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-0003361
Centre county:	Kerry
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ann Sheehan
Lead inspector:	Breeda Desmond
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	6

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 December 2015 08:00	08 December 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 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was a follow-up inspection to the inspection on 29 April 2015 and it was the fifth inspection of the centre. The purpose of this inspection was to monitor compliance with the Regulations and monitor actions agreed with the provider in their 'Improvement Notice', to ensure the safety and welfare of residents. Overall, the inspector noted further improvements regarding the safety and welfare of residents.

The issue which remained outstanding from the 'Schedule of Improvement' notice was remedied, whereby a full-time person in charge was appointed with the appropriate qualifications, skills and experience necessary to manage the centre with responsibility and accountability for the service.

As part of the inspection process, the inspector met with residents, the person in charge, senior nurses and members of staff. The inspector observed practices and reviewed documentation such as care plans, medical records, staff training records, complaints, incident and accident records.

Areas for improvements to ensure compliance with Regulations included:

- daily fire safety checks
- residents' finances

- aspects of residents' care documentation
- staff training
- schedule 5 documentation.

The action plan at the end of the report identifies actions 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 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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:
The complaints process was on display and was in an accessible format for residents living in the centre. The person in charge was responsible for overseeing complaints and all complaints were submitted to the complaints officer for review and analysis. Previously, it was identified that the complaints log required attention as issues were recorded as comments and not recognised as complaints; this was now remedied, whereby a separate complaints log was in place which recorded only complaints; comments and compliments were recorded separately. The policy was amended to reflect the change in practice. The complaints log was reviewed and complaints were dealt with in a timely fashion and outcomes were recorded.

There was documentary evidence that residents were consulted with and participated in decisions about their care and in the organisation of the centre. The inspector observed residents were given choice in their care and activities. Residents were treated with dignity and respect by staff.

Judgment:
Compliant

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:
Significant improvements were noted regarding communication strategies for residents. For example, seven I pads were acquired for residents with additional games and applications to enable residents to read, write, play games and music, and interact to improve their dexterity. Residents were observed using this and appeared to enjoy the activity.

One staff member outlined that they were in the process of introducing picture-enhanced communication which would be displayed throughout the centre as well as having resident-specific pictures which would be displayed in individual residents' bedrooms.

Comprehensive minutes of residents meetings were evidenced and many issues were discussed including fire evacuation safety as well as outings, activities and work. Residents as well as staff signed these minutes.

The residents' guide was displayed in each unit and it was in an accessible format for residents.

Residents had access to televisions, radio, music centres and I-pads. Some residents had televisions in their bedrooms and large flat screen televisions were in communal sitting rooms. Staff were aware of individual communication needs of each resident and demonstrated effective communication with those residents with complex communication needs; communication requirements formed part of residents' personal care plans.

Residents had access to multi-disciplinary professionals such as speech and language therapy, occupational therapy, eye care, audiology, psychology and psychiatry to assist them in their communication needs.

Judgment:
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:
Previous inspections highlighted that care was based on a medical model. The findings of this inspection suggested that the transition programme being developed was more integrated into the daily lives of residents in the centre. Staff were observed promoting independence and life skills and assisting residents where necessary. Previously, an 'individual daily activity' form was introduced which was a two sided sheet to enable the day services to report on one side and the residential services report on the flip side. Items such as the residents' involvement in the service and activities/outings/skills were recorded. While this was an excellent forum for cross-communication between day services and residential services however, it was not used to its full potential. Invariable, there was very little or no information included in this to inform circumstances and new developments.

A clinical risk assessment was in place that included assessments related to risk of suicide, neglect, aggression/violence, self harm and abuse. In addition there was an evidenced-based falls risk assessment, skin integrity and nutritional risk assessment with the national consistency descriptors for modified diets incorporated. The sample of personal care plans reviewed contained person-centred information and were updated appropriately. However, there was also an activity of daily living assessment and care plan documentation, but this was not being used as a functional document. This was discussed at feedback meeting where the person in charge was requested to review this document as it did not appear to add value to the overall resident information.

All residents were assessed by the dietician and speech and language therapist (SALT) with reports evidenced and actions implemented following these assessment. Residents had access to occupational therapist (OT) when necessary. Residents were reviewed by the dentist in-house and externally and treatment was completed where necessary.

