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:	Ocean Crescent
Centre ID:	OSV-0005383
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bernadette Donaghy
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	29
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:
22 August 2017 10:00	22 August 2017 19:00
23 August 2017 08:30	23 August 2017 17:30

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:
The purpose of the inspection was to inform a registration decision and to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres' for Persons (Children and Adults with Disabilities) Regulations 2013.

How we gathered our evidence:
The inspector met with one resident, five staff members, the person in charge, two clinical nurse managers and the provider nominee during the inspection process. The inspector reviewed practices and documentation to include residents' personal plans,

incident reports, complaints registers, risk registers, policies and procedures, fire management related documents and various risk assessments.

Description of the service:
This centre is managed by the Health Service Executive (HSE) and is part of a campus setting, located close to a Sligo town. The centre comprised of five chalets 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 accommodates male and female residents, from the age of 18 years upwards. At the time of inspection, all residents in the service were female. Two of the chalets provide accommodation for seven residents and three of the chalets provide accommodation for five residents. There were no vacancies at the time of inspection.

The person in charge has the overall responsibility for the centre and is based in the campus on a full-time basis. They were supported by two clinical nurse managers and the provider nominee. The person in charge holds an administrative role and regularly visited each chalet to meet with residents and staff. Each chalet has a communal kitchen and dining area, sitting room area, bathroom facilities and bedroom spaces for residents.

Overall judgment of our findings:
Overall, the inspector found that since the last inspection of this centre on the 29th June 2017, the provider continued to ensure effective systems were in place to monitor this centre. Areas of good practice were continued through the centre's governance, risk management and safeguarding systems. Each chalet was found to be clean, well maintained and provided a homely environment for residents living there. Staff demonstrated to the inspector the individualised and person centred care that was being provided to residents on a daily basis. Staff were also found to be very respectful of residents and were knowledgeable of each resident's needs.

Of the 18 outcomes inspected, ten were compliant, three were in substantial compliance, four were in moderate non-compliance and one outcome was found to be in major non-compliance relating to the provider's workforce arrangements.

Details of these findings can be found in the body of the report and 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:
Overall, the inspector found residents were regularly consulted about decisions around their care and how they wished to spend their time. The provider had no actions in relation to this outcome from the last inspection. However, some improvements were required to the management of complaints and how residents were supported to manage their own finances.

Residents' meetings were held on a regular basis and the inspector saw staff discussed areas such as activity planning, complaints, safeguarding, family contact and menu planning with residents at these meetings. Residents had access to advocacy services and a photograph of the advocacy officer with their contact details was displayed in the centre. Staff who spoke with the inspector reported that more emphasis was being placed on ensuring routines had become more resident focused, and all efforts were being made to ensure residents spent their day as they wished.

Residents' right to privacy and dignity was also respected, and a seminar was scheduled for the 25th of August, 2017 with all residents to inform them of their rights. The inspector observed staff to interact with residents in a respectful manner and knock before entering residents' bedrooms. However, the inspector found that the privacy and dignity of residents within shared bedrooms was compromised. Although bed screening was provided within these bedrooms, this screening did not adequately encompass residents' bed space to provide adequate privacy for residents.

There was a complaints procedure in place for the recording, response and management of complaints. There were no active complaints being managed at the time of this inspection. The inspector found residents had an understanding of this procedure, with

one resident informing the inspector who the complaints officer for the centre was, and that they would not hesitate to tell staff if they had a complaint to make. Staff who spoke with the inspector were very knowledgeable of the complaints procedure and of their role in the local management of complaints received. While procedures and practices were in place to manage complaints, some gaps were found by the inspector to the maintenance of documentation. In one instance, the inspector observed inconsistencies in the recording of complainants satisfaction levels following the outcome of their complaint. In addition, the inspector found the complaints procedure displayed did not correspond with the procedure as outlined in the centre's complaints policy. An easy-to-read version of the complaints procedure was available to residents; however; it did not clearly inform residents how to make a complaint, how the complaint would be responded to or what the appeals process was if they were not satisfied with the outcome of the complaint.

