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-0003368
Centre county:	Sligo
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Thelma O'Neill
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	107
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, 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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
09 April 2015 09:30	09 April 2015 19:30
13 April 2015 10:00	13 April 2015 22:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce

Summary of findings from this inspection

Given the level of non compliances, and their impact on the safety, quality of life for residents and failure to protect the rights of residents, the Authority undertook a series of inspections and regulatory engagements with the provider. Following the previous inspection, the Authority required the provider to attend a meeting to discuss serious concerns about the safety and quality of life for residents in the centre. In addition, the provider was told that governance and management in the centre was not adequate, as evidenced by repeated non compliances across the inspections. The provider informed the Authority of plans to review the management of the centre and ensure improvements in the quality of service for residents.

On this inspection, inspectors found that there had been improvements across a number of outcomes, but there continued to be a significant level of non compliances. Governance and management in the centre continued to be insufficient. While the provider informed inspectors about plans to review the quality of care in the centre, inspectors continued to find non compliances and also found that the provider had not taken sufficient action to ensure that learning from non compliances was being implemented across the centre. The action plan responses issued on the last inspection on the 20/2/15 were reviewed. There were 18 actions in total.

Inspectors found that six actions were completed, seven partially completed, and five had not been addressed.

Inspectors followed up on the two immediate actions issued on a previous inspection. The actions required were to immediately address the risks of burns to residents from a very hot radiator and insufficient staffing levels in the centre. The inspector found that while the provider had taken action in the units previously inspected, there continued to be deficits in staffing levels elsewhere in the centre which were having a direct impact on the quality of life for residents. Residents with behaviour issues were not receiving the support they needed and the opportunity for residents to participate in meaningful activities was very limited. Inspectors again observed residents spending significant periods of time without structured engagement or interventions. Assessments of residents' care and support needs had improved but were not adequately comprehensive to inform the individual support plans for residents.

The provider had taken action to improve the nutrition and dining experience for residents in two of the units. However, inspectors also found that the early closure of the central kitchen at weekends and public holidays meant that arrangements for dining and meal choices for the majority of residents was very poor at these times.

The provider had commissioned an external fire safety consultant to complete a fire risk assessment of all areas in the campus. The consultant had not identified any actions that needed to be taken immediately to address fire safety, but did identify a range of actions that the provider had to take within a three to six month period.

Inspectors found that all staff had still not completed training in mandatory areas such as fire safety, manual handling, and infection control or managing behaviours that challenge.

The centre is located approximately 5 km from the town of County Sligo. In the main building there were eight adult units and one children's unit accommodating thirty-nine full time residents and one children's respite bed which provided accommodation to five children on a rotational basis. In addition, there were sixty eight residents accommodated in the twelve chalets which were situated on the grounds of the campus.

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

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
On all of the previous inspections, inspectors had identified that there were insufficient staff supports during the day for most of the residents which meant that residents had very limited access to meaningful activities. Some residents had not accessed the community for months at a time. Personal plans were not always available in an accessible format and had a health focus rather than considering all aspects of the residents' lives. Personal plans viewed did not adequately address resident's psychological and social care needs or preferred daily routine.

On this follow-up inspection, inspectors reviewed the actions taken by the provider and person in charge to improve the quality of life for residents and address the areas of non compliance. Inspectors found that there had been progress in this area:
1. Some units had commenced a transitional process of moving residents into the community.
2. A structured social programme had commenced for 19 residents on a session basis.
3. A contracted psychologist and three assistant interim psychologists were developing integrated planning processes; to aid the development of person centre planning.
4. A new social care assessment document called "Listen to me" was being implemented for each resident and their social and community activity wishes was currently being assessed.
5 Adaptive behaviour assessments had commenced for residents presenting with behaviours that challenge.
6 Annual multi-disciplinary reviews now included social, recreational and diversional activity plans as well as identifying healthcare issues.

