Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005330
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Marie Matthews
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 4 day(s).

The inspection took place over the following dates and times

From:	To:
08 September 2015 16:30	08 September 2015 20:30
10 September 2015 10:30	10 September 2015 17:30
14 September 2015 17:00	14 September 2015 21:30
15 September 2015 12:00	15 September 2015 17:00

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

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 17: Workforce

Summary of findings from this inspection

This monitoring inspection was the first inspection of this centre by the Health Information and Quality Authority which comprised of five community houses in the Cartron area of Sligo. The designated centre is managed by the Health Service Executive (HSE) Cregg Community Services, Sligo. The purpose of the inspection was to ensure that the service was compliant with relevant legislation, national standards and good practice ensuring that the service provided was in accordance with the service users' assessed needs and preferences. The inspector requested the consent of the service users to enter their home and to review their personal plans and care files. Consent was granted and the inspector reviewed policies, procedures, personal plans, medical records, accident and incident records, minutes of staff meetings and policies and procedures and observed practice.

This designated centre provides accommodation for twenty males and females residents with a moderate intellectual disability seven days a week. Accommodation is provided in five separate houses. Most residents accessed day services, suitable for their needs and abilities. One resident had retired. Some residents went home to their families during the summer and at the weekends.The inspector observed staff interacting with residents in a warm and friendly manner. They displayed a good understanding of individual residents' needs, wishes and preferences. However, there was a reliance on agency staff and this was resulting in unfamiliar staff working with residents.

Residents spoke with the inspector during the visit and confirmed that they were happy living in their houses and were treated respectively by staff. They confirmed that they had been given the opportunity to be involved in their care and that any issues of concern were discussed and addressed immediately by staff. Some of their needs had changed and adaptations were now needed to accommodate these. Each house had two storeys and some residents' mobility had declined making the stairs more difficult for them to manage and increasing the risk of a fall. Each house had a bath which some residents were finding difficult to access. Similarly some houses were built on an incline and had uneven driveways making access difficult. The management response to risk was not responsive and risks identified by staff had not been addressed. New risks were also arising as the residents became more immobile which were not been planned for.

Health needs were appropriately assessed and residents took part in a range of activities according to their preference and ability. Those residents who spoke with the inspector described the staff as caring and said they responded to any issues or concerns as they arose. Documentation of complaints was poor and consequently the person in charge didn't have an oversight of the issues arising in each house. Staffing deployment also required review to ensure residents' needs were consistently met by familiar staff. Non- compliances identified are discussed further in the report and included in the Action Plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Residents were consulted on the running of the centre. There were weekly house meetings in each house where residents were supported by staff to make decisions about their routine. Residents told the inspector that they chose their evening meals and the activities they took part in. There was evidence that residents were involved in the development and review of their care plans. The inspector observed staff and residents communicating freely and residents were complimentary of the staff.

Resident 'bedrooms were decorated to their individual preferences with their pictures and personal possessions on display however some residents had to share a bedroom and there was no curtain or screen between the beds to ensure their privacy. Each house had separate kitchen/dining room and sitting room so residents could meet with visitors in private. Staff on duty said that several residents chose to meet with visitors in their bedrooms.

The centre had complaints policy and an accessible version was displayed in each house together with a picture of the complaints officer. The complaints policy was not specific and did not clearly identify the person to whom complaints could be made initially or the person who oversaw that all complaints were appropriately responded to and did not clearly describe the appeals process. A picture and contact details for an independent advocate available to assist residents was displayed in each house. Residents told the inspector that the staff responded to their complaints or concerns promptly and they were able to identify the name of both the complaints officer and the independent advocate to the inspector. A complaints log was not available to some houses so it wasn't possible to review the nature of the complaints or determine if there were any patterns or reoccurring trends. Furthermore on review the format of the log did not