Residents were supported to manage their own finances. Where residents' money was maintained by the centre, the centre had records in place to show all transactions and lodgements made to residents' personal accounts. A record of purchase receipts were also numbered to correspond with the relevant transaction. Monthly financial audits of these accounts were also completed by staff. A spot check of personal balances was completed by the inspector and a staff nurse and no errors were found. Financial competency assessments were completed for each resident to assess their ability to look after their own finances. Staff informed the inspector of the support required by some residents when in possession of their money and when making purchases. However, no guidance documentation was in place to guide on this level of financial support required by each resident. This was brought to the attention of staff on the day of the inspection, who had completed a number of financial support plans for residents by the close of the inspection.

Judgment:
Non Compliant - Moderate

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:
Overall, the inspector found effective communication systems were in place to meet residents' communication needs.

There was a communication policy in place, and communication profiles were in place

for residents who had communication needs. A sample of these communication profiles were reviewed by the inspector and were found to detail residents' preferred communication styles. Staff who spoke with the inspector were very knowledgeable of residents' communication needs, and demonstrated to the inspector how they communicate with residents who are non-verbal.

Easy-to-read versions of written agreements, the complaints policy and statement of purpose were available to residents. Picture boards were also in use to inform residents of what staff were on duty each day and night. Pictorial menus were also available for residents to view and choose their daily meal choices. No residents were in use of specific communication tools at the time of the inspection; however, assistive technology assessments were recently completed for all residents to identify if any such aids could enhance their quality of life.

Judgment:
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:
Positive relationships between residents and their family member were supported. Residents were able to receive visitors in private with no restrictions on family visits. Residents were also supported to go on overnight stays with their families. Over the course of the inspection a number of residents were on holiday with their families. Some residents showed the inspector photographs of their family and friends which they had displayed in their bedrooms. Staff who spoke with the inspector said that family members are invited each year to participate in residents' annual reviews, and that regular communication is maintained between families and staff members.

The inspector found residents had regular opportunities to engage in the local community. Some residents were found to have specific roles and responsibilities at weekly mass, while other residents had involvement in local community groups. Furthermore, all residents were recently placed on the electoral role in order to be able to vote.

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):
No actions were required from the previous inspection.

Findings:
There was a policy and procedure in place for the admission, transfer, temporary absence and discharge of residents. However, some improvements were required to the details of charges as outlined in residents' written agreements.

The clinical nurse manager informed the inspector that new written agreements were recently provided to residents and their families, and were awaiting these signed agreements to be returned. The inspector reviewed a sample of written agreements and found that although these stated a maximum fee that residents would be required to pay each week, it did not indicate the exact amount residents would be required to pay, and was unclear what services residents were receiving for the fee charged.

Judgment:
Substantially 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:
This outcome was inspected as part of the centre's last inspection and no actions were

required. Since the last inspection, the inspector found the provider had continued to put arrangements in place to meet the assessed social needs of residents, to the development of personal plans and to transitional planning.

No additional social care hours were put in place since the last inspection on the 26th of June, 2017. The previously allocated 39 hours social care support were continuing to be allocated between the five chalets in the centre. The fortnightly schedule was still in place and demonstrated the dates and times this social support was available to residents. Residents were still consulted each week about what activities or personal appointments they wished to attend, and these personal requests were incorporated within the overall social support activity schedule. Sensory activity schedules were still in place for residents with cognitive impairments and a log of residents' participation in these activities was continuing to be maintained. The inspector spoke with a number of staff during the course of the inspection, who stated that the increase in social opportunities for residents in recent months has had a positive impact on residents and on the quality of service provided by the centre.

A sample of residents' annual assessments, personal plans and personal goals were reviewed by the inspector. Annual assessments were found to be up-to-date and residents' personal goals were continuing to be worked towards. The inspector observed that personal goal action plans were still updated regularly with the progress made by residents to achieve their goals. Staff informed the inspector that a schedule of reviews was recently put in place for residents who were close to their annual review.

No residents transitioned from this centre to the community since the last inspection. The provider told the inspector that the centre was still awaiting transition dates to be confirmed. In the interim, compatibility assessments were being completed. Residents' preferences for transition were being recorded and regular meetings were being held with the transition team, residents and staff to ensure those involved were being updated on the progress being made towards transition.

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):
No actions were required from the previous inspection.

Findings:
Overall, the inspector found all five chalets in this centre were clean and well maintained. Regular maintenance works were carried out to residents' equipment and records of these were available for review. However, some improvements were required to general state of the premises.

