

**Health Information and Quality Authority  
Regulation Directorate**

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



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| <b>Centre name:</b>                                   | A designated centre for people with disabilities operated by Health Service Executive |
| <b>Centre ID:</b>                                     | OSV-0002440   |
| <b>Centre county:</b>                                 | Tipperary   |
| <b>Type of centre:</b>                                | The Health Service Executive  |
| <b>Registered provider:</b>                           | Health Service Executive  |
| <b>Provider Nominee:</b>                              | Carol Moore   |
| <b>Lead inspector:</b>                                | Noelene Dowling   |
| <b>Support inspector(s):</b>                          | Caroline Connelly;  |
| <b>Type of inspection</b>                             | Announced   |
| <b>Number of residents on the date of inspection:</b> | 6   |
| <b>Number of vacancies on the date of inspection:</b> | 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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

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

|                        |                        |
|------------------------|------------------------|
| From:                  | To:                    |
| 03 November 2015 10:00 | 03 November 2015 19:30 |
| 04 November 2015 08:30 | 04 November 2015 16:00 |

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

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| Outcome 01: Residents Rights, Dignity and Consultation                     |
| Outcome 02: Communication  |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services          |
| Outcome 05: Social Care Needs  |
| Outcome 06: Safe and suitable premises                                     |
| Outcome 07: Health and Safety and Risk Management                          |
| Outcome 08: Safeguarding and Safety  |
| Outcome 09: Notification of Incidents                                      |
| Outcome 10. General Welfare and Development                                |
| Outcome 11. Healthcare Needs   |
| Outcome 12. Medication Management  |
| Outcome 13: Statement of Purpose   |
| Outcome 14: Governance and Management                                      |
| Outcome 15: Absence of the person in charge                                |
| Outcome 16: Use of Resources   |
| Outcome 17: Workforce  |
| Outcome 18: Records and documentation                                      |

**Summary of findings from this inspection**

This was the second inspection of this centre which is designed to provide care for adult residents of mild and moderate intellectual, physical disability and mental health issues. All documentation required for the purpose of registration was available.

This inspection was announced and took place over two days. All 18 of the outcomes required to demonstrate compliance with the legislation and regulations were inspected against. As part of the inspection the inspectors met with residents, relatives and staff members. Inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident

reports, and policies, procedures and staff files. The Authority received a number of completed questionnaires from relatives and residents and the commentary in these was very positive in regard to the care and service received.

Staff were observed to be respectful, attentive and very knowledgeable on the resident's needs.

This inspection found that the provider was in compliance with the regulations in significant areas with some improvements required. There were effective and suitable governance arrangements in place. Staffing levels and skill mix were satisfactory and all mandatory training was up to date.

There was evidence of good practice found in complaint management, health care and access to allied health care services including mental health services was evident.

Residents had significant involvement in the development of comprehensive personal plans to ensure their health and social and personal care needs were identified and supported according to their wishes. To this end staff demonstrated a high degree of sensitivity to the residents social history and previous placement experiences. The premises were fully compliant and suitable to cater for the needs of all the residents.

Some improvements were required in the following areas:

risk management procedures

behaviour supports, restrictive practices and safeguarding

adequacy of multidisciplinary review

systems to ensure that the views of the residents and relatives were included in the annual service review.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities)

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

It was apparent to and observed by inspectors that the management and staff were committed to promoting resident's dignity, personal development and choice in how they lived their lives. Residents to whom inspectors spoke stated that they felt safe and spoke very positively about the care and consideration they received. Inspectors observed staff interaction with residents and noted staff promoted residents dignity and maximised their independence, while also being respectful when providing assistance. There was evidence that the residents and their representatives were actively involved in the running of the centre and their lives within this.

There were a number of options for residents to voice their views including the residents' committee meetings. The records of these meetings which were in pictorial and written format demonstrated that the opinion and views of the residents were heard and acted upon. For example, options for meals and activities were discussed and changes were made accordingly. Relatives occasionally attended to represent the residents. They and their representatives were involved in the personal planning process.

Staff understood the resident's means of expression including non verbal clues and were able to respond to their expressed preferences. Advocacy services had been sourced for a resident as needed to ensure her rights were protected.

Residents were supported to develop personal interests such as attending at day service and activities of their choice including horse riding and swimming. Staff knew the individual preferences of residents for example, the food they preferred and their preferred choice of clothing and hobbies and treatment options.