prompt staff to record the date the complaint was responded to or if the resident was happy with the outcome of the complaint.
There was policy available on the management of residents' property and finances, as required by the Regulations. Residents had their own post office accounts and lodged and withdrew money as required. Residents also managed their own pocket money and staff supported them to record their day to day spending and to reconcile their receipts. There were written records of all items of expenditure for the residents and these were checked by the inspector and no discrepancies were found. There were separate independent auditing systems in place to ensure residents' finances were adequately safeguarded. Some residents also had funds in a collective resident account held by Cregg Services. Some families had expressed dissatisfaction with this arrangement and had requested this money to be released to the residents' personal accounts. At the time of the inspection this hadn't occurred but the inspector was informed that arrangements were being made to transfer these monies to a 'patient property account' held by the Health Services Executive (HSE).

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

Findings:
A communication passport was available on each residents file and the staff were aware of each residents communication needs. Residents that required specific communication supports had an individualised communication profile in their personal plan, for example, one resident was non verbal and her individual communication requirements were highlighted in her personal plan. Copies of the residents guide and complaints policy and procedure were available in an accessible format and picture references were used to indicate the staff on duty and the meal choices available to residents

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

Findings:
There was evidence that the residents in each house were actively encouraged and supported to get involved in the local community. Some residents told the inspector they attended community association meetings and others described how they're neighbours visited them from time to time. There was a network of community houses run by the service located in the area and residents visited each other for meals and other social gatherings. In one house the residents had lived in the house for over twenty years and they described to the inspector how they enjoyed being part of a close knit neighbourhood.

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

Findings:
There was currently no contract of care or written agreement in place between residents and the service to outline the services provided and fees charged. The person in charge commented that she understood that the HSE have produced draft contracts which are currently under review. The PIC was requested to forward a copy of the contract once agreed.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-

based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
A comprehensive assessment of health, personal and social care needs had been completed for each resident. There was evidence of a multi-disciplinary team input in the resident's files, such as psychiatry, physiotherapy and speech and language therapy (SALT). The inspector found that residents and their relatives were involved in the development and review of a personal centred plan (PCP). These plans included information relating to residents' health care needs and as well as person goals identified by residents during their annual review. PCP's were reviewed annually at a multidisciplinary meeting.

The inspector saw that most goals identified for the previous year had been achieved or alternative activities organised instead. Goals included going on holidays, going to concerts, pantomimes' or to attend activities such as swimming regularly. In some instances the goals identified were to continue with an activity that the resident enjoyed. While this may have reflected the wishes of the resident at the annual review there was not always evidence that staff encouraged or supported residents to choose new goals which would maximise their potential.
There was evidence that residents' were encouraged to pursue a variety of social interests and were supported by working arrangements between the staff in their house and the staff in neighbouring houses run by the service. The inspector was told that residents attended swimming, horse riding, line dancing and pottery classes once a week. One staff member in each house facilitated each event and organized transport and supervision so that the residents' interests were fulfilled. Staff from several community houses liaised to arrange for residents to attend various activities as a group. However, those residents who did not choose to attend one of organized activities, did not have the choice to stay in their own home during the activity as staff were not available to supervise them. This is discussed further under outcome 16 on resources.

Judgment:
Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets

residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The inspector found the five houses which formed this centre provided comfortable, clean, pleasantly decorated, personalised accommodation for residents. However, the design and layout of the centre did not meet the needs of some residents whose mobility had decreased and who consequently required level access accommodation.

There was a kitchen cum dining/sitting room in each house and a separate sitting room. The kitchen contained all of the equipment needed to store, prepare and cook food. There was a washing machine and tumble drier for residents to use. Bedrooms were personalised and appropriate storage was available in each and residents told the inspector they had chosen their own duvet covers and curtains.