The inspector visited each chalet over the inspection process. Three chalets provide accommodation for five residents and two chalets provided accommodation for seven residents. Each chalet had a kitchen and dining room, two shared bathrooms with shower facilities, a staff room and residents' bedrooms. Of the 29 residents living in this centre, 25 residents had their own bedrooms, while four residents resided in two shared bedrooms. Bedrooms were found to be very personalised and one resident showed the inspector her recently redecorated bedroom. Adequate seating was provided for residents in sitting rooms and dining rooms, and residents were facilitated to bring their own furniture from home if they wished. Residents had access to wardrobe facilities, sink and televisions within their bedrooms. The inspector observed that risk assessments were in place for the management of overcrowding in the two chalets providing accommodation to seven residents. Staff who spoke with the inspector were aware of the potential risks associated with this number of residents living together. Staff confirmed that these risks were tightly managed and that no incidents impacting on the safety and welfare of residents had occurred, and felt each chalet provided and safe and suitable premises for the residents living there.

Some refurbishment works were completed at the time of this inspection to include painting of some residents' bedrooms, new shower facilities and the removal of all moss from external walk-ways. Assistive technology was also recently provided to one chalet to assist residents with poor mobility needs to safely use bathroom facilities. Further works were scheduled to be completed for mid September 2017, including the refurbishment of another chalet bathroom. Staff informed the inspector that where any chalet required general maintenance work, a maintenance requisition was completed and responded to in a timely manner. The inspector observed that some residents' furniture required minor repair works, which was brought to the attention of the person in charge who rectified this before close of the inspection. However, the inspector observed some further work was required to the up-keep of the centre to include repair to skirting boards and furniture and the suitable re-location of televisions in some sitting rooms.

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):
No actions were required from the previous inspection.

Findings:
This outcome was inspected as part of the centre's previous inspection and no actions were required. During this inspection, the inspector found the provider had continued to ensure adequate risk management and fire safety management systems were in place.

A heath and safety and risk management folder was held in each chalet within the centre. The management of this system was overseen by the clinical nurse managers and person in charge. The inspector reviewed a sample of organisational risk assessments and these were found to clearly identify the hazard being risk assessed and the controls in place to mitigate this risk. Where risks were rated as high, these were being escalated to senior managers for immediate review. However, upon review of a risk assessment for the management of oxygen therapy in the centre, the inspector observed the current and additional controls required were not accurate to the controls being practiced by staff. This was brought to the attention of clinical nurse managers who rectified this by the close of the inspection. Incident review meetings were occurring on a monthly basis and these were attended by the person in charge.

Regular fire drills were occurring within the centre and a sample of these drill performances reviewed by the inspector demonstrated the centre could safely evacuate residents. The inspector spoke with one resident who demonstrated how they would evacuate the centre if the fire alarm sounded. The inspector spoke to a number of staff during the inspection, who informed of how they would be alerted to a fire in the centre, how they would evacuate residents, of their responsibility to alert the emergency services and where the location of the fire assembly point was. A traffic light evacuation system was displayed in the centre which informed on the level of staff support required by residents in the event of an evacuation. Staff also informed the inspector of the difference of how they would respond to the fire alarm system should they be lone-working in the centre or have staff support available to them. However, the fire procedures displayed in each of the chalets, did not adequately guide on the different staff response required where they were working alone in the centre if they fire alarm was activated. In addition, fire procedures did not guide staff on the management of oxygen therapy in the event of a fire. This was brought to the attention of the clinical nurse managers and person in charge, who rectified this by the close of the inspection. Residents' personal evacuation plans were displayed in each residents' bedroom and guided on the residents understanding of the fire alarm and of the staff support they required in the event of an evacuation. All staff had up-to-date training in fire safety at the time of this inspection.

Judgment:
Compliant

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.

Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
This outcome was inspected in the centre's previous inspection, and no actions were required. Overall, the inspector found the provider continued to put measures in place to safeguard residents and to ensure residents with behaviours that challenge were supported.

Some restrictive practices were still in place since the last inspection. These were found to have appropriate risk assessments and protocols for their use in place. Where required, environmental restrictive practice risk assessments were found to also give consideration to the impact the restrictive practice had on other residents living in the centre. The inspector observed multi-disciplinary input was in place for the review of these practices. Staff who spoke with the inspector were very aware of the restrictive practices which were in place and of their requirement to ensure residents' safety when the restrictions were in place. Staff informed the inspector that they conduct regular checks of residents when restrictions are applied. Records of the rationale for every time the restrictive practice was used, were also available for the inspector to review.