The manner in which residents were addressed by staff was seen by inspectors to be respectful, amicable and familiar. They were seen by inspectors to respect the resident's privacy of space. One of the residents had the key to her own room and some locked their bedrooms at night. The mechanisms allowed staff to open them should they need to.

The centre and the resident's rooms were seen to be very personalised with photos and mementoes, books, toys, music systems, televisions and other equipment chosen by the residents themselves. Some residents were assessed as being suitable to self-medicate to some degree and this was facilitated. Resident's religious and spiritual needs were facilitated and a number of the residents attended mass in the local churches. Where possible some residents did their own laundry with the support of staff.

Gender preferences were seen to be respected in the provision of personal care and support. All residents' personal belongings were carefully itemised.

However, a listening devise was being used for two residents in their bedrooms. This was a highly intrusive process and there was no clear rational for its usage which was not overseen via multidisciplinary team or a rights committee.

The person in charge informed inspectors that they had selected a group of suitable people from the locality and the organisation to participate in such a committee and were in the process of outlining the terms of reference for this.

Inspectors reviewed the complaint policy which contained all of the requirements of the regulations. A review of the complaint log indicated that the provider had responded appropriately to complaints and did seek the views of the complainant on the outcome. The policy was available in pictorial and easy read format.

The actions from the previous inspection related to the locking of the front exit door and the use of external CCTV cameras for security purposes. While the use of the cameras was satisfactorily resolved improvements were still required in the use of restrictive practices and the rational and oversight of these to ensure they were the least restrictive and reasonable. This is actioned under outcome 8 Safeguarding and Safety.

Relatives who forwarded questionnaires to the Authority or who met with the inspectors stated that they knew how to make a complaint and were confident that it would be addressed. Personal plans took account of the residents stated or known preferences and were seen to be person-centred and not influenced by staffing or resources.

**Judgment:**

Non Compliant - Moderate

**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

The inspector's observed details in personal plans outlining resident's communication needs and there were very comprehensive communication passports available in the event of a resident requiring care in another service. Staff were observed to be very familiar with the resident's non verbal communication and what it meant. Where the residents could verbalise staff were patient and supportive. There was a significant emphasis on visual and pictorial communication systems which were seen by inspectors to be used to good effect.

The person in charge stated that a number of residents required speech and language intervention for communication but due to shortages in personnel this was not yet available. The provider stated that a recruitment process was currently underway to address this.

Residents did not currently have access to tablets, mobile phones or other technology to support communication. Communication logs were used between the staff to ensure continuity of care.

The personal plans were synopsised in a suitable pictorial format for the residents. Despite the centres location on a medical campus the residents were a significant part of the local community. For example, they did their shopping locally, attended at various facilities including leisure clubs and religious services. Families stated how pleased they were to meet them constantly out and about in the locality.

**Judgment:**

Compliant

**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**

Individualised Supports and Care

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

No actions were required from the previous inspection.

**Findings:**

Inspectors saw evidence from records reviewed and from speaking with residents and information received from family members that familial and significant relationships were respected, maintained and supported. There was evidence of regular communication with families who were involved in all decisions and planning with the residents and with the residents consent and agreement. Relatives confirmed this.

There were no restrictions on visiting times and this was observed during the inspection. There was ample room in the centre for visits to take in private. Holidays and visits home were regular and there was evidence that staff ensured residents were able to attend and be present at all special family occasions.

There was evidence that families were quickly informed of any incidents or changes in health status. Records of these visits and all communication was evident. Residents could if they wished have friends to visit in the centre.

**Judgment:**

Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**

Effective Services

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

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

**Findings:**

There was a policy on admissions which outlined the pre-admission assessment and decision making process. Inspectors reviewed the process for the most recent admission and found that it was comprehensive in assessing the resident's needs and there was an opportunity to visit the centre for the resident and the family. Relatives confirmed this process. However, the policy did not adequately outline how the admission procedure would ensure that residents were suitable to live together and all persons would be protected from potential abuse.

By virtue of their care needs and assessments it was observed that admissions and care practices were congruent with the statement of purpose.

There was detailed information on health, medication, social care and communication available in the event of transfer to acute care.

As required following the previous inspection the contractual arrangements for the

service had been resolved and all fees and additional payments and services were clearly defined within this.