7 The provider nominee was also reviewing the accessibility of transport for residents to attend social outings.

However, personal plans were still not in an accessible format for residents to read or understand. There were unclear personal outcome goals for residents and no clear time frame for achievement of the goals or responsible person identified that would implement the care plans viewed. Although the provider told inspectors of plans to move residents towards community living in the near future; there was no evidence in most of the resident's files of any transitional planning taking place.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Inspectors had found over the course of previous inspections serious deficits in fire and risk management. These findings had led the inspectors to issuing three immediate actions in relation to both risk management and fire safety on dates 15/12/14 and 30/1/15 20/2/15.

On this inspection, inspectors found that the provider had taken action to address the areas of concern. This action included:
- There were keys located in fireboxes at all fire exits.
- A fire risk assessment had been commissioned by an external fire safety consultant for the entire centre and this had been done over a number of dates in February 2015.
- A fire register was now in place in all units.
- The records in the fire register were now up to date and contained records of all fire safety precautions in place in these units.
- Personal Evacuation Egress Plans (PEEPs) for each resident had been reviewed and were now up to date.
- Unit-specific evacuation plans were now available.
- Inspectors found there were now fire alert procedures displayed in each unit, and there was guidance as to where residents should evacuate to in the event of an emergency.
- Inspectors interviewed staff members on duty regarding emergency evacuation procedures. All staff interviewed were aware of the fire evacuation procedures in their units.
- Day and night time fire evacuation drills had recently taken place.

- The manager had ordered a bariatric fire evacuation stretcher for one resident living in this centre; to aid the response time in the event of an emergency evacuation.
- Fire training for all staff had commenced however, were not yet complete.

A copy of the fire consultants report was issued to the inspectors on the evening of the 09/4/15. The fire consultant had not identified any area for immediate action but had identified a large number of actions that had to be completed in the centre within a three to six month period. The report did identify a number of bedrooms that should not be used for residents who were not fully mobile.

However, inspectors were concerned that the provider had not identified fire related issues or taken action in relation to them until the inspectors brought them to her attention. The provider had not ensured that all staff had received fire training. Inspectors identified that at least 20 staff, mostly on night duty, who had not yet had up to date fire training. In addition, some residents who had difficulty mobilising continued to live in the bedrooms identified as unsuitable to meet their needs by the fire consultant. The inspector informed the provider of these findings The provider issued an immediate directive to all managers that all staff working on night duty were not to work on nights until they had received fire training. The provider also gave an immediate directive that the residents accommodated in the bedrooms identified as unsuitable for residents with high mobility needs in the fire risk assessment would be moved bedrooms by the end of the week.

Inspectors identified similar risk management issues over the course of the previous inspections. These included the risk management which policy did not reflect the local policies and procedures to provide adequate guidance to staff on managing risks. The management of accidents and incidents was inadequate. Residents were left unattended while staff were occupied with other residents. Nurses were leaving their units to administer medication to unfamiliar residents in other units. Staff had received injuries while moving and handling residents and they did not have the mandatory moving and handling training.

On this inspection, inspectors found that:
1. Nurse managers were now keeping a copy of all accidents/incidents that occurred under their responsibility, so that they could monitor risk in their areas.
2. All Clinical Nurse Managers (CNM2’s) now have been sanctioned to log accidents/incidents onto the centre's computer system. Previously CNM'S required the signature of one of the three senior managers. The procedure has now been reviewed and all incident forms were processed in a timely fashion to ensure that they were recorded and that the information was available to nurse managers for learning purposes.
3. A Risk Management Group and an Incident Review Group had been established to review incidents and accidents on a monthly basis, and provided a monthly report/log to all managers. Previously, the auditing tool used to monitor accidents and incidents in this centre was found to be inadequate.
4. Measures had also been put in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies.
5. Previously, inspections had found that the organisation's risk management and emergency planning policy and procedures were not clear and did not provide easy to

