

**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:	OSV-0003359
Centre county:	Co. Dublin
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Paudie Galvin
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From:	To:
19 March 2015 09:00	19 March 2015 18:30
20 March 2015 13:00	20 March 2015 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first monitoring inspection of this designated centre for adults with a disability by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to assess 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. The designated centre is part of the parent organisation the Health Service Executive.

The inspector met the nominated person on behalf of the provider, the person in charge and director of nursing at this inspection. The person in charge was present in the centre throughout the inspection.

The designated centre consists of five houses within a campus based residential facility. It is located in an urban setting, in close proximity to the local community and the city centre. There are good public transport links nearby. The centre can accommodate up to 24 persons. The inspector met many of the residents and the

staff during the inspection.

The inspector found areas of non compliance over all outcomes monitored. These related to outcomes on social care needs, health care needs, the management of restrictive practice and behaviours that challenge. The filing of residents records and policies in place did not consistently guide staff practice.

The centre was not decorated to a good standard throughout, and the maintenance of the grounds required improvement. The monitoring and review of the safety and quality of care required review. Furthermore, the systems in place for the training, recruitment and supervision of staff also required improvement.

There was also evidence of some good practice across most of the eleven outcomes monitored. Residents were familiar with the staff, who in turn were knowledgeable of the residents health and social care needs. Staff were observed to interacted and speak to the resident's in a respectful and dignified manner. There were systems in place to protect residents with staff knowledgeable of the fire precautions in place.

These non compliances are discussed in the body of 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, 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):

This was the centre's first inspection by the Authority.

Findings:

The inspector reviewed one component of this outcome in relation to residents' personal possessions.

There was a policy in place to provide guidance on the care of residents' property and finances. The provider and person in charge had also put systems in place to safeguard the finances of residents. However, the arrangements in place to support residents to have their own bank account required improvement. For example, residents did not have a bank account in their own name, and residents monies such as pensions or disability allowance were paid directly into a bank account in the centres name, and eventually transferred into a centralised bank account belonging to the organisation. The inspector discussed this with the provider and person in charge.

The handling of residents day to day monies was managed in the main office of the centre. The inspector met staff responsible for the handling of all transactions, who described the procedures in place. The inspector was shown how residents were using the balance of their pension or disability allowance each week. The inspector reviewed a number of these and noted transactions were being signed by staff. However, only one staff member signed for each transaction carried out. This is discussed under Outcome 18 (Documentation).

Judgment:

Non Compliant - Moderate

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:

This outcome was reviewed in relation to the contact of care for residents.

The residents had no written agreed agreement of the terms of the provision of services in place with the service provider. This was discussed with the person in charge and director of nursing at the opening meeting. The inspector was later shown a draft of a tenancy agreement for residents. However, it was yet to be agreed with and signed by the residents.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were identified in the the assessment and completion of personal plans for residents. The provision of and access to opportunities to participate in meaningful activities appropriate to their interests also required improvement.

The residents' welfare and wellbeing was maintained by an good standard of care and support, by staff who were familiar with their social care needs. The residents identified needs ranged from a mild to severe intellectual disability which required staff support and assistance. The inspector reviewed the personal plans of four residents. However, the files were contained within three large folders, therefore making it difficult to identify the most up-to-date information on each resident. This is discussed further under Outcome 18. The inspector found the development of personal plans were not holistic and focused on limited aspects of residents' lives, such as their health care needs. Therefore, apart from health care, there was no evidence that personal plans impacted positively on the lives of the residents.

The personal plans were completed annually and regularly reviewed with the residents or their relatives input however, there was no evidence of a multidisciplinary input into the completion of the plans. In addition, the residents were not provided with copies of their personal plans in an accessible format. These matters were discussed with the person in charge and the provider following the inspection, who acknowledged improvement was required.