**Judgment:**

Substantially Compliant

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The action from the previous inspection had been resolved. This was to ensure that residents had access to opportunities for occupation and recreation in the evenings and at weekends.

Inspectors reviewed the personal plans, medical records and daily records of three residents and found good practice in the systems for the assessment of resident needs with some improvements required in the multidisciplinary review process.

There was evidence of a range of assessment tools being used for fall, nutrition or pressure areas. These were then updated following any changes in the resident's status. There were appropriate care plans implemented in relation to any risks identified. For example, a resident had crash mats and wore hip protectors due to the risk of falls.

There was documentary evidence of multidisciplinary reviews being held annually or more frequently. However, the records did not clearly demonstrate that the residents overall care and welfare or the effectiveness of the plans was reviewed at these meetings. The primary emphasis of the reviews was on behavioural or psychiatric supports as opposed to multidisciplinary and multifaceted. Families or next of kin did not attend these meetings which would be appropriate taking the residents needs into account. However, separate meetings were held with the families and the person in charge. Relatives confirmed this involvement to the inspectors.

A booklet entitled "personal plan" was seen to be very person-centred, reflected of the residents' needs, wishes and social aspirations. This had been completed with the residents.

The care plans were comprehensive and based on range of domains including health, nutrition, safety, communication, behaviour, training, family supports and social inclusion. Additional plans were implemented for counselling or mental health support as needed. Most but not all of the plans included timeframes and most but not all verified that the plans had been achieved.

There was evidence of appropriate multidisciplinary involvement in residents care with good access to services such as physiotherapy, occupational therapy, psychiatric and mental health services. The personal plans were outlined in a suitable pictorial format for the residents.

The social care needs were driven by residents own preferences. Social goals were found to be well supported with residents having access to activities they enjoyed and being supported to do so. One resident told inspectors how she had wanted to go on holiday with staff and had done this. A resident attended a suitable day service. A suitable swimming pool had been sourced for a resident who required the use of a hoist and another met a friend socially for events or a drink.

Inspectors observed that while some activities in house were organised daily if the residents no longer wished to take part in an activity on a day, staff were flexible and changed the activity to the their preferred choice. These included activities such as baking, art and music.

It was apparent that the outcomes of the personal plans were in most instances achieved with the residents and that there was a commitment to continued improvement and development for the residents.

However, the documentation used despite being copious was not amenable to ease of access, retrieval and completeness. There were two sets of care plans being utilised and this did not support clarity of care or goal setting for the residents or monitoring by key staff. In some instances there were two plans for the same assessed need such as moving and environmental safety.

This was discussed with the provider at the feedback meeting and it was agreed that the documentation would be revised.

**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 centre was a modern purpose built facility which had originally been built to provide rehabilitative care on the grounds of a medical facility. In 2010 the function was altered to provide a psychosocial model of care for residents who were transferring from another type of facility.

The premises accommodates up to 6 residents in large single en suite bedrooms. All en suites were assisted and suitable for the use of equipment or wheelchairs. The premises were easily accessible, modern, and bright with large windows, well ventilated, had central heating and decorated to an adequate standard. The premises met the needs of residents by making good use of soft colours, suitable furniture and comfortable seating.

Although initially built as a clinical facility good use had been made of the space and decoration to make it homely and comfortable. There were adequate showers and toilets with assistive structures in place including core safety features such as hand and grab rails and suitable flooring to meet the needs and abilities of the residents.

There were adequate sitting, recreational and dining spaces separate to the residents' private accommodation and separate communal areas, which allowed for a separation of functions. Residents that showed inspectors their rooms stated that they were happy with the living arrangements and all had personalised their rooms with photographs of family and friends and personal memorabilia.

Inspectors noted that apart from their residents' own bedrooms there were options for residents to spend time alone if they wished with a number of communal sitting rooms and dining rooms available. In addition, the premises provided suitable facilities for residents to receive visitors.

Laundry facilities provided within the premises were adequate. Residents to whom inspectors spoke were happy with the laundry system and confirmed that their own clothes were returned to them. Inspectors noted that there was adequate storage in the premises. Equipment for use by residents or people who worked in the centre included wheelchairs, a specialised trike, hoist and specialised chairs were in good working order and records were up-to-date for servicing of such equipment. Vehicles used also had evidence of roadworthiness.

Inspectors noted that there was an accessible external garden that was secure and attractive and residents had good access to this. There were bird boxes, a washing line and residents helped with the gardening. There was colourful garden seating and tables provided. A number of the bedrooms had doors leading directly to the garden.