Each house had two floors and most bedrooms were located upstairs. Handrails were provided on both sides of the stairs to support residents. Residents with impaired mobility were accommodated downstairs in two of the houses. In discussion with residents, the inspector was told that some residents accommodated upstairs were starting to find the stairs difficult to use. The main bathroom was located upstairs in each house and there was no suitable level access shower provided for residents on the ground floor. Some residents told the inspector they found it difficult to get in and out of the bath. Similar issues were identified in each house:

House No 1. accommodated 4 female residents. Two residents shared a bedroom which impacted on their privacy and dignity. Although residents told the inspector they were happy to share, the space available to each resident was considerably reduced. A downstairs shower/toilet was located in the garage however this shower was narrow and difficult for residents to access. Most of the remaining garage space was used for storage and required refurbishment. There was evidence of dampness on the wall to the rear of the house. Access to the house was also difficult as it was built on a steep incline and the driveway surface had deteriorated which resulted in a steep and uneven surface. There was no handrail provided to support residents.

House No 2 is connected to house Number 1 via kitchen, through connecting doors. It is also a two storey semi-detached house and also accommodates 4 female residents and one sleepover staff. There are 4 bedrooms – 3 single bedrooms and 1 double bedroom shared by two residents which impacted on their privacy and dignity. The inspector observed that one resident could not easily access the shelving in her wardrobe which was too high. Again the residents told the inspector that they had been in the house for several years and their needs had changed and they felt work was required to adapt the

house to make it more accessible. Some residents said they were finding it difficult to use the stairs. A shower is provided over the bath in the main bathroom upstairs and some were fearful using this facility. This had been identified as a risk for residents. Access to this house was also made difficult by the steep incline and the uneven surface. There was no handrail provided to support residents.

House No 3 is also semi-detached and is situated in a nearby housing estate which accommodates 3 female residents. It has similar accessibility problems. There is also an incline down to the front door from the street with no handrail to support residents and at the rear there is a very steep step from back door into the garden. There are three single bedrooms provided upstairs (one used by sleep over staff) and the garage downstairs has been converted to a bedsitter with one bedroom/sitting room, shower, toilet and one kitchenette. The main bathroom is upstairs and has a shower over the bath. A separate kitchen and sitting room are provided downstairs.

House No 4 is a two storied semi detached house in a neighbouring housing estate which accommodates 3 male residents in single bedrooms. It has a small garden to the front and rear of the building. There are 4 bedrooms (one used by sleepover staff). The main bathroom is located upstairs and has shower provider over the bath. Residents in this house said they could manage the stairs and the bath but provision needs to be made for the needs as they age.

House No 5 is also a small two storied semi detached house in a housing estate which accommodates 5 female residents. There are 3 single rooms (one used by the sleepover staff member) and one double bedroom shared by two residents which impacted on their privacy. Only one wardrobe was available in this room. There is a steep incline towards the front door in this house which created a risk for residents. There are 3 small bedrooms up stairs and one bedroom downstairs has been created from a converted garage. The main bathroom is upstairs and has a shower provided over the bath. There is also a toilet and shower down stairs off the bedroom converted from a garage. Several residents use this toilet and shower during the day but access is through a resident's bedroom, which impacts on her privacy.

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

Findings:

There was a system in place to manage adverse events but this required review as instances were found were it was not responsive to risks identified. An accident/incident report was completed when an incident occurred and these were forwarded to the PIC who reviewed them, in-putted them on the services computerised system which captured data on accidents and incidents in the centre and produced a report for each centre. A monthly list of incidents was produced for each house however staff could not access this system so this information was not available so it wasn't possible to review any trends occurring or assess the outcomes of reviews carried out by the PIC to prevent a similar incident re-occurring.

A copy of the services risk management policy was available in the office. A risk register was in use in each house to identified and assess risks and the controls required to manage them. During the inspection the inspector identified a number of risks which were not included on the register. For example, risks associated with leaving residents unsupervised in the house, self medicating or residents accessing public transport unsupervised were not recorded or included in any of the risk registers reviewed. Other risks were identified in the risk register but had not been addressed. For example, the driveway leading to two of the houses was on steep incline and surface was damaged and uneven. Residents complained to the inspector that this posed a risk to their safety as there were no handrails to support them. This risk was identified by staff in the risk register but no action had been taken to address the risk. Similarly the bath was identified as a risk but it had not been replaced with a more accessible facility.

