**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:** | A designated centre for people with disabilities operated by HSE Midlands Area |
| **Centre ID:** | ORG-0008639 |
| **Centre county:** | Laois |
| **Email address:** | diana.oneill@hse.ie |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Maura Morgan |
| **Person in charge:** | Diana O'Neill |
| **Lead inspector:** | Sheila Doyle |
| **Support inspector(s):** | None |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 19 |
| **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 and the National Standards for Residential Services for Children and Adults with Disabilities.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 04 March 2014 10:00 | 04 March 2014 19:30 |
| 05 March 2014 10:00 | 05 March 2014 17:00 |

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 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

**Summary of findings from this inspection**

This was the first monitoring inspection in this centre. The inspector met with the person in charge at the centres' head office reviewing policies and procedures, staff records and collecting other information required to inform the inspection. The centre provides services in four houses based in the Portlaoise area. The inspector visited and spent some time in each. The inspector observed practices, joined some residents for tea and reviewed documentation such as care plans and records.

Overall, the inspector found that residents received a good person centred quality service. The inspector found that the residents were comfortable and person centred care was provided by a committed team of staff. The inspector found that the health and safety of residents and staff was promoted and protected. Fire procedures were robust.

The health needs of residents were met and there was evidence of safe medication management practices although improvement was required around the prescribing of medication to be crushed. Improvements were also required to the presentation and preparation of meals that required modification. In some cases the inspector found that the social care needs of residents were not consistently recorded or reviewed. Additional improvements were required around the use of restrictive procedures such as bedrails and lapbelts.

Some staff files did not comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities.

These areas are discussed further in the report and included in the action plan at the end of this report.

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector was not satisfied that the care and support provided to residents consistently and sufficiently reflected their assessed needs and wishes.

Nurses were responsible for assessing and reviewing resident's needs and care plans. The inspector reviewed a sample of residents' care plans which contained information on their assessed needs. There was evidence of a limited range of assessment tools being used and residents' needs were reviewed and care plans revised on an ongoing basis. This however tended to focus on health care needs with minimal evidence of social care needs assessments or plans to meet those needs. Staff told the inspector about new documentation recently introduced called 'my personal care plan'. This should have addressed many of the deficits in the previous documentation. Whilst the inspector saw many examples of where this provided insight into the social care needs of residents, in other incidents it was not being used as a live document. For example the inspector saw where this document had not been updated following the transfer of a resident into the service four months previously. The inspector also saw where some care plans had not

been updated. For example the inspector saw where water therapy was recorded as a possible intervention but staff confirmed that this was no longer available.

The inspector also noted that some of the residents had pressure relieving equipment such as alternating mattresses in use. However there were no documented assessments completed regarding the risk of pressure ulcer development to guide product selection. In addition, staff spoken with were not familiar with the correct settings to be used for individual residents.

There was evidence that residents were supported in transition between services. A document called 'my hospital passport' had been developed for each resident. This contained useful information such as personal details about the resident, a photograph, aids and assistive devices used, communication needs including how the resident would express pain etc.

There was an extensive range of activities available to the residents both in the centre and out in the community. Transport was available and the inspector saw where photographs of the various outings were on display. The inspector also saw that in some cases, staff had gained insight into the lives of the residents and had completed a 'bucket list' for the resident. This included new experiences for the resident such as spending a night in a hotel. This information was then used to plan activities.

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

**Theme:**
Effective Services

**Judgement:**
Compliant

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

**Findings:**
The inspector found that the health and safety of residents and staff was promoted and protected.

There was a Health and Safety Statement in place. The risk management policy was recently updated and met the requirements of the Regulations. There was a health and safety committee with representatives from the four houses which met on a regular basis. The assessments were being updated regularly as risks were identified or changed for residents. For example the inspector saw where plans were in place to change the locks on a front door as a risk had been identified. Risk assessments were also carried out on the use of staff vehicles to transport residents. Files reviewed by the inspector contained evidence of staff vehicle insurance cover and driver licences.

The inspector found that other fire precautions had been put in place. There were regular fire drills and all staff had received training and staff spoken with were knowledgeable. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergency lighting. An emergency evacuation plan was in place for the four houses. In addition an individualised evacuation plan was in place for each resident which included details of transport requirements, next of kin and alternative emergency accommodation.

The provider had ensured that arrangements were in place to manage the risk of infection. There was adequate alcohol gels, gloves and aprons available in the houses. All staff had attended the mandatory training in moving and handling.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector found that although systems were in place to promote the safeguarding of residents and protect them from the risk of abuse, additional improvements were required around the use of restrictive procedures such as bedrails and lapbelts.