Although food is prepared in a central location the kitchen was suitably equipped to prepare food. There were suitable systems in place for the management of general and clinical waste. There were car parking spaces including a number of designated disabled

car parking spaces available that were accessible for car/mini bus transport.

**Judgment:**

Compliant

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

**Findings:**

The actions required from the previous inspection were satisfactorily resolved with adequate risk management of cleaning systems and ventilation implemented. However improvements were found to be required in the implementation of systems for learning and review and in the content of the risk register to ensure adequate controls were implemented for all relevant risks.

There was a signed and current health and safety statement available. A number of safety audits of the environment and work practices had been undertaken and were updated regularly.

The risk management policy was current and complied with the regulations including the process for learning from and review of untoward events. However, this was not adequately implemented in practice.

Safety procedures such as key pad locks on the external doors were in place to prevent unauthorized persons entering the units or residents placing themselves at risk by leaving inadvertently. Given the vulnerability of the residents this action was deemed appropriate. Residents were observed having access outside with staff support as they wished so the inspector was satisfied that this system was proportionate to the risk.

There were policies in place including a detailed emergency plan which contained all of the required information including arrangements for the interim accommodation of residents should this be required. Emergency phone numbers were readily available to staff.

The policy on infection control was detailed and staff articulated good practice in relation to this. Staff were observed taking appropriate precautions and using protective equipment including gloves and sanitisers as this was necessary.

However, the risk register was not sufficiently comprehensive to provide the framework for managing risks and was not updated as incidents or risks were identified. It referenced only three risk factors; residents absconding, lack of access to speech and

language and the potential for choking incidents. Other pertinent and ongoing risks including the risk of pressure areas, epilepsy, behaviours that challenged or peer to peer assault were not listed and controls identified.

From a review of the accident and incident log including the clinical incidents records there was insufficient evidence of adequate review which would support the identification of trends, time-frames or predisposing factors and help to prevent re-occurrences. A significant amount of data was collated but was not analysed such as the number of falls experienced by a resident.

At operational level there was evidence from the monthly team meeting held by the person in charge that incidents were reviewed and staff were updated on changes to practices in order to manage risks.

There were pertinent risk assessments and management plans for each individual resident available. These were found to be pertinent to the residents assessed needs including risk of pressure areas, choking or absconding.

A number of risks had not been adequately addressed. These included:

- inadequate adherence to a resident's swallow care plan

Fire safety management systems were found to be good in general but a fire door to the kitchen was wedged open which negated the value of the procedures. Fire equipment including the fire alarm, extinguishers and emergency lighting serviced quarterly and annually as required. Personal evacuation plans had been compiled for each resident. These were detailed and identified how much support or direction the residents would need.

Inspectors reviewed the fire safety register and saw that fire drills had been carried out at two monthly intervals and included the residents. Staff were able to articulate the procedures to undertake in the event of fire. A resident also confirmed this to the inspector.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspectors reviewed the policy and procedures for the prevention, detection and response to allegations of adult abuse and the protection of vulnerable adults. While staff have not yet had training in the revised policy there was a synopsis available for staff. The person in charge was the designated officer and had undergone the training and was familiar with her responsibilities. All staff had updated training in " Trust In Care " policy. The provider informed inspectors that a number of staff were to be trainers for the revised policy and would then undertake the training with the staff group. Staff expressed their confidence in the actions of the person in charge should any abusive incident occur. They were very clear on the fact that she expected the residents to be treated with respect and protected.

The residents were found to have staff support and where particular vulnerability were identified additional therapeutic care was sourced. There was evidence that the person in charge oversaw their care. Residents who could communicate with inspectors stated that they felt safe, could and would let staff know if anything was wrong.

Inspectors were informed by the person in charge that there were no allegations of this nature made or being investigated at this time but also how the process would be managed should this occur. A resident had been supported by an external advocate sourced by the person in charge with regard to personal decision making.

However, inspectors noted a number of incidents of peer to peer assault which primarily impacted on one resident. These had been notified to the Authority. From a review of the safeguarding plans implemented, inspectors were not satisfied that the actions to prevent these occurrences were sufficiently robust. The plans primarily dealt with supporting a resident after such an incident.