Training records reviewed by the inspector indicated that all staff members had completed training in fire safety but some staff were overdue training in the safe moving and handling of service users. A vehicle used by residents was appropriately serviced and had an up to date certificate of road worthiness. Appropriate fire fighting equipment and emergency lighting was located throughout the houses and there was evidence that equipment was serviced regularly. Weekly and monthly fire safety checks were recorded in the centres fire register. Fire exits were observed to be unobstructed. There was evidence that the staff carried out regular fire evacuation drills with residents and these were recorded in the centres fire register and on the residents' personal plan. A personal emergency evacuation plan (PEEP) was available for each resident in their personal plan which described the assistance they would require in the event of an evacuation. A summary copy of this was also kept at the front door.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Measures were in place to protect residents from being harmed or suffering abuse. A policy was available for the prevention, detection and response to allegations of abuse. It included procedures to guide staff on the different forms of abuse and their responsibility if they suspected any form of abuse and the procedure for managing an allegation or suspicion of abuse. The name and contact details of the designated contact person was included in the policy. The staff members interviewed by the inspector were aware of their responsibility to report any allegations or suspicions of abuse. Residents also identified the designated person who they would speak to if they had concerns and pointed to a picture of this person which was displayed in the house. The PIC confirmed that there were no allegations of abuse currently under investigation.

Inspectors observed that the staff interacted with residents in a caring respectful and dignified manner in each house. Training records reviewed confirmed that staff had completed training on protection. Residents told the inspector that they felt safe in the centre. There were no residents who were displaying significant behaviour that challenged at the time of this inspection. Behaviour support polices and specialist behaviour support personnel were available to the organisation if they required same. The inspector was informed that there were no restrictive procedures in place at the time of this inspection.

Judgment:
Compliant

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:
Safe Services

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

Findings:
Accident and incident forms were completed for all incidents and staff were aware of the notifications that were required by the Authority and these had been supplied.

Judgment:
Compliant

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

Findings:
Residents had opportunities to engage in social activities. External activities were available through the various day services and residents also participated in range of varied interests such as swimming, horse riding, line dancing, education courses, art, crafts and pictures of residents participating in various activities and arts and crafts made by residents were displayed in the centre.

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

Findings:
Residents were supported to achieve and enjoy the best possible health . A comprehensive health assessment had been carried out for each resident and the inspector saw that appropriate screening/checks were in place to ensure optimal health. There was evidence that residents were appropriately referred to specialist health services including physiotherapy, speech and language therapy, chiropody, optometry and dentistry. The inspector found that residents were supported to attend these appointments.

The medical records of residents in each house confirmed good access to the general

Practitioner (GP) and this was also confirmed by staff and by residents. An out of hour's service GP service was also available. Some residents described as possibly showing early signs of dementia, had been referred to a Clinical Nurse specialist in Dementia for assessment.
Residents had their main meal in their home every evening and had brought a lunch with them to their respective day services. They told the inspector that they helped plan the meals for the week and were involved in shopping for the food with the help of staff. A bank procurement card was used by residents to buy groceries from local supermarkets. Meals were prepared mainly by staff in the evenings and staff interviewed said some residents liked to help peel vegetables. In two of the houses, the evening meal was prepared and cooked by the morning staff and reheated in the evening. The inspector was told this was done on the evenings when residents attended an activity and the rationale was that the meal was ready on their return but this practice meant that residents did not have the option to help prepare or choose their evening meal.

Meal choices for the week were displayed in each house and a recipe book described how to prepare the meal in simple steps with pictures to illustrate the steps which residents said they found helpful. The inspector found that there was an ample supply of fresh and frozen food available in each house and residents could have snacks in between if they chose. Some residents had special dietary requirements provided by the speech and language therapist. These requirements were met but the inspector found there was no overall nutritional care plan to provide guidance to staff as to appropriate meal choices or exercise plans to support one resident who was identified as needing to lose weight.