Residents who presented with behaviours that challenge had behavioural support plans in place. A sample of these were reviewed by the inspector and were found to be very detailed. These informed staff of the residents' behaviour types, individual strategies to use in different circumstances, supportive and directive techniques and effective crisis management interventions if required. A log of behaviours continued to be maintained by staff. Staff reported that a minimal number of behavioural incidences had occurred since the last inspection. All staff had received up-to-date training in the management of behaviours that challenge.

No active safeguarding plans were in place at the time of this inspection. All staff were found to have up-to-date training in safeguarding. Staff who spoke with the inspector were aware of their responsibility to report any safeguarding concerns to the person in charge.

All staff were found to have up-to-date training in safeguarding and in the management of behaviours that challenge.

Judgment:
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:
A record of all incidents occurring in the centre was maintained, and where required, notified to the Chief Inspector. No gaps in the reporting of notifiable incidents was found during this inspection.

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:
The inspector found that residents were supported to participate socially in activities suitable to their age, interests and needs.

Residents were engaged in social activities, internal and external to the centre. Residents regularly engaged in day-services, local community groups, day trips, personal appointments and were supported to go on holidays with family. Staff who spoke with the inspector told of how some residents were involved in computer courses in a local college. While others were attending graduate courses through a local community group.

No residents were in employment at the time of this inspection.

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:
Overall, the inspector found that where residents had specific healthcare needs, they were supported to achieve the best possible health. Residents had timely access to allied healthcare professionals and health services. Annual residents' assessments were completed to inform the healthcare needs required by residents. However, some improvements were required to personal plans available for residents with palliative care needs.

The centre had a comprehensive assessment process in place to identify residents' healthcare needs. The inspector reviewed a sample of assessments and personal plans in place for residents who presented with neurological and nutritional specific healthcare needs. These medical assessments were up-to-date and personal plans guided staff how to support residents with these needs. Staff who spoke with the inspector were very aware of their responsibility to support residents with neurological and nutritional needs. Areas of good practice were observed in the management of skin integrity for residents who had specific nutritional care needs. For instance, finger pricking and abdominal mapping records were in place for residents who required daily blood sugar monitoring. The inspector found residents had timely access to various allied health professionals such as nutritional specialists, behavioural specialists and occupational therapists. Residents had access to a General Practionner (GP) service and a record of all correspondences from these health professionals was maintained by the centre.

Some residents living in the centre required palliative care and were referred to, and see by the appropriate allied healthcare professionals to assess for the level of support required. Staff who spoke with the inspector were very knowledgeable of the pain management plans and interventions in place for these residents, the current level of allied healthcare professional input and of their requirement to observe for additional symptoms. There was no similar plan in place to guide on the residents' palliative care needs, their end of life wishes, plans for symptom management or to guide staff on circumstances which may trigger further involvement from relevant allied healthcare professionals.

Kitchen and dining spaces were available to residents within each chalet. Dinnertime meals were delivered to each chalet from a centralised kitchen based on the main

campus. Residents are provided with a choice of meals from this kitchen and where they wish to choose a different option, it is prepared in the chalet kitchen. Staff and residents complete grocery shopping for each chalet each week and the inspector observed that the kitchens were stocked with snack options, drinks and ingredients. Residents were also supported by residents to prepare their own meals if they wished to do so. Residents are consulted each week about menu planning and residents food likes and dislikes are well documented within the centre.

Judgment:
Non Compliant - Moderate

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 provider had clear written operation policies in place relating to the ordering, prescribing, storage and administration of medications. Medication prescription and administration records were found to be well maintained; however, some improvements were required to the assessment of residents' capacity to take responsibility for their own medication.

All medications within the centre were administered by a registered staff nurse. Medications were dispensed using a single pack system and secure storage arrangements for these medications were in place, in each chalet. Prescription and medication records reviewed by the inspector were found to be clear and informative. No gaps were found in medication administration records. Medications were delivered to the centre on a monthly basis and a checking system was in place to ensure the correct medications were received, in line with residents' prescriptions.

No residents were self-administering their own medications at the time of this inspection. However, self-administration assessments had not been completed to consider residents' abilities to take responsibility for their own medications.