A multi-disciplinary team was established with monthly meetings to support the transition programme; members included the person in charge, consultant psychiatrist, Clinical Nurse Manager 2 (CNMs 2), psychologist, risk manager and representatives from the external service provider. A transition programme for one resident was reviewed. This included GP letter and prescription; OT and physiotherapy assessments with associated actions. An inventory of furniture and personal belongings to be taken was evidenced along with a list of the resident's favourite food and treats. The resident had been going to their new abode several days a week until the planned final transition in mid December. Staff reported that the resident had settled in very well to the new surroundings.

The inspector joined residents at breakfast and lunch. Residents were observed setting

the table and assisting with dining room duties. They reported to the inspector that this was their 'job' and it was obvious they enjoyed and took pride in their involvement. The inspector observed that staff encouraged and promoted residents' dining room skills.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
Regular fire drills and evacuations were completed by staff and residents. Fire evacuation advisory signage was displayed in each unit; floor plans which identified a point of reference were displayed prominently. There were adequate means of escape and emergency escape signs were at each exit. The inspector examined fire safety records and noted that while fire safety checks were usually completed, there were several gaps noted in the daily fire check record for both day and night duty checks. Certificates were in place for annual servicing of fire safety equipment and emergency lighting, and bi-annual testing of emergency lighting.

The handle of the fire exit door was missing in one unit so the inspector was unable to open the door from the inside. This was highlighted to the senior staff and the issue was remedied before completion of the inspection.

A 'Personal Emergency Evacuation Plan' (PEEP) was completed for each resident which outlined the degree of assistance required for their safe evacuation.

The incidents and accidents logs was reviewed and this was comprehensively completed and included interventions to mitigate recurrences where possible. This was also reflected in the personal outcomes plans as well as in residents' positive behavioural support records.

A comprehensive infection prevention and control (IP&C) inspection was completed by the IP&C nurse specialist. The action plan demonstrated that issues were timely addressed by the relevant staff.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Most staff had completed training in adult protection since the last inspection. Those staff interviewed articulated appropriate responses regarding actions to be taken following reporting of an allegation of abuse. The HSE policy 2014 'Safeguarding Vulnerable Persons at Risk of Abuse' was in place and staff interviewed were aware of this policy and its contents. There was a flow-chart displayed in the centre for response and reporting suspicions of neglect and abuse.

Many staff had completed training in positive behavioural supports and others were scheduled to attend further sessions. However, cognisant of the complex behaviours of some residents, 14 staff had not completed this training. Some staff had completed the professional management of aggression and violence training (PMAV), however, this was method was difficult to implement if ones' duty colleague had not completed this training. Nonetheless, pertinent residents were scheduled to be assessed by a specialist in their own environment regarding PMAV pre/peri/post behaviour episodes to direct staff in appropriate interventions to alleviate and/or mitigate behaviours.

Most debit and credit transactions were co-signed in line with best practice, however, all transactions were not co-signed. In addition, balances brought forward were not co-signed. Receipts were co-signed by staff to safeguard both the resident and staff member involved in the financial transactions.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Medication was stored securely in each bungalow. The medication administration record was examined and noted that administration of medications was recorded appropriately.

Photographic identification was in place for all residents as part of their prescriptions in line with best practice. Prescriptions were reviewed regularly by the GP and psychiatrist; maximum dosages for PRN medications were documented; discontinued medicines were discontinued in line with best practice.

Medications care plan was in place for each resident and epilepsy care plans when relevant. These were detailed and gave comprehensive instruction to staff to inform care and welfare. A new form was introduced to 'record as required (PRN) medication given'. This was comprehensively completed; PRNs were reviewed and audited on a monthly basis by the person in charge and results were trended. This informed the positive behavioural support strategy for pertinent residents as part of the restrictive practice committee meetings.

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

Findings:
The person in charge was full-time in post with the appropriate qualifications, skills and experience necessary to manage the centre with responsibility and accountability for the service as required by the Regulations. She demonstrated adequate knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. She demonstrated a positive approach towards meeting the regulatory requirements and a commitment to improving

quality of life and care.

The 'Management Governance Group', 'Restrictive Practice Committee' and 'Transition Management Team' were embedded and each convened once a month to manage and monitor the service holistically, with attendees from across the service involved. Management systems to ensure the service was safe and effectively monitored were demonstrated, for example, incidents and accidents were effectively monitored; recording of complaints was effectively monitored to enable learning and mitigate risks; policies procedures and guidelines were reviewed and updated on a monthly basis. Minutes from all these meetings were evidenced with action plans, accountable persons named and progress status of issues identified.

Unannounced visits to the designated centre as described in the Regulations had occurred. Reports were evidenced with actions, responsibilities and timelines assigned. Staff meetings had occurred to discuss these findings. Notifications were submitted in accordance with regulatory requirements.

