services to people with an intellectual disability, who have been identified as requiring low to high levels of support. The service is nurse-led and can accommodate male and female residents, from the age of 18 years upwards. Four of the units provide accommodation for six residents, one of the units provides residential accommodation for five residents and one of the units provides accommodation for four residents. Two of these units provides care for residents with late stage dementia. There were no vacancies at the time of inspection.

The person in charge had overall responsibility for the centre and is based in the centre on a full-time basis. He was supported by four clinical nurse managers and the provider. The person in charge held an administrative role and regularly visited each unit to meet with residents and staff. Each unit had a communal kitchen and dining area, sitting room area, bathroom facilities and bedroom spaces for residents.

Overall judgment of our findings:
This was a follow-up inspection to identify if the seven actions the provider said they would do following the inspection on the 21st and 22nnd of March 2017 were satisfactorily implemented. These seven actions related to social care needs, health, safety and risk management, safeguarding and safety management, governance and management and workforce. Upon this inspection, the inspector found the provider had made improvements to the service being provided to residents. However, the provider had not completed all actions within the timeframes given in the previous action plan response. The inspector found improvements were still required to ensure adequate staffing and transport arrangements were provided to meet the assessed social care needs of residents.

On the day of inspection, an immediate action was issued to the provider in relation to the arrangements in place to meet the needs of residents with epilepsy, who required emergency medication to be administered to them, within prescribed timeframes. Measures were implemented by the provider and person in charge on the day of this inspection in response to the immediate action. Confirmation of these measures was followed up in writing to the inspector by the provider.

Of the seven actions followed up on this inspection, the inspector found two actions were fully completed, while five actions were not yet satisfactorily completed. The findings of this inspection identified one outcome in compliance, three outcomes in moderate non-compliance and one outcome in major non-compliance.

The findings and their actions are further outlined in the body of the report and 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 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:
Since the last inspection, the provider has made significant improvements in updating residents' personal plans in order to reflect their progression towards achieving their personal goals. However, some actions required from the previous inspection were not satisfactorily implemented. Improvements were still required to the provision of personal plans in an accessible format to residents and to the overall arrangements in place to meet the social care needs of residents.

A sample of residents' personal plans were reviewed by the inspector and these were found to now be regularly updated to demonstrate the progress made by residents to achieve their personal goals. Staff who met with the inspector had knowledge of the goals in place for residents and of what actions were required to support them. Some staff told the inspector that, along with annual goals, monthly goals were recently implemented to enable some residents to work towards more attainable goals suitable to the nature of their disability. Staff informed the inspector that this has provided a more effective personal goal programme for these residents.

An easy-to-read personal plan format was developed by the centre since the last inspection. This was found to provide information on residents' general health, family involvement and social care preferences. However, the inspector found this was the only alternative format available to residents, which did not meet the communication needs of those with cognitive or visual impairments. Furthermore, the easy-to-read personal plan did not provide specific information to residents in relation to their identified goals, or about the actions that were in place to support them to achieve these goals.

Since the last inspection, 48 additional social care hours were allocated to the service. The person in charge informed the inspector that these hours have been allocated to weekends, to ensure staff support is available to residents to engage in social activities. Since the introduction of these additional social care hours, staff told the inspector that residents have increased opportunities to go on day trips, have one-to-one personal trips away from the centre, and engage in activities of their choice. In addition, the centre was provided with increased access to transport in the evenings and at weekends. Staff informed the inspector that this increased access has enabled more group activities to be scheduled for residents in the evening, and has had a positive impact on the social care activities that staff are now able to offer residents.

Although the inspector found the additional staff support had improved the quality of social care, being provided to residents since the last inspection, the delivery of social care was still found to be routine led and still did not adequately meet the assessed needs of all residents. For instance, as the additional staff support hours were shared between the different units in the centre, this support was only accessible to residents at certain times of the day. This meant residents had to wait their turn to access this additional staff support, which was scheduled to be in the unit for either morning or evening, pending the roster. Also, where residents wished to access transport, this was still required to be booked in advance. Staff who spoke with the inspector said that this meant residents had limited choice in what social activities they could engage in if another unit within the centre was using the centre's transport. Although taxi services were always available to residents to use, this was not a suitable mode of transport where residents wished to go out on a group activity.