A review of a sample of the records pertaining to resident's monies being withdrawn from the personal property accounts for specific purchases or as weekly pocket money indicated that the systems for recording this money and its usage were detailed and transparent. All monies given for residents use were dated and the expenditure was recorded and receipted for the finance office. Records were available for review at any time.

Money paid in on behalf of residents in fee payments were recorded clearly and the records including savings on behalf of residents were transparent although they were still held in the central account. The person in charge informed inspectors that she was in the process of negotiating personal accounts with a local agency. Records were available for review at any time.

Some improvements were required in the system for the support of behaviour that challenges and the use of restrictive practices.

There was an up-to-date policy on the management of behaviour that challenges. A revised policy on the use of restrictive practices was available. This did not take account

of the use of chemical restraint and did not demonstrate sufficient understanding of the differentiation between enablers/ restraints and crucial safety measures.

The policy also required that decision for all such practices to be signed and reviewed by the multidisciplinary team. This did not occur and in fact they were signed by the GP and the person in charge in most instances. The restraint register indicated that features such as prevention of unsafe access to the treatment room was a form of restraint yet bed rail documentation for a resident provided two different rationales for its use and was not reviewed.

In the weeks before the inspection there was evidence of intervention from a suitably qualified practitioner who had commenced reviewing a number of resident's behaviour support plans. Staff spoken with and records demonstrated a sensitivity to the resident's needs and presenting behaviour. However, it was apparent to inspectors that the system prior to this had provided insufficient guidance and was not specific to the individual residents. For example, in one instance the plan stated that staff would undertake a physical restraint with the resident. The person in charge was very clear that this would not occur.

Overall there was no clarity as to the procedure for implementation or overview of the restrictive procedures which included some locked doors and all in one clothing or bed rails and the use of medication.

From a review of incident reports, medication administration charts and nursing records it was evident that sedative medication was used on a PRN (as required) basis to manage behaviours. These were correctly prescribed and reviewed by the psychiatric service.

However, the frequency of usage suggested that the strategies required overview by a multidisciplinary team including behaviour support in order to reduce the use of such medication. While inspectors were not overly concerned that practices were unduly restrictive or implemented without due reason an adequate policy, system for decision making, overseeing and review of all such practices requires to be implemented.

There was evidence that families had been consulted in relation to the use of this medication and other restrictive practices. Staff had received training in an approved method of managing behaviour which includes physical interventions de-escalation and prevention when this is deemed absolutely necessary and as a last resort.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

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| Safe Services   |
| <p><b>Outstanding requirement(s) from previous inspection(s):</b><br/>No actions were required from the previous inspection.</p> <p><b>Findings:</b><br/>A review of the accident and incident logs, resident's records and notifications forwarded to the Authority demonstrated the provider's compliance with the obligation to forward the required notifications to the Authority. A number of notifications were forwarded retrospectively once the person in charge was clear on the requirements.</p> |
| <p><b>Judgment:</b><br/>Compliant</p>   |

**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):**  
No actions were required from the previous inspection.

**Findings:**  
Inspectors were satisfied that residents were supported and encouraged to develop meaningful day-to-day activities, skills and long term aspirations pertinent to their needs and preferences. There were framed certificates detailing completion of courses in arts and crafts, music and gardening by the residents. One of the residents goes to day care service /training twice weekly and she told the inspectors that she was learning skills which suited her. These included road safety and money management and personal care and cookery.

One resident did gardening. Within the centre they were encouraged to take responsibility for their own personal care as far as possible with some shopping and laundry with support from staff as required. Where formal day care was not deemed suitable social care staff and external staff including an art therapist undertook cookery and other activities with the residents. Personal plans provided details as to the level of personal care support and also details as to personal tasks residents could undertake themselves. There was a significant level of social participation for residents, for example going to shopping centres or for meals out or to local events. There were two suitable vehicles available for the residents.

It was evident from the resident's records and speaking with family members that

considerable progress had been made in the years since the centre opened to improve the residents' quality of life ability to self care in a supportive environment.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found evidence that resident's healthcare needs were very well supported. A local general practitioner (GP) service was responsible for the health care of residents and records and interviews indicate that there was frequent and prompt access to this service. Some of the residents had a good understanding of their own health care needs and one resident told inspectors of the healthy eating and weight loss plans they had embarked on to good effect.

