

**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:	Frank Morrison
Lead inspector:	Marie Matthews
Support inspector(s):	PJ Wynne;Thelma O'Neill
Type of inspection	Announced
Number of residents on the date of inspection:	31
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 compliance with National Standards. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
12 May 2015 10:00	12 May 2015 18:30
13 May 2015 09:00	13 May 2015 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This monitoring inspection was the 6th inspection of this centre by the Authority. The centre is part of large congregated setting run by the Health Services Executive (HSE). It is located approximately 5 km from the town of Sligo on a large site and provides residential accommodation for 107 residents with an intellectual disability. There are 17 units on the campus. The area inspected on this occasion consists of five individual bungalow dwellings based on the campus. The provider has a plan to de-congregate this centre and relocate all of the residents into community houses which is dependent on the provider securing funding for additional accommodation. The service is managed by the provider nominee for the Health Service Executive (HSE). The governance structure was under review but at the time of inspection and an Area Manager was identified as the person in charge (PIC). He reports directly to the a Director of Services and he is responsible for the residents accommodated in 17 units on the campus. A Clinical Nurse Manager (CNM2) was responsible for the 12 residents in the five units inspected.

This inspection focused on the residents in 5 units which together provide residential accommodation and support services for 31 adults with severe to profound

intellectual disability and associated mobility issues with complex needs including dementia, and visual impairment. Inspectors met with some of the residents, staff members and the management team during this inspection. They observed practices and reviewed documentation including care plans, medical records, accident and incident reports, and policies, procedures and staff files. Two houses accommodated 7 residents and the remaining three houses accommodated five residents. Most residents had their own bedrooms which were decorated to reflect their own taste and there were two shared two bedded bedrooms.

The authority had previously inspected 8 other units on the campus and identified serious non compliances relating to governance, staffing levels, fire safety, a lack of social activities, institutional care practices and risk management which resulted in the authority issuing immediate action notices. Deficits were identified in the current governance arrangements. This has been a consistent finding in all of the inspections of this centre and the provider was requested to meet with the Authority to discuss a plan for bringing the centre into compliance.

Inspectors found that the systems ensure staff concerns about the quality and safety of the care and support provided to residents were responded to by management were not effective. The need for a change of environment for residents was identified in several residents' risk assessments but had not resulted in any action to relocate residents. The provider outlined plans to relocate all residents on the campus to community houses however difficulties securing accommodation were delaying movement. Inspectors also reviewed an investigation by the provider into an allegation of abuse in the centre and found that the response had not ensured residents were adequately protected from being harmed or from suffering abuse ,as the staff members involved were not been appropriately supervised as recommended in the centres policy on protection.

Staff and residents appeared to have good relationships and the staff had a good knowledge of residents' needs and preferences however, Inspectors found that the the current deployment model was limiting resident's opportunities to participate in activities, appropriate to their interests and preferences. These issues are discussed further in the report and included in the reports Action Plan.

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

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Inspectors found that in general resident's privacy and dignity was respected by staff that were observed to knock before entering residents' bedrooms. With the exception of two residents who shared a bedroom, residents had their own bedroom which were decorated to their tastes and had storage space for their personal belongings.

There were written records of all items of expenditure for the residents. Inspectors reviewed daily recording of resident's money and were satisfied that they were appropriately maintained with records of all transactions however only one staff signature was present for most transactions which did not afford the resident or the staff the maximum protection. The receipts covered a range of social outing which residents had attended.

The arrangements in place were supported by a policy on the management of monies including petty cash dated August 2012. Inspectors found in practice this policy was not fully implemented and practice in this regard was inconsistent. For example the policy referred to lockable storage however; there was no lockable storage provided in one of the houses and alternative arrangements were been made by staff to manage residents monies. Cash balance sheets were also been completed in some houses but not in others and the balance checked by inspectors for one resident did not match with the recorded balance. Inspectors also identified that the practice of a staff member bringing home the key of the residents safe was resulting in residents not been able to access their monies on occasions.

Inspectors observed that the routines and practices in place did not always encourage or

promote residents independence and choice. Inspectors found that although each house had a kitchen, meals were prepared in a central canteen and residents didn't have an opportunity to be involved in planning, shopping for groceries or preparing their own meals. The PIC stated that this area is been addressed and each house is been provided with a bank card to allow them the autonomy to complete their own weekly shopping.

