

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	ORG-0011650
Centre county:	Westmeath
Email address:	maria.woulfe@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Maura Morgan
Person in charge:	Maria Woulfe
Lead inspector:	Jillian Connolly
Support inspector(s):	Catherine Rose Connolly Gargan;
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	1

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 1 day(s).

The inspection took place over the following dates and times

From: 13 March 2014 09:30 To: 13 March 2014 19:30

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

The designated centre provides residential services for people with an intellectual disability and is managed by the Health Service Executive (HSE). This was the first inspection for the service and was completed over one day. The person in charge met with inspectors on commencement of the inspection. Feedback was provided to the person in charge at the conclusion of the inspection. Inspectors did not meet with the person nominated to act on behalf of the registered provider on this inspection.

There were two primary purposes for the inspection. The Authority had been informed of the change of the purpose of one residential house to also provide respite services. Inspectors sought to be satisfied that this change in purpose did not impact the quality of life of the existing residents or of any individuals accessing respite services. Inspectors were not satisfied that the evidence available confirmed this.

The service had also indicated its intent to register eleven community houses as one designated centre with the Authority under the Health Act 2007. Inspectors aimed to ascertain if this was a feasible proposal in regards to the safe and effective delivery of services for the residents accessing the services.

Inspectors inspected three of the eleven houses which are proposed to be part of one designated centre and were not satisfied that the systems were in place to provide effective services based on the diverse function of the houses and the geographical distance between houses. Inspectors reviewed documentation, spoke to

residents and staff, and observed practices.

Of the seven outcomes inspected, there was evidence of moderate non - compliance in all areas. The action plan at the end of this report identifies the areas for improvement in order for compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Inspectors also requested that the provider review the number of individual houses being proposed as being part of one designated centre.

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:

Inspectors reviewed a sample of personal plans on inspection. There was evidence of comprehensive personal plans developed for residents of the designated centre, which identified the needs and wishes of the individual and both short and long term goals for individuals. There was evidence that individuals had participated in the development of their personal plans, and that relatives had been invited to also participate. Members of the multi - disciplinary team were included in the development of the personal plans, however inspectors were not satisfied that all relevant members of the multi-disciplinary team necessary to meet the assessed needs of the resident were involved. An example of this was there was documented evidence of individuals exhibiting behaviours that challenge. Referrals had been made to the relevant professionals but assessments had yet to be completed. One individual was awaiting an assessment for seven months. This is discussed more comprehensively in Outcome 8. There was also evidence that the achievement of personal plans was monitored on a regular basis, however there was insufficient evidence that plans were fully implemented for all residents and that the outcome for the resident was an improvement in their quality of life. An example of this was the limited opportunity some residents had to access the local community. From review of documentation and discussion with staff, one rationale for this was resource based, which included not only the staffing levels but also the financial circumstances of residents.

The Authority was notified prior to the inspection of the change in the purpose of one residential community house from providing only full time residential services to a dual purpose of respite and full time residential services. Inspectors reviewed the information

pertaining to the admission of residents on a short term basis to the residential setting and were not satisfied that the appropriate measures were implemented prior to the transition. There was no evidence that individuals were consulted regarding the transition or that the current residents of the house were consulted about someone moving into their house on a short term basis. There was evidence that efforts had been made to assess the supports necessary for the individual whilst staying in the designated centre. However the supports were not planned in advance of the transition and any assessments were conducted once the individual was staying in the centre.

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:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The designated centre has a policy relating to health and safety. Each individual house within the designated centre has a safety statement for the individual house. There is a risk management policy in place and as part of the safety statement of each house there is a risk register, however inspectors were not satisfied that the risks identified were specific to each individual house or the designated centre as a whole. Inspectors identified numerous risks on the day which were not reflected in the risk register. One example was raised lips at doorways which was a hazard associated with the generic risk of slips, trips and falls. Staff reported that they experienced challenges completing risk assessments. The person in charge informed inspectors that this was being addressed through the scheduling of training which had not yet taken place at the time of inspection.

There was evidence of individual risk assessments completed in relation to individuals in their personal files, as per the policy of the organisation. However inspectors were not satisfied that appropriate risk assessments were completed for individuals as a result of an adverse event, such as a fall. The organisational policy also states that all entries will be signed and dated. Inspectors found on numerous occasions' risks assessments were not signed or dated.

Inspectors also found significant risk associated with behaviours that challenge, this is discussed in Outcome 8.