The provider had made progress since the last inspection and put in place arrangements to meet the social care needs of residents with cognitive impairments. A clinical nurse manager told the inspector that staff from the centre and from day services worked together to assess the activities residents with cognitive impairments respond well to. Staff who spoke with the inspector were familiar with the activities identified for each resident with a cognitive impairment; however, there was still no plan in place to guide staff on the appropriate implementation of these social care programmes.

Judgment:
Non Compliant - Moderate

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 action required from the previous inspection was not satisfactorily completed. The inspector found adequate arrangements were still not in place for residents with epilepsy, who required emergency medication within prescribed timeframes.

A large number of residents residing in the centre presented with epilepsy. These residents were found to have clear protocols in place to guide staff on residents' seizure type, seizure frequently and the medications to be administered within prescribed timeframes when a seizure occurs. The inspector found some residents required medication to be administered on the onset of the seizure occurring, while other residents required medication to be administered between two to five minutes of the seizure occurring. Upon review of residents' seizure records, the inspector found some residents were experiencing up to seven seizures a month, some of which were between 20.00 and 08.00hrs. An audit was recently completed by the provider which identified one of the six units in the centre required a staff nurse to be present at all times to ensure the needs of residents with epilepsy in that unit were met.

In the response to the action plan from the previous inspection, the provider informed the Chief Inspector that a staff nurse was now based in this unit during night hours to facilitate administration of emergency medication if required. Since the last inspection, an additional agency staff nurse was provided to this unit to cover five out of seven nights on the roster; however, the inspector found this still left two nights a week where a staff nurse was not always present in the unit.

The provider was issued with an immediate action to put in place adequate arrangements to ensure the needs of residents with epilepsy, who required emergency medication, were met at all times by the provider. On the day of the inspection, the person in charge put immediate measures in place to ensure a staff nurse was present in the unit at all times to meet the needs of residents requiring emergency medication. In addition the provider provided a written confirmation of the arrangements which were put in place, and the arrangements in place to ensure the governance and oversight of this arrangement in the future.

Since the last inspection, the provider had updated the risk assessment and risk register to reflect the measures in place for epilepsy management. However, the inspector found these assessments still did not adequately describe the current control measures and additional control measures in place to mitigate this risk. For instance, the centre had identified the specific risks associated with the number of residents in the centre who had epilepsy; however, the control measures that were documented on the risk assessment were not relevant to the specific risk identified. Furthermore, it was unclear from the risk assessment the timeframe for when the additional controls would be implemented by.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
The actions required from the previous inspection were satisfactorily completed.

The inspector reviewed the staff training records for the centre and found all staff had now received up-to-date training in the management of behaviours that challenge. In addition, refresher training dates were identified for each staff member and the person in charge informed the inspector of additional training days allocated to ensure all staff receive refresher training in accordance with these dates.

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:
Some actions required from the previous inspection were not satisfactorily completed. Improvements were still required to the systems which oversee the delivery and achievement of action plan deadlines.

The person in charge is supported by four clinical nurse managers who work in an operational capacity to oversee care delivery in the centre both day and night. Since the last inspection, the person in charge informed the inspector that he now meets with the clinical nurse managers on a weekly basis to discuss staff and resident specific issues. Weekly conference calls are held with the person in charge and senior managers to discuss operational related issues.

The annual review report, six monthly provider visits report and quality improvement plan for the service were reviewed by the inspector. All actions identified within the annual review and the six monthly provider visits were found to be completed within their timeframes. However, three actions still remained outstanding since February 2017 from the centre's quality improvement plan. These outstanding actions were in relation to staffing arrangements, maintenance of Schedule 2 documents and scheduled works for completion.The person in charge said that these actions are reviewed each week as part of the organisations conference call with senior managers, but a revised deadline date for achievement has not yet been provided to the person in charge to work towards.