The inspector reviewed a sample of residents' health care plans. However, care plans in place for residents identified needs did not consistently guide practice and incorporate the recommendations of allied health professionals. For example, dysphagia. Additionally, care plans were not developed for all residents identified needs for example, dementia, falls risk, dysphagia and behaviour support plans.

The inspector found the provision of activities and access to day services for residents required improvement. During the inspection, a number of residents went to work or out on a day trip to the community. However, the majority of residents remained in the centre during the day, with little or no activities for them to do. Furthermore, the residents did not attend or have a formal placement in an external day service. The inspector was informed a day service had once operated in the grounds of the centre, but due to lack of staff resources, it had ceased activity.

A number of external service providers visited the centre and provided activities a few days a week such as bakery classes, gym classes, siel bleu, and staff also facilitated activities. There was an activities programme in place for each resident, and staff informed the inspector they facilitated these activities also all residents required some degree of support. The inspector read where some residents enjoyed going on walks and hill walking. However, these activities were were based on staff resources and were not consistently carried out or available to all residents.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector reviewed one component of this outcome in terms of the decoration of parts of the centre and the maintenance of the grounds.

There were five houses in the centre, each of which were visited by the inspector. They were clean and well maintained however, some of the houses required redecoration. While residents personalised their own bedrooms (with ornaments, furniture, pictures and photos) the communal areas, bathrooms and hallways in some houses were not so homely and required decoration.

The external parts of the centre required upkeep in areas. There was overgrown grass in places, and unused or old equipment was being stored outside bungalows.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspector found there were systems in place to promote and protect the health and safety of residents, staff and visitors to the designated centre. However, the management of fire safety procedures, along with the investigation of incidents involving residents in the centre required improvement.

The inspector found there were systems in place manage spread of fire. However, improvements were required in the review of fire drills. For example, where issues were reported by staff during routine fire drills, there was no evidence of follow up action being taken to address the issues raised. This was brought to the attention of the person in charge during the inspection. The inspector read daily and weekly fire safety

records completed by staff. However, there were inconsistencies in their completion, with no records seen for four of the five houses. The inspector reviewed records of services checks of fire equipment. While there was evidence on the fire extinguishers and the fire alarm of the most up-to-date service date carried out, it was unclear from the documentation provided what equipment had been serviced and if it was in good working order. For example, the invoices provided were not clearly written to verify same.

The staff spoken with were familiar with the procedures to follow if the fire alarm went off. The staff confirmed they had attended training. Records were read of fire safety training provided in the centre. However, it could not be identified from training records if all staff had completed up-to-date training. This is discussed under outcome 17.

There were health safety, and risk management policies in place. The risk management policy met the requirements of the Regulations. An area of improvement was required in the investigation and follow up of incidents that occurred in the centre required improvement. The inspector read an accident record book, in which a summary of each incident that occurred in the centre were recorded. However, there was no record of who had reviewed each incident and what action had been taken to prevent their recurrence. An incident form was found by the inspector, that described an incident between two residents. The form was not dated and there was no record of what follow up action had been taken or review of the incident. The person in charge was required to provide a detailed account of the incident following the inspection.

There were systems in place to identify and assess risk in practice. The inspector read where clinical and environmental risk assessments had been carried out, with the risk rating and control and measures were in place to control them.

There was an emergency plan in place. Personal evacuation procedures were in place for each resident and reviewed regularly.

The inspector saw hand gels were present throughout all units in the centre and hand-washing guidelines were displayed for staff.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The inspector found measures were in place to protect residents. However, the systems in place for the management of behaviours that challenge and restrictive practices required improvement.

There were systems in place to manage behaviours that challenge. However, improvements were required. A number of residents presented with challenging behaviours. The inspector reviewed records of incidents, which ranged from self injurious behaviours, sexually inappropriate behaviours to hitting out. There was access and referral to a specialist team, which included a clinical nurse specialist in behaviours that challenge. The inspector saw minutes and reports completed by the team of various reviews of the residents. The team developed behaviour support plans and reactive strategies. While the behaviour support plans reviewed provided guidance, some were not updated to include the recommendations of a psychiatrist for a resident. In addition, some residents did not have a behaviour support plans where they had been identified as having behaviours that challenge.