Inspectors reviewed the centres complaints policy which was also displayed in an accessible format for residents and clearly stated the name of the services complaints officer. The name of an advocate available to residents was also displayed. The policy contained an accessible complaint form for residents which used pictures to prompt residents as to the nature of their complaint. Inspectors noted that there were no recorded complaints so far for 2015. There was evidence available that resident meetings were held regularly.

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):

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

Findings:

The inspectors identified that practice had improved in this area. A comprehensive assessment of the health and support needs of each resident had been completed and inspectors found that since the last inspection a social assessment called 'listen to me' had been introduced which captured residents' personal and social care needs. There was evidence of the involvement of residents and /or their families in the assessments completed.

The statement of purpose submitted in advance of the inspection stated that residents attend various day services depending on their needs. Inspectors identified that the residents attended five separate day services within the campus on a sessional basis. Records reviewed indicated that the residents also engaged in some external activities, including horse riding, bowling and cookery. Through interviews with staff and observation during the inspection, it was clear that the social activities available to

residents were led by the routine and resources of the service, rather than by the resident support needs and wishes. Several residents had high support needs and required the support of two staff. The current deployment of staff did not support each resident to participate in activities appropriate to their interests.

Personal goals had been identified for residents and although some of these were limited in their scope, inspectors saw that goals were being achieved. While staff interviewed said that they were at the developmental stage of this aspect of the personal plans; there was good information collected on each residents' social interests and the people who were important to them which will help to develop broader personal goals over time.

Two residents had recently been moved from their home to a nearby house. Although there was evidence that these residents were supported, practice was inconsistent and other residents appear to have had been moved between units within the campus without appropriate transitional plans to support them in those changes.

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):

No actions were required from the previous inspection.

Findings:

The design and layout of the houses was broadly in line with the description in the centres statement of purpose however an additional house had been included which was not included on the original premises profile notified to the Authority. The service was provided in 5 detached single storey houses located on the grounds of a large congregated setting in County Sligo. There is ample green space around the houses and pathways and steps connecting all of the residential areas.

Inspectors found the houses were clean and appropriately decorated to provide a home like environment. They had suitable heating, lighting and ventilation. Photographs of residents were displayed throughout the houses. Bedrooms were personalised to reflect resident's individual taste and had storage for residents' belongings. There were adequate bathrooms and showers provided to meet the needs of residents. Inspectors observed that some bathroom doors were not fitted with locks to allow residents privacy.

Each house had a well-equipped kitchen with an open plan dining area / sitting room with an open fire and a television however, there was no alternative communal spaces provided for residents wishing to meet relatives in private. Two houses accommodated 7 residents and inspectors saw that several residents presented with behaviour that challenged which was contributed to by their environment. This was identified in behaviour support plans.

Most residents had their own bedrooms, however two residents in one house shared a bedroom which impacted on their privacy. There was no lock on one bathroom door to ensure the privacy of residents using this facility. There was no lockable storage provided in one of the house for the safe keeping of the residents monies.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Inspectors observed that fire equipment, a fire alarm and emergency lighting were provided in each of the houses inspected. Inspectors reviewed records which showed that these were appropriately serviced and maintained in good working order. Records also showed that regular checks were completed on this equipment by staff. Escape routes from the houses were via the front and back doors which were kept free of obstructions.

Inspectors reviewed records of fire drills which took place on a regular basis. These were conducted with both staff and residents and the outcome of these drills were recorded. Drills were conducted during both day and at night. Staff interviewed were knowledgeable about evacuation when asked by inspectors. A personal emergency evacuation plan (PEEP) was available for each resident which took account of their mobility and cognitive understanding. Staff had completed fire training and knew what to do in the event of a fire but some staff had not completed fire training in over a year.

Inspectors reviewed the incidents and accidents recorded for the units and found them to provide clear information about the incident and actions taken. Individualised risk assessments were completed for each resident and risks such as their mobility were assessed. Two residents whose behaviour was negatively impacting on other residents had been relocated to another house and this action had greatly reduced the number of incidents occurring. Inspectors found, however, that the systems in place to reduce risk were not effective and control measures were not implemented as a result of risk

assessments carried out. Several risks were identified during the inspection which had also been identified by staff members and actions had not been taken to remove or reduce the risks. For example, one residents care notes identified the need for a change of environment to reduce the incidents of challenging behaviour and self harm but no action had been taken to address this issue for the resident. In another example, the advice of an occupational therapist to provide a handrail for a resident had not been implemented. A resident in one of the houses was identified as being at risk of absconding. Inspectors found that although the doors had been secured the windows had not been secured.