Judgment:
Substantially 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):
This was the centre's first inspection by the Authority.

Findings:
The processes in place for the handling medicines was safe and in accordance with current guidelines and legislation. Most residents self medicated with the support of staff. Risk assessments were completed prior to the decision been made and appropriate support was provided according to the residents ability to manage and store their own medication. Each resident stored their medication in cash boxes which they kept in their bedrooms and the keys were held by staff.

The inspector reviewed a sample of prescriptions and medication administration records and found that they were clearly written and complied with best practice with a signature of the prescribing doctor for all medication administered and a date and signature for any medication discontinued. The maximum dose prescribed for as required (PRN) medications was stated on the medication charts.

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

Findings:
A statement of purpose which set out the services and facilities provided by all of the community houses run by the service was submitted by the provider. This needs to refined and resubmitted to the Chief Inspector so that it describes each service individually. The aims, objectives and ethos of the centre were clearly defined, however, details of specific therapeutic techniques available were not described as required by schedule 1 of the regulations.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Some of the management systems are in place required review to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. As discussed under outcome 7, the governance arrangements for the management of risk were not responsive and did not ensure that risks were promptly and appropriately responded to. As discussed under outcome 1, there were issues with the management of residents' finances which required review to ensure that residents were encouraged to take financial responsibilities. As stated under outcome 4, residents did not have a written agreement of the terms on which they resided in the centre.

The inspector met with the person in charge (PIC) and interviewed her in relation to governance of the centre. She was suitably qualified and had the knowledge and experience commensurate to her role. She had worked in management position within the service for a number of years and held the post of community co-ordinator. She worked in a full time capacity, 39 hours per week.

The PIC reported to the service area manager who in turn reported to the provider nominee. In addition to the 5 houses in this designated centre, she was responsible for an additional 6 other community houses. The PIC told the inspector that she tried to visit each house once a week and was available by phone if required. Staff and residents confirmed that they enjoyed good access to the PIC. There was a system in place to ensure that the documentation required for staff employed in the centre was in place however this required review. This is discussed further under outcome 17.

The PIC completed audits of some aspects of the service including medication, personal plans and dependency levels. There was evidence that the provider nominee had arranged for her deputy to complete unannounced visits or 'walk about' to the designated centre and a copy of the reports arising from her visit were submitted following the inspection. The scope of the visits and corresponding reports was limited however and they did not fully address the safety and quality of care in the centre and although it highlighted issues such as the need for maintenance and refurbishing there was no details of a plan to address these issues.

Judgment:
Non Compliant - Moderate

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

Theme:

Responsive Workforce

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

Findings:
The level and deployment of staff required review. The statement of purpose submitted described these residents as having a moderate intellectual disability however the section on staffing indicated that the 5 houses were staffed as a low dependency houses. In general, one care assistant worked in each house from 7.30am to 11.30am and supported residents to get dressed and have their breakfast before going to day services. A care assistant was on duty in the evening to support residents to prepare their evening meal and facilitate any evening activities. This staff member slept over at night. An additional twilight staff from an agency had been added to the rota in one house where a resident had become unwell. Residents were also supported by a Clinical Nurse Manager 2 (CNM2) and a nurse who worked opposite each other and who supervised residents care and was based in one of the houses. Staff in various community houses run by the service worked well together to facilitate residents' to attend various activities such as swimming. However; residents who didn't attend the planned activity did not have the choice to stay in their own home or do an individual activity as there was no staff available to supervise them and usually they were brought to another community house for supervision.

There was also a heavy dependency on agency staff and this caused difficulty for some residents whose personal plans identified that they required continuity and familiar staff. The PIC said she tried where possible to ensure staff familiar to residents worked in the houses however this was difficult. Staff were observed to treat residents respectfully and they displayed an in-depth understanding of individual residents' needs, wishes and preferences. Residents who spoke with the inspector during the visit spoke favourably about the staff present and about the PIC and area manager and confirmed that they visited them regularly.