read guidance for care staff on managing and recording risks. This policy was in the process of being reviewed.
6. A Quality and Safety Walk around had been completed by the provider nominee on the 8/4/15 to identify risks, highlight trends and discuss measures to minimise the re-occurrence of risks.
7. Individual assessments were completed for resident's clinical risks. For example, the risks of resident's falling or displaying behaviours that challenge had been recorded. However, on all previous inspections and on this inspection, inconsistencies were identified in the approach to completing these risk assessments and some risk assessments viewed did not include adequate control measures. It was clear from the assessments reviewed that that staff required training in identifying, assessing and managing risks.
8. A staff training programme had commenced in safe moving and handling for all staff, which was due to be completed in July 2015 but to date, many of the staff had still not completed this training. The provider nominee informed inspectors that she would organised this training in-house immediately for all staff.

On the inspection dated 10/2/15 inspectors found infection control issues in the kitchen/utility shared by two units. The design of the kitchen and utility area were open plan and there was no storage space for mop buckets or laundry, despite some of the resident's clothes being laundered there. A fridge was kept in the utility area due to a lack of space in the kitchen area. The sink in the kitchen was being used as a sluice sink for cleaning as well as food preparation use.

Since the last inspection, the provider had taken some actions to improve the management of infection control in the kitchen/utility area of two units. However, precautions were still not adequate. The actions taken to improve infection control included:
- A panel had been installed to separate the kitchen and laundry areas
- A separate water supply had been sourced for cleaning and sluicing equipment.
- Cleaning trolleys were no longer stored in the utility rooms.
- All laundry was now being sent to the main campus laundry, however there continued to be inadequate cleaning storage facilities in the unit.
- The collection and delivery of laundry was now through the front door and not through the kitchen.
- A new shed had been purchased to store soiled laundry.
- New laundry bags had been ordered as well as laundry trolleys for the moving of soiled laundry.
- A flat mop system has been introduced for infection control purposes.

However, inspectors found that staff had still not completed training on hand hygiene or training on infection control procedures as a response to a recent infection outbreak. Prior to this inspection, the case holder had been informed that two units had an influenza outbreak on the 30th of March 2015. The units were in isolation for two weeks. Nine residents were very unwell during this period. One resident was hospitalised. Inspectors found that the appropriate safety precautions were adhered to and the Department of Public Health were notified and guidance was sought from the specialists on the management of the outbreak. The Occupational Health Department set up a vaccination clinic for all staff but the manager told inspectors that only 16 staff

out of the 300 staff in total had received the vaccination.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The policy on protection of vulnerable adults had been revised to give more specific advice to managers on the actions to take in the event of an allegation of abuse. A programme of training has been completed by the Principal Social Worker and inspectors were told that most staff have now completed training in adult protection, however, not all staff working in the centre had up to date training.

Inspectors were notified of two allegations of physical abuse in this centre over the past few months that were currently being investigated and a further allegation that was a historic, but the investigation was still not complete. The Authority were assured by the management that the safety of residents had been prioritised following the allegations, and that two separate investigations been established in accordance with the organisations policy on the protection of vulnerable adults. An follow up report had been submitted to the Authority for the first reported allegation and the Authority was informed the investigation was complete on the 6/3/15. However, The Authority had not yet received the outcomes of the second investigation, as inspectors were told that the investigation was still in progress. During the inspection, the management team confirmed that there were no new allegations of abuse currently under investigation.

On this inspection an inspector visited a chalet where one resident lived alone due to behaviours that challenge. The inspector found that there were inadequate arrangements, and risk assessments in place to support and protect the resident during an behavioural incident. In addition; the residents personal files, were kept in the staff office in the another building, which limited the care staffs ability to record information in the residents personal files.