Inspectors reviewed evidence of the maintenance of fire equipment. There was no evidence that the fire extinguishers in one service unit had been maintained within an appropriate time frame. There was evidence that internal weekly fire checks were

completed in the designated centre and any deficits noted were referred and rectified by the appropriate member of staff. There was also evidence of an external contractor maintaining fire equipment. There were fire evacuation plans in place and each resident had an individual fire evacuation plan in place and there was a colour coded system in place, which assisted staff in knowing the appropriate level of assistance a resident would need at a glance in each bedroom. Staff spoken to demonstrated appropriate knowledge of the actions to be taken in the event of a fire.

Inspectors did not review the systems in place pertaining to infection control on this inspection.

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 designated centre has a policy in place for the procedure to occur in the event of a suspicion or allegation of abuse. Staff spoken to demonstrated an understanding of the appropriate actions to be taken in the event of a suspicion or allegation of abuse appropriate to their role. There were no allegations or suspicions of abuse being investigated by the designated centre at the time of inspection. Inspectors observed staff being courteous and respectful of residents.

Inspectors reviewed the system in place to support individuals who display behaviours that challenge. There is a policy in place regarding the management of behaviours that challenge. The policy states that for individuals who present with recurring behaviours that challenge that there should be an individual personal plan in place. Inspectors found that this was inconsistent within the designated centre. There was evidence of good practice for some residents however there was evidence that some residents were not being supported appropriately. All individuals who presented with behaviours that challenge had individual risk assessments in place. However there was not sufficient evidence that the least restrictive practices were being utilised to alleviate the individuals' behaviour. There was evidence that individuals were administered medication as a reactive strategy, however there was no evidence of the alternative

strategies utilised prior to this form of restrictive practice being implemented. There was also insufficient evidence of reviews taking place, analysing the cause of the behaviour following the administration of the medication. Staff spoke to inspectors of their rationale however there was no documented evidence of a review.

There was evidence that referrals had been completed to the appropriate member of the multi - disciplinary team regarding behaviours that challenge, however there was also evidence that the appropriate assessments had not been completed in a reasonable time frame. Staff stated that this was a resource issue.

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:

Inspectors reviewed the individual plans of residents and found that the appropriate assessments were place regarding their health care needs. There was evidence that residents' needs were met through timely access to G.P services and appropriate treatments were received. Staff were knowledgeable of the health care needs of residents. Staff spoke with inspectors of the proactive strategies that were in place to promote healthy living choices, for example residents who smoked were provided the opportunity to address their addiction if they so wished. There was also evidence of residents who had a high Body Mass Index being actively support to reduce this through healthy food options and regular exercise.

Inspectors were not satisfied documentation regarding the health care needs of residents was consistent and identified areas of risk. For example, there was evidence that residents had allergies in one personal record however it was documented that they did not in another record.

There was evidence of referrals to some Allied Health Professionals, such as Occupational Therapy however as stated in Outcome 8, inspectors were not satisfied that all residents had access to the appropriate allied health care professional to support them in relation to behaviours that challenge.

Inspectors observed staff preparing food for residents however did not comprehensively inspect food and nutrition on this occasion.

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 - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

There were written operation policies and procedures in relation to the ordering, prescribing, storing and administration of medications. However inspectors found that they were not kept under review. The person in charge informed inspectors that there is a new draft policy which has yet to be implemented. Inspectors reviewed the medication plans for individuals and as stated in Outcome 8 and were not satisfied that the appropriate reviews took place in respect of medication being utilised as a chemical restraint.

There was also evidence that not all information was present on the medication prescription sheet, for example the address of residents was omitted in some instances.

There were inconsistencies in the storage of medication, and inspectors observed medication being stored in filing cabinets. Medications were also being crushed on the day of inspection however this was not prescribed by the General Practitioner (G.P). Inspectors also observed in some instances that the maximum dose for medications which were administered as required was not stated on the medication record. Inspectors were not satisfied that there were appropriate systems in place for the review and monitoring of safe medication practices.

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:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

On the day of inspection, Inspectors met with the person in charge and three front line managers. Inspectors reviewed documentation which demonstrated the systems in place to support the delivery of services. Inspectors reviewed minutes of monthly meetings and were informed of the reporting mechanisms to ensure that the Person in Charge is engaged in the governance, operational management and administration of the centre of a regular basis.