The inspector was not satisfied with the management of restraint. The overall usage of restrictive procedures was low. However there was no documented evidence that all alternatives had been considered prior to the use of bedrails. In addition, while risk assessments and safety checks were carried out when bedrails were in use, there was no documented evidence that this also occurred for the use of lapbelts. Staff spoken with did not know that this was necessary or required by the policy in place.

Otherwise the inspector was satisfied that measures were in place to protect residents from being harmed or suffering abuse. There was a policy in place on the prevention, detection and response to abuse and staff had received training. Staff spoken with and the person in charge outlined the procedures they would follow should there be an allegation of abuse.

All staff spoken with and records reviewed confirmed that the overall incidence of challenging behaviours had reduced substantially since moving to the community houses. Staff mainly attributed to the more appropriate premises and greater emphasis on activity provision and supervision. The inspector noted that all staff had received training on the management of behaviours that challenge and the person in charge considered that this was mandatory.

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Resident's health needs were regularly reviewed with appropriate input from multidisciplinary practitioners where required, with reports evidenced in files. The inspector reviewed some care plans and medical notes and found that they had access to a general practitioner (GP), to an out of hours GP service and to a range of allied health professionals such as physiotherapists, dieticians, chiropodists, opticians and dental services. Residents' files contained records of reviews by medical specialists. For example, the inspector saw where a resident had been referred to an occupational therapist for specialist chair advice.

However the inspector was concerned that residents who required their meals in a modified consistency were not consistently receiving the appropriate texture as recommended by the Speech and Language Therapist (SALT). Some staff told the inspector that the when food is modified it is to a pureed consistency and yet the inspector saw that the residents were recommended various consistencies. In addition, one staff member spoken with told the inspector that generally the food is liquidised together rather that in individual food groups. The inspector also saw that a resident was offered a drink which had been thickened to the required consistency but the resident was not sitting in an upright position as recommended by the SALT. This was addressed immediately when discussed with staff.

The inspector did note on-going improvements underway in all the houses as regards determining residents' choices for meals. Photographs had been taken of various meal choices and these were used to assist residents with communication difficulties. The inspector also saw where various adapted equipment had been provided to assist residents including modified cutlery and crockery. The inspector saw that staff sometimes joined residents for the meal with residents and staff sitting together. The

inspector observed staff interacting with residents in a respectful, warm and caring manner. Snacks and drinks were freely available.

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

**Theme:**
Health and Development

**Judgement:**
Non Compliant - Minor

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

**Findings:**
The inspector was satisfied that there was evidence of good practices. However further improvement was required regarding the prescribing of medication that required to be crushed.

Some residents required their medication to be crushed. The inspector reviewed a sample of their prescription and administration records and saw that this was not individually prescribed as such, in line with the centre's policy and professional guidelines.

Otherwise the inspector was satisfied that each resident was protected by the centre's policies and procedures for medication management. All medications were administered by a registered nurse. Having reviewed prescription and administration records, procedures for the storage of medication including those requiring refrigeration and procedures for the management of medications that required strict controls, the inspector was satisfied that appropriate medication management practices were in place guided by a comprehensive policy.

Staff had received training and were knowledgeable about the medications in use. There was also evidence of weekly auditing of stock balances taking place.

**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

**Judgement:**
Compliant

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

**Findings:**
The inspector found that the person in charge of the centre was suitably qualified and experienced. She was knowledgeable about the requirements of the Regulations and Standards, and had a very good overview of the health and support needs and personal plans of all the residents. She was clear about her role and responsibilities and about the management and the reporting structure in place in the organisation. The person in charge told the inspector that she received regular support from her line manager. The provider had established a clear management structure, and the person in charge was clear about the various roles and responsibilities of staff. The provider had established weekly formal teleconferencing and three weekly management meetings.

The person in charge had undertaken a number of audits and reviews of quality of service and safety of the service. Risk management systems and incidents and accidents were regularly reviewed and the analysis discussed at management meetings.
A yearly audit plan was in place covering areas such as medication process, restrictive interventions and care plans.

**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

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
The inspector was not satisfied that all staff had been recruited, selected and vetted in accordance with best recruitment practice.

The inspector reviewed a sample of staff files and noted that some did not contain the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Items missing included some references and photographic identification. The inspector saw that the person in charge had made efforts to ensure that each file contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Each staff member had been contacted and requested to submit the documentation. Whilst most had complied, some were still outstanding. In addition the provider had failed to maintain a record of current registration details of some nursing staff. This was discussed with the person in charge during the inspection and was being addressed prior to the end of inspection.