The inspector found one resident had not been referred to senior psychology services on the recommendations of the psychiatrist on two occasions. This was brought to the attention of the person in charge, who was not aware of the matter.

There was a behaviour support policy in place. However, it did not fully guide practice. For example, how staff should respond and monitor incidents, the accessing of or referral to psychology services. See outcome 18.

The staff spoken with were familiar with the residents and could describe their behaviours along with the reactive strategies in place. However, it was reported to the inspector in one house that incidents between residents continued to occur. The records of these incidents were also read by the inspector. Staff stated due to the placement of one resident there was an increase in the number of incidents. However, there was no evidence of appropriate action being taken. As reported above, the behaviour support plans in place did not fully identify all the reactive strategies for the residents to be followed in the prevention of the behaviours from occurring. A follow up report was submitted to the Authority regarding this matter, that outlined additional measures being taken to address this matter.

There were practices in place for the management of restrictive practices, with some improvement required. The main gates to the centre were locked however, there was no evidence of this restrictions having been assessed, what alternatives tried and least restrictive form of restraint considered and the rationale for its use. There was a restraint policy in place. However, it did not provide direction to staff. For example, the assessment of restraint, the consideration of alternatives, development of a rationale and regular review of restraint. In addition, the policy did not reflect the National Policy "Towards a Restraint Free Environment". This is discussed under outcome 18.

The inspector found measures were in place to protect residents from harm or from suffering abuse. The staff spoken with were familiar with the types of abuse and the reporting arrangements in place. However, while some staff had completed training in the prevention of abuse, there was no formal plan in place for the remaining staff who were untrained, this is actioned under outcome 17.

There were no incidents, suspicions or allegations of abuse prior to the inspection. The person in charge was familiar with the procedures in place to carry out an investigation if required. The inspector read a policy on the prevention and investigation into allegations of abuse, which had been reviewed in October 2014. However, did not provide sufficient direction to staff. For example, the notification of allegations to the Authority, consulting with a general practitioner (GP), and reference to the new Health Service Executive policy and procedures on "safeguarding vulnerable persons at risk of abuse". See outcome 18.

Judgment:

Non Compliant - Moderate

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found the provider had systems in place to ensure residents' health care needs were met. However, improvements were identified in relation to aspects of health care management and access to specialist clinical services.

The inspector saw evidence of referral and regular consultation with allied services, however an area of improvement was identified to ensure residents were seen where required or recommended. As discussed under Outcome 8, on two occasions one residents had been recommended they be seen by senior psychology. However, no referral had been carried out. This was brought to the attention of the person in charge.

The inspector reviewed records that confirmed residents had access to the services of a medical practitioner. A general practitioner (GP) visited the centre and the residents three days a week. Records and interviews demonstrated that there was regular access to the GP and staff were observant and responsive to any changes in the health care status of the residents.

There was access to psychiatric services and a clinical nurse specialist provided further service for behavioral management and support for residents. There was evidence that where a resident refused treatment or intervention this was documented but also that every support was afforded. There was evidence of access to speech and language therapy, occupational therapy, physiotherapy services, dentistry and, and chiropody services.

A documented annual review of each resident health care needs was completed by staff. Overall, care plans were developed to provide guidance to staff. However, they were not developed for all residents identified needs. For example, dementia, falls and dysphagia. In addition, some care plans did not provide sufficient guidance for dysphagia. The action in relation to this is detailed under Outcome 5 (Social Care Needs).