As stated previously, inspectors inspected three of the eleven service units which the organisation is proposing will be registered with the Authority as one designated centre. Inspectors were not satisfied that the person in charge can sufficiently comply with their legislative and statutory responsibilities based on the number of service units and the diverse function of each service unit. The systems in place are reliant on information being provided by frontline staff as opposed to the person in charge being actively engaged in the operations of each service unit. Due to the geographical distance of each service unit from each other, the person in charge is not in a position to physically visit each service unit on a regular basis. Inspectors formed the view that a risk was present as there are no arrangements in place for supervision of staff in the absence of frontline management not being on duty. For example, due to the system of rostering frontline management may not be working alongside staff for a period of time, and are reliant on the documentation to review the competency of the staff they are responsible for.

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:

Inspectors reviewed the rosters of staff and observed that there was a planned and actual rota in place. Inspectors identified a risk in the systems in place for maintaining the actual rota. It was in pencil and inspectors were concerned that if an adverse event occurred it could be challenging to ascertain the number of staff actually on duty at the

time. There was a safeguard of a staff sign in book at the commencement of their shift however inspectors noted that this was not always completed. Inspector also informed the person in charge that as the times of shifts were not recorded in the twenty four hour clock, it was challenging to identify the exact number of staff on duty at various times of the day. Inspectors formed the view that this decreased the accountability of staff.

The evidence regarding the needs of the residents being met by the number and skill mix of staff was inconsistent. In some instances staff reported that there was sufficient staffing and in other instances staff reported that the staffing levels were sufficient to meet the basic needs of residents however the social care needs of residents could not be addressed based on the staffing levels. Inspectors reviewed the documentation pertaining to the day to day life of residents and confirmed that there is an inconsistent approach within the designated centre to meeting the social care needs of the residents. However due to the deficits in the management systems, as identified in Outcome 14, it was challenging to ascertain the rationale for this.

Through discussion with staff and review of documentation, inspectors also observed a risk in the system of rostering of agency staff. There was evidence of an agreement with specific agencies to ensure that all staff had mandatory training prior to supporting residents. However there was also evidence that agency staff who had limited knowledge of residents were responsible for their care at night without the support and supervision of regular staff. On one occasion two agency staff were rostered to support residents at night without the support of a regular staff. Staff spoken to were not clear of the formal induction process which should take place with agency staff at the commencement of a shift. As there were no reviews of adverse events in place, there was no evidence on the impact this had on residents.

Inspectors reviewed training records and identified that all staff had received mandatory training and that there were systems in place to complete refresher training within appropriate time frames.

Inspectors did not review staff files on this inspection.

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:

Jillian Connolly
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 report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	ORG-0011650
Date of Inspection:	13 March 2014
Date of response:	22 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all individuals who had been identified as exhibiting behaviours that challenge had appropriate assessments and supports implemented by the relevant professional.

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:

A full review of all individuals who present with behaviours that challenge within the areas inspected will be undertaken using the following:

Antecedent Behaviour Consequences (ABC) Chart

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

Care Plans
Mental Health Team Reviews
Person Centred Plans (PCP)
Current behaviour support plans

Following the collation of this data a prioritised list for referral to Psychology/Behaviour Therapy will be made. The management team will liaise with the Psychology department/Behaviour Therapist to facilitate this process.

A service management team review of the HIQA draft report resulted in a review of the structures within the service to support individuals who present with behaviours that challenge. It has been proposed to reconfigure existing resources in order to provide additional supports to people with behaviours that challenge.

A working group with terms of reference will be established to oversee the development of this proposal. The group will consist of General Manager, the person in charge, HR manager, Nurse Practice Development Co-ordinator, Consultant Psychiatrist and Psychologist.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no evidence of planned supports being implemented to assist in individuals transitioning into respite services on a short term basis.

Action Required:

Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

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

The service will develop a procedure to support the admission of individuals into the service on an emergency admission basis only. This will include the provision of information to individuals accessing the service in a format appropriate to their needs.

Proposed Timescale: 30/05/2014

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:

There was insufficient evidence that risk assessments and appropriate control measures

are implemented following an adverse event.

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 nurse manager of each house will conduct a full review of risks specific to their area to ensure that the risks identified are relevant to that particular area, signed and dated. Following this review the risk register will be updated.

A review of the designated centre will be undertaken by the service with a view to identifying three separate designated centres for the service. The Statement of Purpose and Function (SPF) will be revised from one overall Statement of Purpose and Function to three separate documents.