The inspector reviewed a sample of staff rosters and noted that on the days of inspection the roster reflected the number of staff on duty. There was a staff nurse on duty at al times in each of the four houses. The person in charge told the inspector that the staffing levels were based on the assessed needs of the residents. Staff spoken with confirmed there was adequate staff on duty. The inspector noted that when required agency staff covered absences. The inspector read confirmation from the agencies that all necessary recruitment and training documents were in place.

A training plan was in place and the inspector confirmed that all staff had attended the mandatory training. Additional training was also provided including communication, the management of swallowing difficulties and the management of behaviour that challenges. Staff spoken with confirmed that there was a range of training available to them.

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

### *Report Compiled by:*

Sheila Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

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

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by HSE Midlands Area |
| **Centre ID:** | ORG-0008639 |
| **Date of Inspection:** | 4 March 2014 |
| **Date of response:** | 26 April 2014 |

## 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 and the National Standards for Residential Services for Children and Adults with Disabilities.

### 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:**
Personal care plans were not in use for all residents and in some circumstances had not been updated following a change in circumstance.

There were no documented assessments completed regarding the risk of pressure ulcer development to guide the selection of pressure relieving equipment. In addition, staff spoken with were not familiar with the correct settings of pressure relieving equipment to be used for individual residents.

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

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

**Please state the actions you have taken or are planning to take:**
A service wide review of all care plans is currently underway and will be completed by April 11th 2014.
Where an up-to-date care plan was not in place for an individual whose circumstances had changed this is currently being rectified and will be completed by 4th April.
Information sessions on care planning will be facilitated by Nurse Practice Development Officer on 7th and 15th of April.
The use of a pressure ulcer assessment tool (Waterlow scale) will be introduced across the service by 30th April.
Contact had been made with the local Public Health Nurse in relation to information session on the use of pressure relieving mattresses and we are currently awaiting confirmation of dates for these information sessions.
All care plans will be reviewed and updated by 25th April 2014.
Where an individual's care plan required immediate attention this care plan will be updated by April 4th
Use of pressure risk assessment tool to be introduced across the service by April 30th.

**Proposed Timescale:** 30/04/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no documented evidence that all alternatives had been considered prior to the use of bedrails.

**Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
A data base of the use of bedrails within the services will be maintained by April 4th 2014.
Restrictive interventions assessments and action plans will be completed with all individuals who currently use bed rails by April 15th. These assessments and action plans will consider alternatives strategies.
The data base of use of bedrails will be completed by April 4th
Service wide assessments on the use of bedrails will be completed by April 15th

**Proposed Timescale:** 15/04/2014

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no documented evidence that safety checks were completed while lapbelts were in use.

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

**Please state the actions you have taken or are planning to take:**
A data base of lapbelts used within the services will be maintained by April 4th.
Restrictive interventions assessments, action plans and associated daily records will be reviewed and updated with all individuals who currently use lapbelts by April 15th.
The data base of use of lapbelts will be completed by April 4th
The revision of assessments on the use of bedrails will be completed by April 15th

**Proposed Timescale:** 15/04/2014

## 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:**
Residents who required their meals in a modified consistency were not consistently receiving the appropriate texture as recommended by the Speech and Language Therapist.
A resident was not sitting in an upright position whilst drinking as recommended by the SALT.

**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:**
Following consultation with the speech and language therapist training dates for all staff on Dysphasia and food consistency have been identified.
A request has been made to the Dietician for education sessions for staff on menu planning. We are currently awaiting confirmation of dates from the dietetic department.
Training dates Dysphasia and food consistency are as follows:
April 22nd – May 7th – May 28th – June 18th

**Proposed Timescale:** 18/06/2014

| Outcome 12. Medication Management |
| --- |
| **Theme:** Health and Development<br><br>**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**<br>Some medication that required crushing were not prescribed as such.<br><br>**Action Required:**<br>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.<br><br>**Please state the actions you have taken or are planning to take:**<br>All medication that is crushed is now prescribed as such by the individual's general practitioner. |
| **Proposed Timescale:** 26/03/2014 |

| Outcome 17: Workforce |
| --- |
| **Theme:** Responsive Workforce<br><br>**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**<br>Some staff files did not contain the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.<br><br>**Action Required:**<br>Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.<br><br>**Please state the actions you have taken or are planning to take:**<br>Staff were informed through the governance meeting on March 10th that this information must be returned to the centred main office by April 14th. |
| **Proposed Timescale:** 14/04/2014 |