The five houses in the centre each had their own kitchen facilities. They were observed by the inspector to be fully equipped with cooking and storage facilities. Food was purchased on a weekly basis following consultation with the residents. Some residents can, as they wish and according to their capacity do their own shopping with the support of staff. Residents meals were prepared by staff. While staff followed best hygiene practice in the preparation of meals, they had not completed food hygiene training. This is discussed under outcome 17. Dietary requirements were supported and where relevant residents are supported with weight dietary advice or special dietary requirements. The staff were able to describe the residents needs to the inspector. Food observed was nutritious and varied in addition to the residents specific tastes and requirements. The inspector observed a number of residents eating their meals, at a time of their choice. There was a daily menu displayed that described the meals. It was noted however, that is not in an accessible or pictorial format for residents to choose the meal they would like.

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):

This was the centre's first inspection by the Authority.

Findings:

The inspector found there were policies and procedures in place for medication management, and overall this outcome was compliant with, improvements required in relation to training.

There were written operational procedures and policies on the ordering, administration and disposal of medications, that provided general guidance to staff.

The inspector reviewed a sample of residents administration and prescription sheets with a nurse in one house. Overall, good practices were observed. All staff who administered medication in the centre were nursing qualified. Staff were knowledgeable of the procedures and adhered to best practice guidelines in the administration of medications. However, staff had not completed up-to-date training in the safe administration of medication. This is an action under Outcome 17 (Workforce).

There were no resident prescribed medications that required strict controls (MDAs) at the time of inspection. In addition, there were no residents self medicating at the time of the inspection. There were procedures in place for the safe storage of medications, which were kept in locked presses in the centre.

The inspector found there was regular GP reviews of the residents' medications. There was a system of monitoring and reviewing safe medication practices and audits of by the pharmacy service had taken place.

There were systems in place to report and investigate medication errors. These were discussed with the person in charge. While a high number of errors had occurred, these were attributed to omissions and record keeping. A sample of incident forms were read by the inspector. There were three form completed, that outlined the incidents, the investigation and the action taken. It was evident that appropriate action was taken following each incident.

Judgment:
Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre is part of a larger organisation with a defined management structure. While the inspector found some governance arrangements were in place,

improvements were required in relation to the systems in place to support and promote the delivery of a safe, quality service.

The person in charge of the centre was qualified and experienced. She had engaged in continuous professional development. While she was familiar with the Regulations there were improvements required for completion of personal plans for residents, the management of behaviours that challenge, the supervision of staff, the provision of up-to-date mandatory training and the records required to be kept for staff.

The inspector found the residents were familiar with the person in charge and they had an easy rapport with each other. She was based full time in the centre, and was included in the staff roster. However, there were no formal deputising arrangements in place to manage the centre in the absence the person in charge.

There were some clear management structures in place, for example the social care workers were supervised by the nursing staff, who in turn reported to the person in charge. The person in charge met the provider and the director of nursing on a monthly basis.

The inspector read audits of medication practices and infection control procedures however, there was no system of continuously monitoring and reviewing the quality and safety of the service provided to residents in the designated centre. While a detailed audit based on the National Standards had taken place in September 2013 none had taken place since.

The provider carried out unannounced visits to the service, and the reports of the visits were read by the inspector. However, there was no overall annual review of the safety and quality of the service as required by Regulations.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspectors found there was an adequate number of the staff to meet the needs of the residents. However, improvements were required in relation to staff documentation, provision of mandatory training, and the system of supervision.

The inspector reviewed the files of a sample of staff in terms of the documents required by the Regulations. Gaps were identified, for example, one of the staff files examined contained no evidence of An Garda Siochana vetting, and there were no references available on two staff files.

Staff training records were reviewed. However, the records did not provide adequate evidence that all training provided was up-to-date as discussed under Outcomes 7, 8 and 12.

There was no formal system of staff supervision or appraisal. The person in charge informed the inspector that a new supervision policy was due to be implemented, and formal appraisals would be carried out with staff.

The inspector reviewed the planned roster in place and found there was an adequate number of staff on duty to meet the residents needs.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The inspector reviewed this outcome in the context of the maintenance of records under Section 6 of the Regulations.