A falls risk assessment appropriate to the users of the service will be identified and introduced across the service.

Risk management training will be facilitated with the managers of the service prioritised for this training

Proposed Timescale:

Review of risks within each house will be completed by June 30th 2014

Each local risk register will be updated by June 30th 2014

Training will begin on 07/05/2014 and continue on 20/06/2014 and 24/06/2014

The revised Statement of Purpose and Function will be submitted to the authority by 30th May 2014.

A falls risk assessment appropriate to the users of the service will be identified and introduced across the service by August 15th 2014

Proposed Timescale: 15/08/2014

Theme: Effective Services

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

There was no evidence of the maintenance of fire extinguishers annually.

Action Required:

Under Regulation 28 (2) (b) (i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

The tender awarded company is currently on site in the Mullingar area carrying out maintenance on the fire equipment.

Proposed Timescale: 31/05/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was evidence of chemical restraint being utilised without appropriate reviews being conducted.

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 full review of the use of restrictive practice in all areas inspected will be undertaken by the nurse manager of each area.

A presentation on the Procedure for the use or restrictive practice to Senior Staff responsible for overseeing the implementation of the procedure will be facilitated.

The senior staff member responsible for overseeing this work will compile:

- a register of restrictive practices in their area of responsibility
- individual Restrictive Intervention assessments and plans
- revise plans where in existence or
- devised plans where required as per local procedure (RID012)

A review date for each restrictive practice in use will be identified on the assessment form.

An audit of restrictive practices will be conducted every six months within each area where such practice is in use.

Proposed Timescale: The development of the register and review will be completed by June 9th

All of the assessments and plans will be revised or compiled by June 9th

Presentations will be facilitated on 07/05/2014 and repeated on 14/05/2014 and 27/05/2014

Proposed Timescale: 09/06/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was evidence that not all residents' needs were met in relation to behaviours that challenge and that alternative strategies were implemented prior to restrictive procedures being implemented.

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 review of the behaviour support plans for individuals where chemical restraint was in used will be conducted to ensure that all other avenues have been explored and if a restrictive practice is in use it is used only, after all other avenues have been explored, is the least restrictive option and applied for the shortest duration.

A full review of the use of restrictive practice in all areas inspected will be undertaken by the nurse manager of each area.

A presentation on the Procedure for the use or restrictive practice for to Senior Staff responsible for overseeing the implementation of the procedure will be facilitated.

The aim of this presentation it to update staff on the local procedure to be followed when assessing an individual's support needs; to reinforce the need to examine all other avenues; to support an individual and avoid the use of restrictive practice and where a restrictive practice is in use, it is in accordance with the local procedure

Proposed Timescale: A review of the behaviour support plans for individuals where chemical restraint was used will be undertaken and revised by 09/06/2014

The review of restrictive practice will be completed by 09/06/2014

Presentations will be facilitated on 07/05/2014 and repeated on 14/05/2014

Proposed Timescale: 09/06/2014

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:

Although there was evidence of referrals to Allied Health Professionals in relation to behaviours that challenge. There was no evidence that each resident referred had access to the appropriate Allied Health Professional.

Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

A full review of all individuals who present with behaviours that challenge within the areas inspected will be undertaken using the following:

Antecedent Behaviour Consequences (ABC)

Care Plans
Mental Health Team Reviews
Person Centred Plans (PCP)
Current behaviour support plans

Following the collation of this data a prioritised list for referral to Psychology/Behaviour Therapist will be made. The management team will liaise with the Psychology department/Behaviour Therapist to facilitate this process.

A service management team review of the HIQA draft report resulted in a review of the structures within the service to support individuals who present with behaviours that challenge. It has been agreed in principle to allocate a position for a Clinical Nurse Specialist in Behaviours that Challenge for within existing resources. It has been proposed to reconfigure existing resources in order to provide additional supports to people with behaviours that challenge.

Proposed Timescale: This group will meet on 20/05/2014.

Proposed Timescale: 20/05/2014

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:

There was evidence that medication was being stored inappropriately.

Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

A local medication management procedure will be developed that addresses the ordering, receipt, prescribing, storing, disposal and administration of medication.

A service wide review of medication managing storage facilities will be undertaken and the practice of inappropriate storage for medications will be discontinued.

Outcome 12

Medication Prescription

On examination of the Kardex in question the medication had been prescribed as requiring to be crushed, this was not clearly noted on the Kardex. This observation has since been highlighted and rectified.