Inspectors also identified that the deployment of staff particularly at night was a risk to residents and this had been identified by staff but not addressed. Two residents were assessed as being at risk of choking and required one to one supervision at meal times yet there was only one staff on duty in this house at night time to supervise residents when residents had their supper.

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:

Inspectors identified that the provider had not put in place appropriate safeguards to ensure residents were protected in response to an allegation of physical abuse of a resident by two staff members. Inspectors reviewed the investigation that had taken place into an allegation made in January 2015. A disciplinary hearing had taken place yet key recommendations of the investigation had not been enacted. For example, one recommendation was that the staff members be rotated onto day duty to ensure adequate supervision; Inspectors saw this had not occurred that both staff members were on the rota to be on night duty on the night of the inspection without any supervision. Furthermore, the staff had been redeployed to a new area and the manager of this area had not been made aware of the allegations. This issue was brought promptly to the attention of the provider who issued a directive with immediate effect to enact the recommendations of the investigation and safeguard residents.

The centre has a policy on the protection of vulnerable adults which had been amended in response to previous inspections to give clear advice to managers on the procedure to follow in the event of an allegation of abuse. The policy and guidelines were available to staff but there were a number of different versions of the policy and staff interviewed were not clear on what which one was the most recent and relevant copy. Staff interviewed confirmed that they had recently completed training in adult protection and were aware of their duty of reporting any incidents or suspicions of abuse to the designated person and knew how to do this. Records of training supported this.

Behavioural management plans were in place to support residents with behaviour that challenged and there was evidence of multi disciplinary team input into reviews. Inspectors observed however that the position of a psychologist continued to be vacant so there was no professional supervision of the support plans in place. Staff members working with residents had not completed training in assist them to manage the behaviour that challenges.

The staff interviewed were knowledgeable about the residents in their care and told inspectors the most effective ways to help reduce their anxieties. Inspectors saw that the interventions and responses described by staff reflected the guidelines in their personal plans.

Judgment:

Non Compliant - Major

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:

Residents informed inspectors of the different things they enjoyed doing, which included going to a local hotel, shopping in the local shopping centre, and going on trips out in the services transport. However, this unit was not managed in a way that maximised residents' capacity to exercise personal independence and choice in their daily lives and routines and practices didn't fully promote residents' independence and preferences. Although residents had some opportunities to engage in social activities, the day services provided on the campus were sessional and the residents' opportunities to take part social activities in the local community were directly affected by the staff resources available. This is discussed further under outcome 17.

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:

The inspectors found that arrangements were in place to assess the health care needs for each resident. There was a comprehensive nursing assessment completed for each resident and inspectors saw that residents were referred appropriately for investigation by specialists where recurrent health problems were observed. Personal plans reviewed were generally detailed and gave very clear guidance to staff on how to care for residents. Resident's that had mobility difficulties had a falls risk assessment completed as required. All residents Body Mass Index (BMI) / weights and nutritional assessments were completed and reviewed monthly. Progress notes were completed for each resident which reported on the care provided.

Care was provided by a medical officer employed by the service who held a clinic on the campus twice weekly. There was evidence of regular reviews by psychiatry and the mental health team. A team made up of Speech and Language Therapy Manager, Clinical Nurse Specialist (CNS) in behaviour, a CNS in mobility, a CNS in dementia, CNS for older person's services and a Principal Social Worker supported residents. However, as discussed under outcome 8, inspectors identified that there were no specialised clinical managers in some areas to support and supervise the nurse specialists. For example; there was no psychologists reviewing the behaviour support plans/ restrictions in place, or physiotherapists regularly reviewing mobility/chest conditions assessments as part of the multidisciplinary team supports provided to these residents.

In one residents' medical file, inspectors saw that a referral to an orthopaedic consultant recommended by the medical officer in May 2014 had not been made until April 2015 and a physiotherapist review recommended over a year ago had still not taken place. There position of physiotherapy was vacant but alternative arrangements had not been made to arrange an appointment privately.

Inspectors found that although an appropriate diet was provided for residents', their independence was not promoted or encourage by the arrangements in place for mealtimes and they were not supported to buy or prepare their own meals. While each house had its own kitchen facilities, all meals continued to be prepared in a central kitchen which catered for the whole campus.