The inspector found all records held in the centre, were secure and provided as requested. However, resident records were difficult to review due to their size and the quantity of information being stored in their files. For example, each residents file

consisted of three large folders and information held was not in order of priority. In addition, historical information as far back as 2006 was held in the folders amongst up-to-date information.

All policies requested by the inspector as per the Regulations were also in place. However, as outlined in Outcome 7 and 8 of the report, the policies were not comprehensive enough to guide staff practice.

There were gaps in some records required to be maintained by Schedule 4 of the Regulations. As outlined in Outcome 7, there were gaps in records of fire drill practices and checks of the fire safety checks.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre 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 report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003359
Date of Inspection:	19 March 2015
Date of response:	15 May 2015

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 residents own monies were not paid into a financial institution account of their own name.

Action Required:

Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered

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

provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

The Registered Provider has put in place that two signatures are required for all transaction in relation to resident's finances.

The registered provider or any member of staff, will not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Plan

- The Registered Provider shall ensure that any resident that is deemed not to have financial capacity will have their finances managed in line with HSE Financial regulations.
- The Registered Provider shall ensure that the Registered Provider and staff, do not pay money belonging to any resident (without financial capacity) into an account held in a financial institution, without informing/discussing with the resident, their next of kin/advocate and the payment is in line with the HSE financial Regulations.
- The Registered Provider shall ensure that staff, do not pay money belonging to any resident (with financial capacity) into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.
- The Registered Provider shall ensure that in the situation where there are difficulties in implementing this review that it is raised at the management team and a plan of remedial action is put in place.

Proposed Timescale: 01/10/2015

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 residents had yet to agree and sign an agreement of the terms and conditions of their residing in the centre.

Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

Action:

Following the Inspector's visit the Registered Provider has provided all residents and

their family member in the Designated Centre with a contract of care.

Where residents were deemed not have ability to sign their consent the next of kin/representative have been asked to sign it on their behalf.

The Registered Provider is consulting with residents who are deemed to have capacity / understanding to give consent and will be supported to sign their contract of care. The contract will be explained to them and their next of kin informed.

Plan:

- The Registered Provider will ensure a copy of the resident's contract of care will be filed in the resident's personal file.
- The Person in Charge will ensure where there are changes in the contract of care that these are discussed and consent is sought to these changes if they arise.
- The Registered Provider will ensure where concerns are raised by a resident or their representative in relation to their contract of care that these will be recorded in the residents care plan.

Proposed Timescale: 01/06/2015

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:

Residents personal plans were not in an accessible format to residents.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

Action: The Person in Charge will ensure that each personal plan will be made available in an accessible format. This will be done on a phased basis.

Plan:

- Person in Charge will review each residents individualised personal care plan in the designated centre.
- Person in Charge will ensure each resident care plan will be made available in an accessible format.
- Person in Charge will ensure that there will be a staff member assigned responsibility for its implementation.
- Person in Charge will ensure that the accessible care plan is monitored and reviewed.

In the event that the plans in accessible format are not being put in place the Person in Charge will bring it to the attention of the management team.

Proposed Timescale: 01/12/2015

Theme: Effective Services

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

The completion of care plans for residents identified required improvement.

The care plans in place for residents identified needs did not fully guide practice.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

Action: The Person in Charge will ensure that each personal plan is reviewed to ensure it guides practice.

Following the Inspector's visit the Person in Charge has commenced a review of each resident's individualised personal care plan in the designated centre.

This will continue on a phased basis.

Plan:

- Person in Charge will ensure that the effectiveness of each individualised plan is reviewed and takes into account assessed needs, changes in circumstances and new developments.
- Person in Charge will ensure that there is documentary evidence of this review with a rationale for any changes made with a staff member assigned responsible for its implementation.
- Person in Charge will ensure that the care plans are monitored and have regular review dates in place.
- The management team will be informed of their effectiveness.