On the 9/4/15 the provider nominee informed the inspectors that an organisation review of practices in relation to safeguarding vulnerable adults was to commence in response to the findings and recommendations of an investigation into an allegation of abuse that was completed in August 2013. However, the inspectors found that the delay in implementing all of the external investigators recommendations could have put residents at risk.

Staff members on duty were clear on the reporting arrangements should they wish to report an allegation or suspicion of abuse and identified that they would contact the designated officer as well as the person in charge. Training records available indicated that most, however not all of the staff, had completed mandatory training in adult protection. Additional dates were also scheduled to ensure some staff members who were absent during previous training dates could attend.

Inspectors found that the provider had taken measures to improve the supports to residents with behaviour that challenges and to improve the management of restrictive practices. On this inspection, the inspectors found that one resident with behaviour's that challenge that previously was impacting negatively on other residents had been moved to an apartment on their own. A resident in another unit also with behaviour's that challenge had also being relocated to a quieter environment as per their revised behavioural support plan. Their medication has been reviewed and the use of chemical restraint had been significantly reduced. A Behavioural support plan for this resident had been reviewed to improve proactive strategies. This resident was allocated individualised support staff from l0 am to 10 pm every day to improve their quality of live.
The services of a psychiatrist and three postgraduate psychology interns had been secured to support some residents with behaviours that challenge one day a week. Since the last inspection; there were a number of case conferences held for individuals that were presenting with aggressive behaviours and positive behavioural support plans had been reviewed.

Inspectors found that there had been improvements in the management of restrictive practices. In three units, the restrictive practice, which included; locking the exit doors were in place due to the risk of residents leaving the unit unsupervised. The provider had now installed keypads on exit doors, with the aim to transitioning to open door units in the future. All internal doors, including the kitchen and dining rooms are now open for residents to access if they wish. Also, on previous inspections, inspectors found that one resident's rights were being restricted by the use of restrictive clothing to prevent scratching. This restriction had been reviewed and was found no longer to be required.

The provider informed inspectors that they were conducting a review all restrictive practices in the centre. A Human Rights Committee was being established.

Judgment:
Non Compliant - Moderate

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training

and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
On previous inspections, inspectors had found that many residents did not have adequate supports to engage in meaningful activities during the day. This had been made worse with the closure of their day service. On the second day of this inspection, nineteen residents commenced a part-time day service. Activities included: arts and crafts, multi sensory therapy, music therapy and hand and foot massages. Also; a new large sitting room near two unit's areas was being opened as a day centre room.

However, the new day service was inadequate as it was only on a sessional basis of one or two morning or afternoons each per week for each of the nineteen residents. Other residents continued to be without adequate opportunities to engage in meaningful activities during the day and those that did participate continued to have lengthy periods of boredom and inactivity.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Previous inspections found that most residents had not had a full medical review in over five years. Care plans had not been updated and there was a poor linkage between care plans and the risk assessments with the delivery of care. Many staff did not have the required training in diabetes, infection control, wound management, or urinary catheterisation to ensure that the healthcare needs of residents were being met.

On this inspection, the inspectors found that the provider had taken action to improve the arrangements to meet the healthcare needs of residents, including:
1. Professional development training has been organised for all staff in areas such as urinary catheterisation, managing diabetes care and wound care.
2. Residents had access to multi-disciplinary supports such as; Dieticians, Occupational Therapists, Speech and Language Therapists, and Clinical Nurse Specialists.
3. There were four Clinical Nurse Specialists (CNS) available to assess and implement resident's health goals; two behavioural support specialists, one mobility specialist and one dementia specialist.
4. The nursing assessments and annual nursing reports had been updated since previous inspections. Resident's that had mobility difficulties had a falls risk assessment completed. The Speech and Language Therapist (SALT) and Dietician reviews were completed for some residents.

However, one of the care plans that were reviewed was not up to date and included incorrect information regarding staffing supports required for the resident and the care plan had not been reviewed annually.