The advice of dieticians and other specialists were sought and implemented in accordance with each resident's personal plan. Staff informed inspectors that snacks

were available throughout the day, and inspectors observed staff supporting residents to eat and drink in a sensitive and appropriate manner. Inspectors reviewed the care plan of one resident diagnosed as a coeliac. The food choices available in the house for this residents evening meal were not suitable which was resulting in this resident having the same meals every day.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Medication was supplied in original containers supplied by a local pharmacist who completed a medication reviews earlier in the year. Inspectors observed that medications were all stored securely in a locked cupboard and systems were in place to ensure stock was checked on receipt and unused medication returned to the pharmacy. A medication fridge was provided in one the houses and daily temperature records were available.

A sample of medication administration records (MARS) was reviewed by inspectors which was completed appropriately and included photographic identification of the resident. No residents were self-administering medication at the time of inspection. Inspectors observed the maximum dosage for PRN or as required medication was clearly stated on the individual prescriptions.

Written operational policies were available to guide staff for the ordering, prescribing, storing and administration of medicines. However the policy did not provide any guidance for staff on the emergency administration of medication to be used for epileptic seizures. Inspectors also identified medication without appropriate labels to identify who it was prescribed for and opened eye drops which were not dated to indicate the date opened.

Judgment:

Non Compliant - Minor

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:

The person in charge worked full-time in the centre and had responsibility for this and 17 other units on the campus. He is a qualified Intellectual disability nurse with considerable experience. Inspectors were told that the management of the centre is under review.

Day-to-day management of the five houses inspected was by a Clinical Nurse Manager. She demonstrated a good understanding of the Regulations and Standards and of residents identified needs and care plans. There was some evidence that the quality and safety of the service was monitored by the management team and inspectors saw that a number of audits of the service had been completed. However, Inspectors found however that current management arrangement was not effective in ensuring a safe service, appropriate to residents' needs. The findings of risks assessments completed by staff identifying risks to residents were not acted upon. The houses inspected were not adequately resourced to allow residents needs to be fully met and the deployment of staff was limiting resident's opportunities to participate in activities, appropriate to their interests and preferences. The measures taken in response to an allegation of abuse were not adequate and the recommendations of an internal investigation had not been followed through by the PIC.

There are not adequate arrangements in place to allow staff to raise concerns about the quality and safety of the care and support provided to residents. The need for a change of environment for residents was identified in risk documentation reviewed but had not been address. The provider outlined plans to relocate all residents on the campus to community houses but difficulties in securing accommodation were delaying movement.

Judgment:

Non Compliant - Major

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 six bungalows inspected were managed by a clinical nurse manager level 2 (CNM2) who worked with a team of 11 nurses, 13 care staff and a multi disciplinary team made up of Speech and Language Therapy Manager, Clinical Nurse Specialist (CNS) in behaviour, a CNS in mobility, a CNS in dementia, CNS for older persons services and a Principal Social Worker. The CNM said the team try to assist residents to live as independently as possible and integrate into their local communities.

Residents appeared comfortable in the company of staff inspectors observed good staff interactions with residents. The staff on duty demonstrated a good knowledge and understanding of each resident's needs, wishes and preferences.

Inspectors were not satisfied from observation, interviews and records available that the skill mix and numbers of staff was satisfactory at all times to meet the needs of the residents. An additional staff member had been provided in each house during the day time as a result of emergency action plans issued by the Authority on previous inspections of the centre. However, there was evidence that residents in some houses required additional support.

There was an actual and planned rota with levels of staff assigned based on the numbers of residents in the houses. Inspectors reviewed the rotas and interviewed staff on duty during the inspection. The normal compliment of staff on duty in each house was one nurse and one care assistant during the day; and one care assistant in each house at night. Inspectors identified there were residents who were at risk of aspiration and required one to one supervision at meal times. However, only one staff member was on duty in the house and was responsible for the supervision of 6 other residents.

A number of residents who required significant support with moving and handling or personal care which meant that residents could not pursue individual activities and all activities involved the group. Staff had not all been provided with the education and training to enable them to provide evidence based care to meet residents needs. For example, inspectors saw that all staff had not completed training on managing behaviours that challenge or safe moving and handling. As discussed in outcome 7, some had not completed training in fire safety. In staff files reviewed the information and documents as specified in Schedule 2 were not available for all staff including Garda vetting.

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:

Marie Matthews
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-0003368
Date of Inspection:	12 May 2015
Date of response:	31 July 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The systems in place to protect residents monies were not consistent and did not ensure residents could retain control of their monies.

1. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably

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

practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Two staff will sign off on all residents financial transactions. Policy "Management of Service Users Monies" will be reviewed to include this. Lockable storage has been provided for residents finances and a system is in place regarding follow-up of all inaccuracies as stated in the Policy. The key for access to resident's funds will be left in a secure location at the end of each shift in the individual unit. Residents will be supported to develop skills around money management as appropriate.

Proposed Timescale: 01/09/2015

Theme: Individualised Supports and Care

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

Residents didn't have an opportunity to be involved in planning, shopping for groceries or preparing their own meals.

2. Action Required:

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

Residents will participate in planning, shopping and preparing their own meals. Procurement cards are ordered and will provide increased opportunities for residents to be more involved in planning meal and food preparation. Accessible recipe books are in place in each area.

Proposed Timescale: 30/09/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

Social activities available to residents were led by the routine and resources of the service, rather than by the resident and their support needs and wishes

3. 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:

All residents have a PCP in place with personal goals identified. 4 areas have additional supports in place including 5 service users with 1:1 staff support to meet the assessed needs. Bridging the Gap programme implemented in another area of campus will be extended to all areas providing increased social opportunities for residents.

Proposed Timescale: 14/08/2015

Theme: Effective Services

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

Some residents appear to have had been moved within the campus without appropriate transitional plans to support them.

4. Action Required:

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

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

Transitional plans are in place for all service users for internal and external Transfers including the provision of information on services available. The provision of information for service users is individually assessed and delivered based on their ability to process it. Transitional planning meeting have taken place in all areas. Adaptive behaviour assessments have commenced for some service users by Psychology department. Transitional plans will be further enhanced following assessments and when appropriate information becomes available.

Proposed Timescale: 30/11/2015

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 residents shared a bedroom which impacted on their privacy.

There was no lock on one bathroom door to ensure the privacy of residents using this facility.

There was no lockable storage provided in one of the house for the safe keeping of the residents monies.

5. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

Lockable storage is provided for safe keeping of all residents' money. Locks have been placed on all bathroom doors to ensure privacy. Decorative screens have been put in place for all residents who share a bedroom to improve privacy and dignity. The Local implementation group are sourcing suitable accommodation for all residents. Transitional planning group will begin to assess service users for compatibility.

Proposed Timescale: 17/08/2015

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:

All risks identified had not been responded to by the provider. In one residents care notes the need for a change of environment had been repeatedly identified in the residents notes to reduce the incidents of challenging behaviour and self harm but no action had been taken to address this issue for the resident. Two residents were assessed as being at risk of choking and required one to one supervision at meal times yet there was only one staff on duty in this house at night time to supervise residents when residents had their supper

6. 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 systems have been reviewed within the service. Risk assessment training has taken place.

Transition planning will commence with immediate effect for 1 service user. Suitable accommodation will be sourced by Local Implementation Group.

Each service user will have a crisis management plan in place in their behaviour support plan to respond to emergencies if necessary.

Additional resources are in place to supervise residents having their supper. Risk assessment has been updated with additional controls added.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

Some staff had not completed fire training in over a year.

7. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

Fire training will be completed for all staff.

Proposed Timescale: 17/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was no professional supervision of the support plans in place and staff had not completed training in the management of challenging behaviour.

8. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Professional supervision will be provided for all support plans. Training schedule in place for Prevention & Management of Challenging Behaviour. Staff supporting service users who present with behavioural challenges will be prioritised for training. 16% have completed this training to date. 80% will be completed in proposed timeframe.

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Inspectors identified the provider that not put in place appropriate safeguards to ensure residents were protected in response to an allegation of physical abuse of a resident by two staff members.

9. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

Immediate safeguarding recommendations have been implemented. Systems have been reviewed to ensure full compliance with Trust in Care: Policy for Health Employers on Upholding the Dignity & Welfare of Patients/Clients and the Procedure for Managing Allegations of Abuse against Staff Members.

Proposed Timescale: 25/06/2015

Theme: Safe Services

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

There were a number of different versions of the protection of vulnerable adults policy in the unit and staff interviewed were not clear on what which one was the most recent and relevant copy

10. 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:

Training in safeguarding will take place for all staff.

Up to date policy on Protection of vulnerable adults is in place in all units.

Proposed Timescale: 14/07/2015

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:

Opportunities to take part social activities education or training were directly affected by the staff resources available.