Proposed Timescale: 01/12/2015

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 multi-disciplinary input into residents personal plans.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

Action: The Person in Charge will ensure that each personal plan is reviewed on a phased basis to assess the plans effectiveness and will take into account any changes in circumstances.

Plan:

- Person in Charge will ensure that all multidisciplinary inputs are recorded in the resident's file.
- Person in Charge will ensure that there is documentary evidence of all reviews with a rationale for any changes made.
- Person in Charge will ensure that the care plans are monitoring and have regular review dates in place.
- The management team will be informed of their effectiveness

Proposed Timescale: 01/10/2015

Theme: Effective Services

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

The personal plans in place were not holistic and focused on residents health care needs.

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.

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

Action: The Person in Charge will ensure that each personal plan will be reviewed to ensure a holistic approach that is focused on all aspects of resident's lives.

Person in Charge has commenced a review of each residents individualised personal care plan in the designated centre.

This is being completed on a phased basis across the service.

Plan:

- The Person in Charge will ensure each resident's care plan will guide practice and edit current documentation to ensure ease of legibility and access.

Proposed Timescale: 01/12/2015

Theme: Effective Services

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

The provision of activities and access to a suitable day services based on residents assessed needs required improvement.

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:

Action: The Registered Provider will ensure that all personal plans are reviewed with the maximum participation of each resident, their key-worker and family/ representative in accordance with the resident's wishes, age and the nature of his/her ability. On identification of further day activities these choices will be supported to provide the resident with a more meaningful day.

The Registered Provider has commenced a review to ensure that more meaningful day activities for residents are identified and acted upon.

Plan:

- The Registered Provider will ensure that meaningful day activities for residents where appropriate are reviewed by the multi-disciplinary team with the maximum participation of each resident, their key-worker/ and family representative in accordance with the resident's wishes, age and the nature of his/her ability.

Proposed Timescale: 01/10/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Some parts of the centre required redecoration.

The grounds required general up keeping.

Action Required:

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

Action: The Registered Provider shall ensure the buildings are maintained in good order.

A number of works have commenced since the Inspectors visit.

Plan:

- The Registered Provider shall ensure that the Designated Centre will have regular

maintenance and upkeep.

- The Registered Provider shall ensure that the Designated Centre will be decorated in a manner to maintain resident's dignity and esteem.
- The Registered Provider shall ensure that maintenance will focus on specific works identified through regular checks.
- The Registered Provider will assign a person who has responsibility for ensuring that the designated centre is maintained.
- In the event where any necessary additional controls identified cannot be managed at local level they will be escalated to the Risk Register and senior management level.

Proposed Timescale: 01/11/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The documentation of investigations into the management of adverse events involving residents required improvement.

Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

Action: The Registered Provider has put in place a procedure to ensure that all adverse events will be reviewed regularly to include a written record of the review, actions taken and signed by the reviewer.

Proposed Timescale: 01/05/2015

Theme: Effective Services

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

There was no evidence of management oversight in the prevention and response to fire safety in the centre for example, the completion of fire safety checks, the review of fire drills and the response to issues raised by staff.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

The fire evacuation drill form now includes a column to identify in writing management response to any issues that arise at the time of the drill. This ensures that staff concerns are captured and responded to and documented.

Action: The Registered Provider shall ensure that external services shall provide documentation to identify the equipment serviced and that it is in good working order.

Plan:

- The Registered Provider shall ensure that this worksheet will identify the specific works carried out.
- In the event where the additional controls cannot be managed at local level they will be escalated to senior management level.

Proposed Timescale: 01/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The completion of positive behavior support plans required improvements.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

Action: The Registered Provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and reviewed as part of the personal planning process.

This will be put in place on a phased basis.