Many of the residents had complex healthcare needs and some had not had a medical review in up to five years. The provider told inspectors that the GP had increased visits to the centre and planned to conduct four medical reviews a week in addition to normal GP service provided. Inspectors found that this action plan by the provider was not sufficient to ensure that residents had a timely medical review. The GP was not achieving the goal of four reviews a week, and had completed two the previous week. In addition, it would take an extended period of time for completion of reviews for all residents at this pace.

On all previous inspections, the inspectors had found that an institutional approach was evident in the provision of food for all residents. The arrangements for meals to be provided from the central kitchen still impacted on the quality of the dining experience for residents. The central kitchen continued to close early at weekends, reducing the choice of meals for residents. Staff told inspectors that residents generally had a choice of either salad or chicken goujons at these times and confirmed that residents who required liquidised diets were offered liquidised salads.

However; inspectors found that some improvements had been made since the previous inspections. Equipment had now been installed on a trial basis in one kitchen that is shared between two units, so that residents can prepare some meals with support from staff. A purchasing card had also been provided for two of the units to allow residents to purchase groceries with staff support. The provider told inspectors that there were plans to implement this in all units and chalets in the centre.

Judgment:
Non Compliant - Moderate

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

medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
On all previous inspections; inspectors had found poor medication management practices. On his inspection, improvements were evident. The designated centres had policies and procedures in place for medication management. A pharmacy review had been completed. Medication audits had taken place. Revised stock control measures were in place; such as new pharmacy requisitions forms. Monthly medication returns were recorded. All PRN medication was recorded according to the organisations protocol for the administration of PRN medication.

There was a new medication management folder in use on all the units that was developed by the pharmacist. Medication charts had all been reviewed and updated.

However, in one unit, the inspector checked the labels on the medication containers against the resident's prescription and they didn't correspond. Inspectors also identified that the practice of the nurses leaving the children's and adults units to go to four other units to administer the 10pm medication had not been addressed. The provider was made aware that these risks were previously identified on earlier inspections of this centre and as they had not been addressed. The provider confirmed that an immediate review of medication management and a risk assessment would be carried out.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily

implemented.

Findings:
Poor governance and management in the centre has been consistently identified in all inspections to date and was the subject of action plans following previous inspections. After the previous inspection, the provider nominee was required to attend a meeting with the Authority where the provider was informed of the serious concerns relating to the safety and quality of life for residents, and management and oversight of the centre. The provider had told the Authority of plans to review the management arrangements in the centre and actions to ensure the care and support needs of residents were being met.

Inspectors found that, while there had been some improvements, the management arrangements in the centre were still insufficient to ensure the safety and quality of life for residents. Inspectors continued to identify the same non-compliances in many of the units inspected. The provider was responding to non compliances that inspectors identified but a number of actions not been completed or only partially achieved. In addition, the provider and management were not ensuring that the learning from each inspection was being implemented in all units across the campus. Neither were they proactively looking at the quality of life of residents and identifying issues for themselves.

Judgment:
Non Compliant - Major

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found that the provider had not assessed or identified the staffing and other resources required to meet the assessed needs of residents. While the provider had recently identified a requirement for additional staffing in response to findings from inspections, the provider had failed to implement the additional staffing.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The provider had received immediate actions in relation to staffing on previous inspections. On this inspection, inspectors found that while there had been improvements in the staffing arrangements, there continued to be inadequate staffing to meet the needs of residents.

The provider had allocated an additional 2.5 Whole time equivalent(WTE) staffing posts for one of the units. Eight residents now had one to one staffing. One resident was assessed as requiring two to one staffing due to serious behavioural issues. However, on the day of inspection there was only one staff available to support this resident until 5pm which increased the risk levels for the resident. In addition, inspectors found that the person in charge was relying heavily on agency staff. In two units, there were locks on the exit doors because there were insufficient staff to supervise two residents who were at risk of leaving the unit. This was impacting on the rights of all of the other residents living in these units.