Judgment:
Non Compliant - Moderate

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 actions required from the previous inspection were not satisfactorily completed. Improvements were still required to the maintenance of schedule two documents and ensuring sufficient staff were working in the centre to meet the social care needs of residents.

Since the last inspection, an additional 48 social care hours were provided to the centre. These hours were divided between the six units within the centre and were rostered for weekends to support residents to access the community and participate in social activities. Staff who spoke with inspectors informed that although this increase in the

staffing arrangement had made a positive impact to the lives of residents residing in the centre, it did not consistently meet the needs of residents requiring one-to-one support to access the community. In addition, the inspector found that residents access to this additional staff support was still determined by the demands of the service.

A sample of staff files were reviewed by the inspector and gaps were found in the maintenance of Schedule two documents including gaps in references and garda vetting for all staff members.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anne Marie Byrne
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-0003368
Date of Inspection:	06 June 2017
Date of response:	22 June 2017

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 05: Social Care Needs
Theme: Effective Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** The provider failed to ensure personal plans were available in a suitable format that met the communication needs of all residents. **1. Action Required:** Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are

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

made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
In consultation with the Speech and Language Therapy Manager on the 19th June 2017 the following actions are in place.
1.Update the extant document on "The Process of Consulting With Residents in Cregg Services" to include extra terminology that will assist communication partners in comprehending, appropriately responding to, and appreciating each individual resident's communication.
2.Identify and review resident's communication style.
3.Training and education workshops for the process will be delivered by the below date.

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure arrangements were in place to meet the assessed social care needs of residents to include:
- adequate arrangements to meet the social care needs of residents requiring additional staff support to engage in social activities
- adequate transport arrangements
- adequate arrangements to support staff to meet the social care needs of residents with cognitive impairments.

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

Please state the actions you have taken or are planning to take:
•Business case will be submitted for additional transport by the below date. Hiring of appropriate transport is also availed of to meet the social care of the residents.
•Business case will be submitted for additional support hours to assist residents to engage in social activities.
•Staff consulted with the Nurse Practice Development Coordinator on 8th June regarding the individualised activity sheets. These were reviewed to incorporate suitable activities for residents with cognitive impairments.

Proposed Timescale: 06/07/2017

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 provider failed to ensure adequate systems were in place for the management and review of on-going risks associated with:
- adequate arrangements for residents who require emergency medication within prescribed timeframes
- accuracy in the identification and recording within risk assessments of control measures and additional control measures for epilepsy management

3. 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 Provider has ensured that the PIC has now adequate arrangements in place to meet the residents with Epilepsy by ensuring there is a Nurse based in Coney and Benbulben View at all times. The Provider has also ensured that there is daily monitoring of duty rosters to ensure there is adequate Nursing cover at all times to meet the needs of residents with Epilepsy. This will involve the day and night managers reviewing the duty rosters and providing an update to the PIC on a daily basis. The PIC will also ensure that residents epilepsy management plans will be audited on a regular basis to ensure plans are effective in meeting the needs of residents.

Proposed Timescale: 07/06/2017

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:
The provider failed to put in place management systems to ensure action plan deadlines were achieved and that these were effectively monitored.

4. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The provider will ensure the centre’s Quality Improvement Plan will be reviewed to target outstanding works for completion. This will be monitored on a weekly basis by Senior Management.

Proposed Timescale: 31/08/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure all information outlined in Schedule 2 of the regulations was maintained for all staff working in the centre

5. 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 provider will ensure all information outlined in Schedule 2 of the regulations is maintained for all staff working in the centre by the below date.

Proposed Timescale: 31/07/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the number of staff working in the centre was appropriate to the assessed social care needs of residents.

6. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
•Staffing review has been completed and submitted to Senior Management for review (Hurst Report 2016).
•Staffing is presently being reviewed the Project Officer for Agency Conversion for CHO Area 1.

Proposed Timescale: 31/07/2017