Plan:

- The Registered Provider shall ensure that all behaviour plans in the designated centre will be reviewed.
- The Registered Provider shall ensure that the all residents who require behaviour support plan focusing on therapeutic interventions will be put in place.
- The Registered Provider will ensure that where specialist inputs are deemed appropriate they are sourced.
- The Registered Provider will ensure that in the situation where there are difficulties in implementing this review that it is raised at the management team and a plan of remedial action is put in place.

Proposed Timescale: 01/12/2015

Theme: Safe Services

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

The management of restrictive practices required improvement.

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:

Action: The Registered Provider will ensure that every effort is made to identify and alleviate the cause of residents' behaviour; 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.

Risk assessments to guide practice in relation to the locked front gate is in place since the Inspectors visit.

The Centre's Restrictive Practice Policy has been reviewed since the Inspectors visit.

Proposed Timescale: 01/05/2015

Theme: Safe Services

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

There were gaps in the training in the prevention and reporting of abuse

Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Since the inspector's visit dates for staff training on Safeguarding Vulnerable Adults have been put in place.

This will be completed on a phased basis.

Plan:

- The Person in Charge will ensure that staff are facilitated to complete the appropriate training in safeguarding vulnerable adults.
- The Person in Charge will ensure that such training is completed in a timely manner.
- The Person in Charge will ensure the training records are reviewed on a regular basis.
- The Person in Charge will ensure that if training is not being provided that there is an action plan put in place.

Proposed Timescale: 01/12/2015

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:

Referral to psychology services for one resident was not provided where recommended.

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:

Action: The Person in Charge shall ensure that where required; psychological therapeutic interventions are engaged and recorded.

Plan:

- The Person in Charge shall ensure that referrals by a Consultant psychiatrist for psychological services are followed up and these efforts are documented.
- The Person in Charge will ensure that where psychological inputs are not available and such inputs are deemed appropriate they are sourced.
- The Person in Charge will ensure that in the event of not being able to source psychological services that this is brought to the management team's attention

Proposed Timescale: 01/05/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The system of monitoring and review of the safety and quality of care provided to residents required improvement.

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:

Action:

Medication management

- The external audit of medication management by Abbey Health Care with an action plan from the PIC and CNM 3 remains in place.
- The review of Kardex and PRN protocols to ensure timely review and compliance with Medication Policy remains in place. This is completed 6/12 and 3/12. This involves the GP and Pharmacist as required.

Fire management and prevention

- The current audit of evacuations has a written action plan for any deficits/ area for improvement identified by staff completed by the CNM 3. A copy of which is available for each of the houses for their information and records since the Inspectors visit.
- Since the Inspectors visit the daily and weekly fire checks are audited and actions where necessary are put in place. This is completed by the CNM 3 and other Nurse Managers on a regular basis and signed of monthly.

Health and Safety

- The auditing of ABC forms which are reviewed with staff by the EIST team to inform support plans for resident's remains in place. Areas of high risk are escalated to the Risk Register and acted upon.
- A review of all incidents/ near misses is provided by nurse managers and brought to the management meetings remains in place.
- Since the Inspectors visit a review by the HSE National Quality Improvement Team took place on the 22nd April 2015. Key areas under governance, training, person centred focus and documentation regarding risk management and self assessments were reviewed by them. Recommendations made are being looked at and the QI are to return to assist the service further.
- Since the Inspectors visit maintenance issues which had been put on the Risk Register have been audited and prioritised for remediation with the Maintenance Officer who regularly attends the monthly management team meeting. Works have commenced on site.
- Since inspector visits Finance department HSE have identified a named person who will review finances in Hawthorns on a regular basis
- Annual hygiene audits continue.
- Since the Inspectors visits The DON has convened a Quality Review Group which will be guided by the HIQA standards since the Inspectors visit. This group will identify area of care practice that require monitoring/ policy/ procedures to be put in place to improve practice and services provided for residents.