11. 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:

- All residents have a PCP in place completed and validated by the CNM group across the campus since May 2015 and reviewed monthly by local CNM team;
- The PCP in practice has been verified as of June 22nd via a random sample stratified audit PIC;
- A directive issued on July 22nd 2015 by the PIC to all campus services teams regarding their roles and responsibilities in ensuring the outcome regarding dignity, privacy and safeguarding rights are protected at all times. The directive clearly advises the full implementation of the HSE Safeguarding Vulnerable Adults Policy;
- Resources were reviewed in respect of 5 persons with significant support needs in Woodlands Close area. This review has resulted in better outcomes for the persons involved. An audit of these outcomes has been completed in June for this group of people by PIC;

- A pilot programme referred to "Bridging The Gap" was implemented since May 2015 for 18 people in Woodlands Close. This has resulted in 18 people accessing and taking part in social activities in the community which has created many opportunities to live an ordinary life. Person responsible PIC;
- An additional group of 12 people will be included in the "Bridging the Gap" social inclusion project starting Monday 7th September. This date is to reflect holiday periods as there are scheduled breaks arranged in August for different people living in Woodlands Close with attached resources. Person responsible PIC.

Proposed Timescale: 30/09/2015

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:

In one residents' medical file inspectors saw that a referral to an orthopaedic consultant recommended by the medical officer in May 2014 had not been made until April 2015 and a physiotherapist review recommended over a year ago had still not taken place.

12. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

All referrals recommended by MDT members are followed up in a timely manner. A referral log to be put in place to monitor all referrals.

Proposed Timescale: 25/06/2015

Theme: Health and Development

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

There was no psychologist or physiotherapist service available to residents

13. Action Required:

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

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

The physiotherapist has returned from leave and is supporting residents as required. A senior psychologist is available 1 day per week. Vacant psychologist will be re-advertised to recruit suitable applicant.

Proposed Timescale: 01/10/2015

Theme: Health and Development

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

One resident was diagnosed as a coeliac and the food choices available in the house for this residents evening meal were not suitable for them.

14. Action Required:

Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

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

All residents with special dietary requirements have choices available in the house. Nutribullet ordered to enhance choices for all residents. The dietician has been consulted and all recommendations will be implemented.

Proposed Timescale: 14/07/2015

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:

Inspectors identified medication in one house without appropriate labels to identify who they were prescribed for and opened eye drops which was not dated to indicate the date opened.

The policy did not provide any guidance for staff on the emergency administration of medication to be used for epileptic seizures.

15. 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:

Monthly audit are completed by CNM11. Medication monitoring standards are discussed at team meetings. Meeting with Pharmacist scheduled for Wednesday 1st July to review systems presently in place.

A Policy has been developed and is in place on the emergency administration of medication to be used for epileptic seizures.

Proposed Timescale: 08/07/2015

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:

Management arrangement and structure was not effective in ensuring a safe service, appropriate to residents' needs.

16. 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.

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

Theme: Leadership, Governance and Management

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

There are not adequate arrangements in place to allow staff to raise concerns about the quality and safety of the care and support provided to residents. The need for a change of environment for residents was identified in documentation reviewed but had not been addressed.

17. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

- Daily walk around checks are being carried out by CNM11 and this facilitates staff to raise their concerns.
- Walk-arounds are carried out by PIC & provider.
- Weekly house meeting with service users.
- Staff team meeting are held with CNM11 on a weekly basis;

Of note: A directive has been issued again in respect of this outcome as of Wednesday 8th July 2015. Person responsible PIC and Provider Nominee.

Proposed Timescale: 24/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The staffing levels and skill mix are not appropriate to meet the assessed needs of residents.

18. 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:

- Additional staffing from 8.15pm-12pm has been put in place to address immediate risk issues. Completed in May and June 2015. Person responsible PIC;
- A review will be completed on the size and layout of the designated centre by August 28th. Person responsible Provider Nominee;

•A workforce planning review will take place involving all stakeholders attached to the Cregg Campus Service. The NMPDU have agreed to conduct this review on behalf of the HSE CHO Area 1 when the Workforce Planning Review terms of reference is identified to reflect researched best practice that will support persons with an ID to live a meaningful life. Due to the detail required the end of August 2015 has been identified to accommodate holiday leave for members of the review team

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

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

Information and documents as specified in Schedule 2 were not available for all staff.

19. 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:

- Managers are continuing to encourage compliance with staff providing documents required.

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:

All staff members had not completed training in manual handling, managing challenging behaviour or fire safety.

20. 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:

Training schedules are in place for all mandatory training.

Proposed Timescale: 30/12/2015