There was evidence from documents, interviews and observation that a range of allied health services were available and accessed in accordance with the resident's needs and changing health status. These included occupational therapy, physiotherapy and psychiatric and psychology services. Consistent and ongoing psychiatric support had been agreed on the relocation of the residents from their previous accommodation. Chiropody, dentistry and ophthalmic reviews were also attended regularly by the residents.

Healthcare related treatments and interventions were detailed and staff were aware of these. Such interventions were revised annually or more often as required. Inspectors saw evidence of health promotion with regular blood tests, vaccinations, medication reviews, and gender specific screening pertinent to the needs of the residents. Inspectors found that there was a cohesive approach to the monitoring of health care, evidence of timely response by the nursing staff and a detailed health summary report was maintained by staff. This included any risk of the development of pressure areas. The documentation indicated that all aspects of the resident's health care and complexity of need was monitored and reviewed. Nutrition and weights were monitored and specific vulnerabilities were noted and acted on such as falls risks or specific dietary needs.

There were protocols in place for the management of epilepsy or head injury and staff were clear on these protocols. Inspectors were informed that if a resident was admitted

to acute services staff had been made available to remain with them to ensure their needs were understood. The person in charge outlined plans to ensure this could be maintained.

There was a policy on end of life care. There was no resident who required this care at the time of this inspection. The policy allows for advanced planning although this has not as yet been implemented. Some but not all of the residents had end of life plans detailing burial or funeral arrangements. The person in charge stated that the resident's wishes to remain in the centre at end of life they will be accommodated as there is the nursing capacity and experience in the centre to support this.

While all main meals were provided daily from a central location residents shopped with staff for additional food preferences and treats. The diverse needs of the residents were addressed in the dietary supports available, for example if meals need to be modified or specific dietary needs were required. There was documentary evidence of advice from dieticians and speech and language therapists available and staff were knowledgeable on the residents' dietary needs. They were also aware of resident's preferences and they had significant choices each day. Resident's weights were monitored regularly. The mealtimes as observed were relaxed and residents who needed support were provided with this in a dignified manner with good staff interaction.

The main kitchen was suitably equipped although access to this was limited for some residents due to reasonable safety precautions. To compensate for this a small room had been converted to cafe type room and equipped with a kettle, fridge and table and chairs. This was more homely than the main dining room and had full access at all times in a homely and relaxed environment. Assistive cutlery and crockery was observed to promote residents independence.

**Judgment:**  
Compliant

## **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:**

The policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory although none were being used at the time of this inspection. There were appropriate documented procedures for

the handling, disposal of and return of medication.

Inspectors saw evidence that medication was reviewed regularly by both the residents GP and the prescribing psychiatric service. All medication was safely stored and there were systems for checking in and receipt of medication. Regular audits of medication administration and usage were undertaken by the person in charge and the pharmacist. Additional food supplements were used only if prescribed by the GP. There was a protocol in place for the use of emergency medication. A small number of medication errors were noted and the remedial actions taken by the person in charge were seen to be appropriate.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

The statement of purpose had been forwarded to the Authority as part of the application for registration. This required some amendments and these were duly made and the revised version forwarded to the Authority. It was found to be centre-specific and compliant with the requirements of the regulations and detailed the care needs and service to be provided.

Admissions to the centre and care practices implemented were congruent with the statement as a service for residents with mild to moderate intellectual and physical disabilities and dual diagnosis.

Inspectors were satisfied that the different needs of the residents were identified and supported in a way which maximised the resident's quality of life in a community environment.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were satisfied that there were suitable and effective governance systems in place. The person in charge had been appointed to the role just prior to the inspection. She was suitably qualified and experienced and had worked as the CNM 11 in the centre for some years. She was very familiar with the residents having been present when they initially moved from their previous placements. Both residents and families spoke very positively about the care she provided and the positive communication she had with them. She had continued her professional development with additional training in behaviour supports as this was pertinent to the residents' needs.

The provider nominee was also responsible for two other designated centres under the umbrella of this organisation. She had suitable experience for the role and was clear on her responsibilities. Throughout the process both the person in charge and the nominee demonstrated an adequate knowledge of the 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.

The nominee of the provider had as required, undertaken an unannounced visit to the centre and had contracted an external agency to compile both a six monthly and annual review of the service. These concentrated on safety and personal planning and outcomes for the residents. Actions arising from these reviews were being addressed or had been addressed. These included resident's meals and availability of choice, the holding of multidisciplinary reviews and the commencement of a formal supervision system for staff. Significant work had been undertaken to ensure compliance with the regulations and the registration process.