There was a system in place to ensure that staff were recruited, selected and vetted in accordance with best recruitment practice. The inspector requested the files of three staff. These were kept off site but were brought to one of the houses for the inspector. Most documents required in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were present however only one reference was available on one staff file and there was no up- to- date contract of employment to indicate the staff members position, duties and work hours on two staff files reviewed.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Marie Matthews
Inspector of Social Services
Regulation Directorate
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Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005330
Date of Inspection:	08, 10, 14 and 15 September 2015
Date of response:	19 November 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy was not specific and did not clearly identify the person to whom complaints could be made or the person who overaw that complaints were appropriately responded to and it did not give describe clearly appeals process.

It wasn't possible to review the nature of the complaints or determine if there were any patterns or reoccurring trends and the format of the log did not prompt staff to record

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

the date the complaint was responded to or if the resident was happy with the outcome of the complaint .

1. Action Required:
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Format of the logs will be updated. Each resident will have identified individuals to whom they can make a complaint or raise a concern, separate from the complaints manager.The Policy will be reviewed to reflect the arrangements in place.

Proposed Timescale: 21/11/2015

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:
There was currently no contract of care or written agreement in place between residents and the service to outline the services provided and fees charged.

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

Please state the actions you have taken or are planning to take:
Contract of care will be issued to residents and families.

Proposed Timescale: 10/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
The premises are not laid out to meet the aims and objectives of the service and the number and needs of all of the residents.

3. Action Required:
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs

of residents.

Please state the actions you have taken or are planning to take:
In consultation with the Registered Provider a detailed plan will be developed, designed to meet the current, changing and future needs of the residents.

Proposed Timescale: 03/06/2016

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:
There was a system in place to manage adverse events but this required review as instances were found were it was not responsive to risks identified.

4. 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:
A system will be put in place where staff at each location will have on going access, to a monthly list of identified risks. New and existing risks will be reviewed and action plans will be put in place to manage same.

Proposed Timescale: 21/11/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no overall nutritional care plan to provide guidance to staff to support one resident who had been identified as needing to lose weight, as to appropriate meal choices or exercise plans.

5. 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:
The resident has been referred to the Community Dietician, awaiting an appointment date.

Proposed Timescale: This action has been completed

Proposed Timescale: 04/11/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A statement of purpose which was specify to the centre was not available in each house. Details of any specific therapeutic techniques available were not described as required in schedule 1 of the regulations.

6. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of purpose will be reviewed and amended to reflect the specific therapeutic techniques available and will be kept under review. The revised statement of purpose will be made available in each house in a format that is accessible to the residents.

Proposed Timescale: 08/12/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The governance arrangements for the management of risk were not responsive and were not ensuring that risks were appropriately responded to promptly.

7. 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:
The registered providers representative has been alerted to the need for an urgent response to the identified risks, currently on the centre's risk register`.

Proposed Timescale: 13/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The scope of the unannounced visit was limited and were not completed every six months or more frequently. The corresponding report on the safety and quality of care and support provided in the centre did not address any concerns regarding the standard of care and support.

8. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
The registered provider representative will draw up a schedule of visits, to commence immediately.

Proposed Timescale: 09/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deployment of staff was not ensuring that residents care needs were met.

All information and documents as specified in Schedule 2 of the regulations were not contained in staff files.

9. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The HR Department are currently updating the staff files

Proposed Timescale: 06/05/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
residents were not receiving continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Please state the actions you have taken or are planning to take:
1.Business Cases have been submitted to the HR Department for additional staff to meet the changing need of residents
2.A submission was forwarded to Registered Provider re: additional staff to (a) meet changing needs of residents (b) to provide individualised social supports (c) to address skill mix issues within the community service.

Proposed Timescale: action completed

Proposed Timescale: 04/11/2015