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):
No actions were required from the previous inspection.

Findings:
The provider had a statement of purpose for the centre and an easy-to-read version of this was available to residents in the centre. The inspector found the statement of purpose was regularly updated to reflect the services provided to residents. However, the inspector found some gaps in the information available within the statement of purpose to include:
- the specific care and support needs that the centre intended to meet
- the facilities to be provided by the registered provider to meet the support needs of residents
- the management arrangements in place in the absence of the person in charge.
- the criteria for emergency admissions to the centre.

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):
No actions were required from the previous inspection.

Findings:
This outcome was inspected in the previous inspection, and no actions were required. Overall, the inspector found the provider continued to ensure effective governance and management systems were in place within this centre.

The person in charge had the responsibility for this centre and was supported in this role

by the provider and two clinical nurse managers, who continued to work in a supernumerary capacity since the last inspection. Weekly meetings were still in place between the person in charge and the clinical nurse managers to review and discuss areas of concern within the centre. Various other meetings were found to be still in operation including monthly staff meetings, fortnightly management meetings, monthly governance meetings and weekly senior management conference calls. Staff told in the inspector that communication between local staff and management had greatly improved and that they felt very informed of what was going on in the centre at an operational level.

The inspector met with the person in charge who confirmed that they had sufficient capacity to meet the requirements of his role. The person in charge told the inspector that the centre had become more effectively managed through the use of the risk management, governance and social care systems now in place. These were being used by the person in charge to identify areas that need to be addressed or discussed with staff and with the clinical nurse managers.

The inspector found continued improvements had been made to the monitoring and review of action plan deadlines. During this inspection, the inspector reviewed action plans from the centre's six monthly provider visit, the annual service review and capital works plan. One action relating to refurbishment was found not completed in line with the initial timeframe set out; however, the inspector was informed by the clinical nurse manager and person in charge that these works were scheduled for completion by mid September, 2017.

Judgment:
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:
Where the person in charge is absent form the centre, the provider has ensured that arrangements are in place for the management of the centre during the absence. The person in charge informed the inspector that the clinical nurse managers would be responsible for the running of the centre in such an 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:
Overall, the inspector found the centre was resourced to ensure the effective delivery of care and support of residents.

The centre had access to a full-time hire vehicle to transport residents to various services. Staff informed the inspector that this vehicle was suitable to transport residents who use wheelchairs. The person in charge told the inspector that a lease agreement was recently approved for two further vehicles, which are expected to be available to the centre in September 2017.

There were no resource issues identified that impacted on the delivery of appropriate service or provision of suitable care to residents at the time of inspection.

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):
No actions were required from the previous inspection.

Findings:
This outcome was inspected as part of the centre's previous inspection, with one action

required. However, this action was not yet due to be completed at the time of this inspection. Overall, the inspector found the staffing arrangements were still not adequate to meet the social care needs of residents. In addition, gaps were also identified in the maintenance of schedule 2 documents for staff.

Since the last inspection, no further additional social care hours were provided to the service. The previously allocated 39 hours social care support was still in place and continued to be allocated between the five chalets. The application of these additional support hours continued to be closely recorded by the clinical nurse managers, to monitor how each resident accessed and benefited from this additional support. A socialisation chart was developed by clinical nurse managers to demonstrate how many times each resident had used this support and the activities they participated in as a result of this support. However, staff who spoke with the inspector said that there continued to be a lack of staffing arrangements to support residents' social care at weekends.

One staff member informed the inspector that due to the lack of staff available in the chalet on one of the days of this inspection, no social activities external to the chalet were occurring on that day for residents. Another staff member informed the inspector that although residents who only required one-to-one staff support benefited from these additional social care hours, it still did not meet the needs of residents who required two-to-one staff support to engage in social activities. The person in charge informed the inspector that since the last inspection, 89 staff had been recruited to a locum panel, some of which will be allocated to only providing social care support to the residents living in Ocean Crescent. However, due to garda vetting of these staff members, this additional support will not be available to residents until mid September 2017, which was not in line with the timeframe of the 1st of September, 2017, as agreed in the centre's previous action plan.