The governance systems included the assistant director of nursing who was the person in charge of another centre and who supported the person in charge. There was evidence of regular management meetings and formal reporting structures. The inspectors found that in order to ensure the systems were safe and effective for care delivery, some improvements were required. While some audits on medication sharps and nutrition were undertaken none were undertaken on significant events such as falls or peer to peer abuse which would guide practice and improvements. There was no evidence of recent or annual sourcing of the views of the resident or relatives on the

quality of care. In addition, there was no clarity as to the on-call system for staff.

**Judgment:**

Substantially Compliant

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

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

No actions were required from the previous inspection.

**Findings:**

Inspectors were informed that there had been no periods of leave which required notification to the Authority over and above normal annual leave periods. The provider had made suitable arrangements for periods of absence of the person in charge and was aware of the responsibility to report any such extended absence to the Authority.

**Judgment:**

Compliant

**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):**

No actions were required from the previous inspection.

**Findings:**

There was evidence that sufficient resources for staffing, health care, equipment maintenance and upkeep of the premises and vehicles used were available and utilised for the residents benefit and to ensure the delivery of the care required by the residents.

**Judgment:**

Compliant

### **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 actions required by the previous inspection were satisfactorily addressed. This included the use of agency staff and the implementation of a supervision system for staff. There had been a significant reduction in the use of agency staff.

From a review of the current and planned rosters inspectors were satisfied that there was sufficient staff and skill mix to meet the needs of the residents. This included both general and intellectual disability nursing staff and social care staff. There were dedicated household staff.

A number of staff had been with the service for some time. There was a detailed induction programme outlined and a recently recruited staff told the inspector how this had been implemented. A formal staff supervision/ appraisal system had been commenced by the person in charge. From a review of the documentation inspectors found that it focused on residents' care needs as well as training needs and development for staff.

There was a centre-specific policy on recruitment and selection of staff. However recruitment process was not sufficiently robust for safeguarding purposes. A small number of agency staff were utilised and the documentation showed that some of these staff did not have the required references.

Examination of a sample of personnel files for permanent staff also showed deficits in recruitment procedures with gaps in documentation and two appropriate references were not available for all staff. There was a reliance on internal references where alternatives were available. As recruitment was undertaken centrally the person in charge did not consistently have access to the documentation prior to the person taking up the post and therefore would not be aware of the deficits.

Examination of the training matrix demonstrated that all mandatory training was up-to-date for the staff including fire training, manual handling, and the protection of vulnerable adults, MAPA (a system for the management of behaviour and physical intervention) and medication management training.

Staff were observed to be respectful fully engaged with and supportive of the residents at all times during the process. Residents stated and demonstrated to inspectors that they were comfortable and at ease with the staff.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

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

**Findings:**

All of the required policies were in place but the policy on the management of records required review as it was out of date.

Documents such as the residents guide and directory of residents were available. The inspectors saw that insurance was available. Reports of other statutory bodies were also available.

Records in relation to staff were not complete and in accordance with the requirements. This is actioned under Outcome 17.

**Judgment:**

Substantially Compliant

**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:***

Noelene Dowling  
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<sup>1</sup>

|                            |   |
|----------------------------|---|
| <b>Centre name:</b>        | A designated centre for people with disabilities operated by Health Service Executive |
| <b>Centre ID:</b>          | OSV-0002440   |
| <b>Date of Inspection:</b> | 03 and 04 November 2015   |
| <b>Date of response:</b>   | 08 December 2015  |

### Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

To ensure that residents privacy was respected at all times. The use of audio equipment was unnecessarily intrusive.

#### 1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

1. One persons listening devise has been removed.
2. The second persons will remain in place at families' request. The rationale for this will be discussed at a multi disciplinary meeting with the Person, their Family, their Key Worker, Acting Director of Nursing, Psychologist and Clinical Nurse Specialist (Behaviour Support) on the 4th December 2015. Follow up in relation to this will be agreed pending the outcome of this meeting.

**Proposed Timescale:** 04/12/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

The policy did not adequately outline how the admission procedure would ensure that residents were suitable to live together and all persons would be protected from potential abuse.

**2. Action Required:**

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

The admissions policy has been amended to include a 3 month trial for new admissions to ensure compatibility for them and the people already residing in Re Nua. Policy now states that all people residing in Re Nua will be protected from potential abuse.