A service wide review is currently underway to ensure that all medications are prescribed appropriately e.g. for the named individual and the practice of crushing of medications.

A full review of any medications used on an as required basis as a chemical restraint will be reviewed as per outcome 8.

Proposed Timescale: Policy development to commence on the 28/04/2014

A service wide review of the medication managing storage facilities will be undertaken and the practice of inappropriate storage for medications will be discontinued.

Appropriate size medication cabinets have been ordered for delivery by 30/05/2014

A review of the behaviour support plans for individuals where chemical restraint was used will be undertaken and revised by 09/06/2014

Proposed Timescale: 09/06/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Not all the appropriate information was recorded on the prescription sheet of residents.

Action Required:

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

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

Medication managing storage facilities will be undertaken and the practice of storage for medications will be discontinued. A newly updated Local Medication Management Policy will be devised and implemented by the end of May 2014. Appropriate size medication cabinets have been ordered for delivery by 30/05/2014

Proposed Timescale: Policy development to commence on the 28th of April 2014

Proposed Timescale: 28/04/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Crushed medication was being administered without being prescribed by the General Practitioner to be administered in that form.

Action Required:

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

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

A service wide review is currently underway to ensure that all medications are prescribed appropriately e.g. for the named individual and the practice of crushing of medications.

Proposed Timescale: This will be completed by: 31/05/2014 and on a continuous thereafter

Proposed Timescale: 31/05/2014

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:

There was evidence that the person in charge cannot fulfill their statutory obligations due to the proposed number of service units in the designated centre and the diverse function of each.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

Following a review of the inspection report, the service management team have devised a plan to review the structure of the Designated Centre.

Following this process there will be three designated centres for the service. These are:

Mullingar Area 1 (Low/Medium Support Houses):

Mullingar Area 2 (High Support Houses):

Mullingar Area 3 (High Support House/Behaviours that Challenge

A named Person in Charge for each of these areas is been identified and this structure will be implemented by the 31/05/2014 Section 69 forms will be completed and returned by 07/05/2014.

Proposed Timescale: A review of the Statement of Purpose and Function for each of these designated areas is currently underway and will be completed and submitted to HIQA by 31/05/2014.

Proposed Timescale: 31/05/2014

Theme: Leadership, Governance and Management

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

Inspectors were not satisfied that the systems in place adequately monitor the service provided to residents.

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:

A review of the current rosters for Nurse Managers will be undertaken to improve the overall governance structure within the organisation. A steering committee will be established consisting of Service management/Human Resource Specialist and Staff representative bodies. This committee will have terms of reference and will report into the General Manager. This will necessitate consultation between Management and Unions. It is expected that it may take some time for agreement to be reached. In the interim, where a manager may not be available in the area for a period of time, in their absence a named person to deputise on their behalf will be identified. This deputy will have the full support of the wider management team.

Proposed Timescale: Group to be identified at the service management meeting on 28th April 2014

First meeting to be held on or before 31/05/2014

The appointment of a named person to deputise in the absence of the line manager to commence with immediate effect.

Proposed Timescale: 31/05/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was insufficient evidence that the social care needs of residents were being met consistently due to the staffing levels.

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:

A review of individual activity schedules will be undertaken in the areas inspected and activity plans developed. The use of external therapy services and volunteer programme will be reviewed in conjunction with the plans.

Proposed Timescale: 30/05/2014

Theme: Responsive Workforce

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

There was insufficient evidence that residents received continuity of care due to the rostering of agency staff without the support of regular staff.

Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Agency Staff: The placement of agency staff in areas will be monitored by the Allocations officer and where there is the potential for an overlap between agency staff who are unfamiliar with the service area internal staff rotation will be enacted. A Local Induction Policy is in force in the centre, this includes a brief induction for Agency/Short Term staff, staff new to areas are inducted during the hand over process and a record is maintained. A clinical Nurse Manager is available on all shifts to support agency staff if required.

Proposed Timescale: With immediate effect and ongoing

Proposed Timescale: 22/05/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was an actual and planned roster in place, however due to the systems of recording it was not transparent the actual number of staff on duty at various times throughout the day.

Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

All off-duty records are now recorded using the 24hr clock and recorded in black pen
A notice will be issued to each area informing staff of the need to sign in on the attendance book on the commencement of each shift.

Proposed Timescale: With immediate effect

Proposed Timescale: 22/05/2014