Inspectors found that inadequate staffing levels were continuing to limit resident's opportunities to participate in activities appropriate to their interests and preferences. However, in the children's unit, in response to a previous immediate action, additional staffing had been provided for an hour and a quarter to assist with preparing the children for school.

The provider told inspectors that they were in the process of recruiting 22 additional health care assistants and five nurses to address the staffing issues.

Inspectors found that the provider had still not obtained all of the documentation for staff required by the regulations to indicate their suitability to work in the centre. The provider had still not obtained Garda clearance for several staff members.

On previous inspections, inspectors found that training to enable staff to effectively meet the needs of residents was not being provided. While there had been some improvement in areas such as diabetes care, wound management and catheter care, there continued to be insufficient staff training. Staff were not adequately

knowledgeable about risk management in the centre, a significant number of staff had not received training in fire safety and staff had not received adequate training in positive behaviour support.
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Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003368
Date of Inspection:	09 and 13 April 2015
Date of response:	18 June 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 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not in an accessible format for residents to read or understand.

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

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

representatives.

Please state the actions you have taken or are planning to take:
The "Listen to Me" document and the "Communication Passport" are in place for each service user in an easy-read format. The use of photos in the PCP has greatly enhanced the accessibility and understanding for service users. A unit specific audit schedule has been devised and will include audits on all PCP's.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Each resident is required to have a comprehensive assessment by an appropriate health care professional of the health, personal and social care needs of each resident.

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:
29% of residents have had their Annual Health Assessment. A tendering process to secure a new G.P. service has been completed. This new GP service commenced 15/06/2015 and Medical Reviews will continue at a rate of 3 per week.

Proposed Timescale: 17/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were unclear personal outcome goals for residents and no time frame for the planned achievement of goals or responsible person identified in the care plans viewed. There was no record in some plans whether the activities had been achieved as planned.

Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
Each resident has a Personal Care Plan in place in easy read format. Person-centred

goals are clearly identified with a community based focus that enhances the person's personal development. These goals are evaluated and reviewed. A Named Nurse is responsible for development of the PCP and its implementation.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider informed inspectors that residents would be moving out of the centre to a more appropriate community based service but there was no evidence in most of the residents files of any transitional planning taking place.

Action Required:
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:
There are Individualised Living Options assessments in all resident's Care Plans to identify their most suitable accommodation needs. All residents who have a community placement identified have a transition plan in place. This is in easy read format and developed based on the needs of the resident.

The Speech and Language Therapy Manager and staff have developed individual Communication Transition Plans for all residents who are due to move to their new accommodation. All residents will have individual transition plans based on their needs. A full Multidisciplinary Review will take place as resident's transition between internal areas.

The Individual Education Plans are used in school for the children to develop life skills for transitioning to community based placement. Each resident has activities that incorporate life skills training in preparation for moving to a community based residence. Fortnightly transition planning meetings are taking place. Further transition planning as housing becomes available.

Proposed Timescale: 30/06/2015

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 organisation's risk management and emergency planning policy and procedures were not clear and did not provide easy to read guidance for care staff on managing

and recording risks.

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:
Risk Management and emergency planning policy will be reviewed and will be amended to include hazard identification and assessment of risk. It will also be individualised to each specific unit.
Risk Assessment Workshops x 2 will take place on 24th June and 1st July for all staff.

Proposed Timescale: 26/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inconsistencies were identified in the approach to completing risk assessments and some risk assessments viewed did not include adequate control measures.

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:
Risk management policy will be reviewed to include arrangements to ensure risk control measures are proportional to the risk identified. This will include an assessment of the impact such measures have on the quality of life.

Risk Assessment Workshops x 2 are taking place on 24th June and 1st July for all staff.

Each resident will have a Risk Summary Sheet for their file documenting their personal risks, the rating, the supports required to minimise and the review date.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors found that although the centre had two units in isolation for two weeks staff had still not completed training on hand hygiene or training on infection control procedures as a response to the infection outbreak. There were inadequate storage

facilities to ensure safe infection control procedures in the centre.

Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
Hand Hygiene trainer is currently providing training. 40% have been completed Hand hygiene training. Refreshers will also take place after an outbreak.

Changes have been made to cleaning equipment and the storage of same and guidelines are now followed. Templates from the Infection Control Policy will be used and cleaning schedules will be displayed on the units.

Proposed Timescale: 30/06/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were impacting on the rights of residents in the centre.

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:
All restrictive practices are reviewed at unit level on a daily basis to ensure they are in accordance with national policy. Each area will carry out a daily review of the use of restraint and keep a register related to each resident. Meeting to be held with Occupational Therapist., CNS in Mobility & Physiotherapist on the 17/06/2015.
MDT Risk Assessments will be in place for all restrictive practices carried out by the relevant team member. Risks identified are placed on the risk register.

A residents Rights Committee will be established.

Proposed Timescale: 31/07/2015

Theme: Safe Services

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

The Authority was not notified of the outcomes of investigations into allegations of abuse and the actions taken to ensure residents are safe.

Staff members were not following the organisational policy or procedures on managing allegations of abuse. Also, there was no risk assessment completed, identifying this issues and there were no control measures or risk rating in place to protect the resident or the staff working in this house..

Residents personal files, were kept in the staff office in the another building, which limited the care staffs ability to record information in the residents file.

Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
Staff members will ensure they are following the organisational policy on managing allegations of abuse and actions will be taken to ensure residents are safe.

Risk assessments are completed and controls identified to protect the resident and staff. Behaviour support plan is in place. The residents' file is now in the resident's current unit.

Proposed Timescale: 30/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff working in the centre had up to date training in protecting vulnerable adults.

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:
82% of staff have been trained under Safeguarding and Protection of Service Users. This training is continuing and a training schedule is in place.

Children's First training has been completed with all staff working with children.

Proposed Timescale: 26/06/2015

Outcome 10. General Welfare and Development
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Residents were not provided with sufficient access to meaningful activities and occupation to provide appropriate stimulation and relief boredom during the day. **Action Required:** Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment. **Please state the actions you have taken or are planning to take:** The Dream programme is now available for each of the residents. It remains on a sessional basis. To enhance this programme for residents, staff are promoting and encouraging alternative activities both on the units and community based for those who don't have a full time day programme. This can include massages, walks, weekend breaks, day trips, meals out, family connections, Snoezlan. E.g. 11 residents have travelled to Knock and took part in the ceremonies.
Proposed Timescale: 18/06/2015

Outcome 11. Healthcare Needs
Theme: Health and Development **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Many residents had not annual medical reviews for over five years and the additional new clinic allocated to complete the residents' annual medicals was inadequate to meet demand. **Action Required:** Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan. **Please state the actions you have taken or are planning to take:** Medical Reviews are taking place as scheduled, these will continue with the new G.P. service from 15/06/2015. 2 to 3 reviews are taking place per week with 29.9% completed to date. Expected full completion for all residents 30th December 2015.
Proposed Timescale: 30/12/2015
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The kitchen closed at 3pm on Saturday's and Sundays reducing the choice of evening meals to residents at the weekends.

Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
4 areas of on the campus and all community houses have acquired a debit card which enables each resident to purchase their own food. This provides adequate food, drink and choice to each resident. A month's trial of providing 2 choices of the main meal has been completed and will now continue. A Food and Nutrition meeting took place on the 10/06/2015 where it was agreed that a survey would be undertaken to get the views of each resident based on what they like for their meals. This will be filed in each resident's Care Plan. This will be reviewed in 1 month by the Dietician.
In addition food options are provided for the residents who require minced/moist diets.

A mealtime audit tool has been approved by the relevant MDT members and will be carried out in all areas to assess all aspects of the mealtime experience. All staff are undergoing food hygiene training.