**Proposed Timescale:** 08/12/2015

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

To ensure that the annual reviews were multidisciplinary in nature and included all of the resident needs and plans.

**3. Action Required:**

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

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

All individuals have reviewed their care plans this year with their families and staff. Annual reviews are scheduled for 2016 and all multi-disciplinary members involved with the person will be invited to attend with the person and their family to ensure a comprehensive review of all needs.

Proposed Timescale: As per schedule of reviews for 2016

**Proposed Timescale:**

**Theme:** Effective Services

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

To ensure that the reviews were conducted with the maximum participation of each resident or his or her representative where appropriate.

**4. Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

All people have reviewed their care plans this year with their families and staff. Annual reviews are scheduled for 2016 and all multi-disciplinary members involved with the person will be invited to attend with person and their family to ensure a comprehensive review of all needs.

Proposed Timescale: As per schedule of reviews for 2016

**Proposed Timescale:**

**Theme:** Effective Services

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

To ensure that the review assessed the effectiveness and implementation of the personal plan.

**5. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

All documentation in relation to care plans will be reviewed by the team with emphasis

on ensuring clear care plans with ease of access and review, avoiding duplication.

**Proposed Timescale:** 01/03/2016

### **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:**

Systems for the assessment and management for risk were not robust. Some risks had not been identified.

These included lack of adherence to swallow care plans.

**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:**

All risk assessments carried out on each person and the environment will be populated onto a risk register and discussed and analyzed at staff meetings monthly. This analysis will ensure consideration of trends, time frames and any other predisposing factors to may be actioned in order to prevent reoccurrence.

Proposed Timescale: Will commence at next staff meeting and ongoing thereafter.

**Proposed Timescale:**

**Theme:** Effective Services

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

To ensure that systems for contain fires were adhered to. The fire door in the kitchen was found to be wedged open.

**7. Action Required:**

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

All wedges have been removed.

**Proposed Timescale:** 08/12/2015

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

That there was an adequate policy, system for decision making, overseeing and review of all restrictive practices implemented.

**8. Action Required:**

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

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

A multi-disciplinary team review will be conducted review all residents restrictive practices in all aspects of their care. A clear rational will be outlined in accordance with best practice guidelines through liaison with team members. A review of all relevant policies will be conducted and edited accordingly to ensure clear protocol and that the systems for decision making and rational for implementation are clearly outlined.

**Proposed Timescale:** 15/01/2016

**Theme:** Safe Services

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

To ensure that staff have sufficient knowledge, guided by consistent therapeutic assessment and intervention to support residents with behaviours that challenge.

**9. 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:**

Ongoing support from the Psychologist for all staff.

Proposed Timescale: 1. Immediate and ongoing

**Proposed Timescale:**

**Theme:** Safe Services

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

Systems to protect residents from assault by other resident was not robust.

**10. 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:**

A holistic plan including, prevention as well as safeguarding will be drawn up for all residents at a multi disciplinary meeting on 15th January 2016

**Proposed Timescale:** 15/01/2016

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

There was no clarity as to the on-call system for staff.

**11. Action Required:**

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

There is a clearly defined management structure in place. When the person in charge is off duty and staff need to seek advice they have been furnished with an on call number to telephone which will be answered by a manager on call.

**Proposed Timescale:** 08/12/2015

**Theme:** Leadership, Governance and Management

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

There was no evidence of recent or annual sourcing of the views of the resident or relatives on the quality of care.

**12. Action Required:**

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

Residents and their families will be consulted in January 2016 to ascertain the most effective way of sourcing their views in relation to quality of care and service planning. This will be done via letters to families, with questionnaires included and via residents meeting.

**Proposed Timescale:** 31/01/2016

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

To ensure that all of the information required by Schedule 2 in relation to staff was available and verified.

**13. 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:**

1. Discussion with local HR and regional HR Managers to ensure that, in the future the information required will be on file and available.
2. Following a full file reviews and identification of gaps in information on files a resource will be identified to address the matter.

Proposed Timescale: 1. completed 2. At the latest 29/02/16

**Proposed Timescale:** 29/02/2016

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

A number of policies required review and updating.

**14. Action Required:**

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

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

As the Policy on the Management of Records is a National HSE Policy the matter has been escalated.

**Proposed Timescale:** 08/12/2015