Plan:

Maintenance and Fire

- The Fire Officer is completing an order of works identified by him for 2015 and when these are complete he will audit and identify any additional works required for 2016.

Key areas identified

Nurse Managers as CNM 1/ CNM 2/ CNM3 will audit a number of key areas going forward and put in place action plans to address gaps where identified. These will be reported on to the management meeting.

Key areas identified include:

1) Quality of Care

- Auditing of medication management practices will begin
- Auditing of care plans will begin
- The unannounced visits by the Director of Services and DON will audit the areas looked at by them and identify where improvement/s is required. This will be brought to the attention of the PIC and to the management meeting.

2) Incidents near Miss Restrictions

- Review of any restrictions put in place for any period of time.
- Audit and review of all incidents and near misses on a monthly basis by PIC and discussed at the management meeting.

Finance

- Audit of finances by Clerical Officer and PIC. Same reported to the monthly management meeting.
- Annual financial audit to take place in 2015 as per HSE guidelines.

Health and safety

- Audit of the service will be completed by HSE Health and Safety late 2015 / early 2016

Clinical audit training

Training in clinical audit has commences for staff in SIDS. Further workshops for staff will be identified for late 2015 to early 2016.

Proposed Timescale: 01/10/2015

Theme: Leadership, Governance and Management

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

An annual review of the quality and safety of care in the centre had not taken place.

Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of

the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

Action: The Registered Provider will ensure there is an annual review for the designated centre. Such a review will encompass quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

- The Registered Provider will ensure that there is a formal system of annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with national standards.
- The Registered Provider will ensure that this review is carried out at least twice annually.
- The registered provider will ensure that the outcome of these reviews will be made available to the resident and families of the designated centre.

Proposed Timescale: 01/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There were gaps in the information required to be maintained for staff as per the Regulations.

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 fire evacuation drill form now includes a column to identify in writing management response to any issues that arise at the time of the drill. This ensures that staff concerns are captured and responded to and documented.

Action: The Registered Provider shall ensure that external services shall provide documentation to identify the equipment serviced and that it is in good working order.

Plan:

- The Registered Provider shall ensure that this worksheet will identify the specific works carried out.
- In the event where the additional controls cannot be managed at local level they will be escalated to senior management level.

Proposed Timescale: 01/10/2015

Theme: Responsive Workforce

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

Training records reviewed did not provide adequate evidence that staff had up-to-date mandatory training.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

A new format for recording most recent staff training and dated, has been put in place since the Inspectors visit.

Proposed Timescale: 01/05/2015

Theme: Responsive Workforce

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

There was no system of staff supervision.

Action Required:

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

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

Action: Training in Supervision has been put in place for PIC's and their deputies since the Inspectors visit.

This will be implemented across the service on a phased basis.

Plan:

- The Person in Charge will ensure that this system is implemented for all staff.
- The Person in Charge will ensure that supervision records are put in place reviewed on a regular basis.
- The Person in Charge will ensure that if supervision is not being actioned that there is an action plan put in place.

Proposed Timescale: 01/12/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Policies in place did not consistently guide practice for example, the prevention of abuse, the management of restrictive practice, the behaviour support policies.

Action Required:

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

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

Policies will be reviewed to ensure they consistently guide good practice particularly in the areas of prevention of abuse, the management of restrictive practice and behaviour support

Proposed Timescale: 01/10/2015

Theme: Use of Information

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

There were gaps in fire safety records required to be in place.

Action Required:

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

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

Action: Since the Inspectors visit all houses are now compliant with filling daily and weekly fire checks and these are audited by management on a monthly basis.

Proposed Timescale: 01/05/2015

Theme: Use of Information

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

Residents records were difficult to review due to the quantity of information contained in files.

Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in

Schedule 3.

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

Action: Since the Inspectors visit all documentation held on residents is being reviewed to ensure ease of access, up to date information and the archiving of historical information. This will be completed on a phased basis.

Proposed Timescale: 01/12/2015