Proposed Timescale: 30/12/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The resident's prescriptions and the labels on the resident's medication containers did not correspond.

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:
All medication is checked in each area - when the delivery of medication is received from the pharmacy, and 10 days before the next order is due. The managers will do a monthly audit of compliance with the policy in each area.
Issues around labelling have been highlighted to the Pharmacist. There is a protocol to follow by managers if labels are found to be incorrect. The issues around labelling have been risk assessed and will be on the Service Risk Register.

Proposed Timescale: 15/06/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Two nurses were administering the 10pm medication at night to residents in four other units they were not directly responsible for.

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 review of current staffing levels, skill mix and responsibilities is being conducted throughout the service. The supervision and delegation of duties including the administration of medication will be the responsibility of the CNM111/11 on night duty. The Service is also exploring the possibility of delivering SAM's training (Safe Administration of Medication) for Healthcare Assistants.

Proposed Timescale: 30/06/2015

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 day to day governance and management of this centre did not ensure that the service provided was appropriate to the assessed needs of 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 Director of Services has taken up post since 2nd June 2015. Management systems have been reviewed in the designated centre. The PIC's have been identified and relevant paperwork has been submitted. The PPIM's have been requested to complete the required paperwork. There is currently a delay in completion of this due to IR difficulties. A revised organisational chart is attached which demonstrates the governance levels with the service.
Quality walk around are carried out on a daily basis by the CNM's, Director & provider. CNM's and frontline staff will be empowered to facilitate change within their areas through the performance management framework & unit level.

Proposed Timescale: 15/07/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate staffing and resources available to meet the assessed needs of the residents, or to plan for transiting to the community.

Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
Staffing levels are reviewed on a daily basis to ensure the safe delivery of care. A full review of staffing/allocation is currently being carried out to assure the Director of Services/ Provider as to meeting the assessed needs of residents including transition planning.
Additional support hours have been introduced to the service in relation to meeting the identified needs of the residents. The overall staffing review will provide a final recommendation on staffing level.

Proposed Timescale: 30/07/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There continued to be insufficient staff to meet the assessed care and support needs of residents.

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

Please state the actions you have taken or are planning to take:
Staffing of the day service has been fully supported which does not involve redeployment.
A review of current staffing levels, skill mix and responsibilities is being conducted throughout the service. The supervision and delegation of duties including the administration of medication will be the responsibility of the CNM111/11 on night duty.

The Service is also exploring the possibility of delivering SAM's training (Safe Administration of Medication) for Healthcare Assistants.

There is a senior psychologist commissioned to provide support 1 days per week and 3 psychology assistants 2 days per week. This will ensure psychology input for residents' with serious behavioural risks identified and restrictive practices in place in the centre. A further psychology post is at national recruitment service to be filled.

Numbers of locum staff will be reviewed as part of the overall staffing review.

Proposed Timescale: 30/07/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider had still not obtained all of the documentation required by the regulations, such as garda vetting, to indicate that staff were suitable to work in the centre.

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:
70% of completed Garda vetting forms are now on file. Managers have been encouraging staff to complete these forms on a voluntary basis.

Proposed Timescale: 30/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not trained in managing risk, and many staff did not have up to date mandatory training in Fire, managing behaviours that challenge, safe moving in handling, infection control, medication management.

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:
Risk Management Training is taking place the 24th June and 1st July for all staff.
Training schedules are in place for all mandatory training.
Safe Administration of Medication training for Health Care Assistant's is being explored.
The following is a breakdown of the current completed training.

Training Required	% Completed
Manual Handling Practical on site	35%
Manual Handling online.	20%
Studio III behaviour support	27%
Protection and Safeguarding	80%
Fire Safety	70%
Infection control Hand Hygiene Practical	38%
Infection control Hand Hygiene Online	33%

Proposed Timescale: 30/12/2015