A detailed programme of works was submitted to the Authority as part of the schedule of improvement notice relating to the transition of residents to de-congregated settings. The provider nominee submitted monthly updates to the Authority regarding this transition .

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

Findings:
There were acting clinical nurse managers (CNMs) on each unit as well as senior staff nurses to take responsibility for the unit when necessary; the person in charge's office was on site. There was a night superintendent on call to support staff.

Most of the items in Schedule 2 were available for staff, however, photo identification was absent for three staff. An Bord Altranais (ABA) registration was not in place for two staff even though their annual HSE 'Patient Safety Assurance Certificate for Nurses and

Midwives' was in place which detailed their current ABA certificate of registration (this document was submitted annually and verified by staffs' line manager).

Staff training records demonstrated that mandatory training including protection, manual handling and lifting was up-to-date. Outstanding staff training was detailed previously in this report.

The person in charge had prepared personal development plans for staff as part of the staff appraisal system and this was in the process of being rolled out.

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:

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003361
Date of Inspection:	08 December 2015
Date of response:	04 January 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The 'individual daily activity' was not used to its full potential. Invariable, there was very little or no information included in this to inform circumstances and new developments.

1. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

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:
1. The External Service Provider has been reminded of the importance of staff completing the daily activity sheet.
2. A daily and weekly checklist has been put in place to be completed by the CMN2's
3. The requirement to complete these checklists has been included on the work plan for the CMN2's and will be part of on-going Performance Monitoring by the PIC

Proposed Timescale: 04/01/2016

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:
While fire safety checks were usually completed, there were several gaps noted in the daily fire check record for both day and night duty checks.

2. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
1. The recording sheet for daily fire safety checks has been modified to simplify day and night recording sheets.
2. Clear notices, with responsible person assigned for fire safety checks, are prominently displayed in each unit.
3. Instruction sheet for completion of daily fire checks is displayed on the notice board of each unit.
4. All staff have been updated on these changes and the requirement to adhere to same

Proposed Timescale: 04/01/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Many staff had completed training in positive behavioural supports and others were scheduled to attend further sessions. However, cognisant of the complex behaviours of some residents, 14 staff had not completed positive behavioural support training.

3. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
1. A detailed behaviour support plan to support one resident with behaviours that challenge is in place with further work being carried out by PMAV instructors on specific techniques to be used as a last resort.
2. All staff supporting this gentleman will be provided with specific training in de-escalation and intervention techniques.
3. There is a comprehensive on-going training plan in place for all the staff in Cluain Fhionnain which includes Positive Behaviour Supports and PMAV training. All staff are advised of training dates and the requirement to attend same.
4. Comprehensive training records are maintained for staff and will be reviewed with individual staff members through Personal Development Plans that are currently being rolled out.

Proposed Timescale: 28/02/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had completed the professional management of aggression and violence training (PMAV), however, this was difficult to implement if ones' duty colleague had not completed this training.

4. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
1. Positive behaviour Support plans are in place for any resident with Behaviours that challenge. These are based on the premis that the least restrictions as possible are used.
2. Training in Positive Behaviour Supports has been provided to most of the staff in Cluain Fhionnain. Further training in Positive Behaviour Supports is included in the Training programme for Cluain Fhionnain.
3. Following any episode of a behaviour that challenges, staff are required to document the episode including the interventions trialled referencing the person's Behaviour Support Plan.
4. This will be reviewed by the Person in Charge and the multi-disciplinary Team and will be presented to the Restrictive Practice Group for review at the next meeting.

Proposed Timescale: 04/01/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Most debit and credit transactions were co-signed in line with best practice, however, all transactions were not co-signed.

In addition, balances brought forward were not co-signed.

5. 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:
1. All staff have been reminded of the requirement to co sign all debit and credit transactions as well as balances being brought forward.
2. CMN2's will be required to audit this regularly to ensure that all staff adhere to it

Proposed Timescale: 04/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Most of the items in Schedule 2 were available for staff, however, photo identification was absent for three staff.

An Bord Altranais (ABA) registration was not in place for two staff even though their annual HSE 'Patient Safety Assurance Certificate for Nurses and Midwives' was in place which detailed their current ABA certificate of registration (this document was submitted annually and verified by staffs' line manager).

6. 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. Contact has been made with staff where items are still outstanding.
2. Most items are now in place.
3. PIC to finalise files on return from Annual leave

Proposed Timescale: 15/01/2016