Staff supervision was on-going at the time of this inspection and this was overseen by the person in charge and the clinical nurse managers. Planned and actual rosters for the centre were made available to the inspector, and these clearly identified the names of staff members working in each chalet, along with the start and end time of each shift. Upon review of the centre's training records, all staff had up-to-date training in hand hygiene, manual handling, fire safety, management of behaviours that challenge and safeguarding of vulnerable residents.

A sample of staff files were reviewed by inspectors and some gaps were identified within these files to include:
- adequate garda vetting
- clear records of employment history

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Overall, the inspector found documentation records were accessible, legible and well maintained.

The inspector reviewed a sample of Schedule 5 policies and procedures available at the centre during the inspection. These were found to be up-to-date, accessible to staff and met the requirements of Schedule 5 of the regulations.

There was a directory of residents in place; however, the inspector observed that not all the information required by Schedule 3 of the regulations was recorded for each resident, including:
- the address and contact number of the residents' General Practitionners
- the name and address of the authority or organisation, who arranged the residents' admission to the centre

Judgment:
Substantially Compliant

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-0005383
Date of Inspection:	22 and 23 August 2017
Date of response:	14 September 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure adequate bed-screening was in place for residents within shared bedrooms.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The provider will ensure that the bed screening in place for residents within shared bedrooms is adequate. Existing privacy curtains will be extended to ensure full privacy for residents by the below date.

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure appropriate guidance was in place for staff to support residents to manage their finances.

2. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
The provider will ensure appropriate guidance is in place for staff to support residents to manage their finances. There will be a financial support plan to reflect the supports required by each resident in relation to managing their own money by the below date.

Proposed Timescale: 18/09/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the satisfaction level of the complainant was consistently recorded following the management of complaints.

3. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
The provider will ensure that the satisfaction level of the complainant is consistently recorded following the management of complaints. This will be audited monthly by the Nurse Managers.

Proposed Timescale: 30/09/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure the complaints procedure displayed adequately guided residents on:
- adequately guided residents on how to make a complaint
- identified the named persons responsible for dealing with the complaint
- informed residents of the appeals process
- was consistent with the information available within residents' easy-to-read complaints procedure

4. Action Required:
Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The provider will ensure the complaints procedure displayed will adequately guide residents on the process involved in making a complaint and will identify the following;

named persons responsible for dealing with the complaint
will inform residents of the appeals process
all of the above will be consistent with the information available within residents' easy-to-read complaints procedure.

Proposed Timescale: 30/09/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure residents' written agreements clearly detailed the services to be provided to residents for the fees charged.

5. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The provider will ensure that the Contract for the Provision of Services for each resident clearly details the services provided to the resident and the fees charged.

Proposed Timescale: 06/10/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure repair work was completed to skirting boards and furniture within residents' accommodation.

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

Please state the actions you have taken or are planning to take:
The provider will ensure that all repair works relating to skirting boards and furniture within Mountain View will be completed by the below date.

Proposed Timescale: 06/10/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure adequate personal plans were in place for residents' who require palliative care.

7. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
The provider will ensure adequate personal plans are in place for two residents who require palliative care. A Full palliative care assessment was completed for one resident on the 5th of September by the Palliative Care Consultant and both residents will have a full medical review by the below date.

Proposed Timescale: 22/09/2017

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 provider failed to ensure that following a risk assessment and assessment of capacity, residents were encouraged to take responsibility for their own medications.

8. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
The provider will ensure Self Administration of Medication Assessments will be completed on all residents by the below date.

Proposed Timescale: 30/09/2017

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:
The provider failed to ensure all information as required of Schedule 1 of the regulations was contained within the statement of purpose.

9. 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 provider will ensure that all information as required of schedule 1 of the regulations is contained within the Statement of Purpose.

Proposed Timescale: 06/10/2017

Outcome 17: Workforce

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.

10. 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:
This action was previously responded to by the provider within the last inspection report's action plan (the inspection took place before the provider's proposed timescale for this action).

Proposed Timescale: 01/09/2017

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 that all information as required of schedule 2 of the regulations was maintained for all staff

11. 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 that all information as required of schedule 2 of the regulations will be maintained for all staff by below date.

Proposed Timescale: 30/09/2017

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 provider failed to ensure that all information as required of Schedule 3 of the regulations was maintained in the directory of residents.

12. 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 provider will ensure that all information as required of Schedule 3 of the regulations is maintained in the directory of residents.
Proposed Timescale: 30/09/2017