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-0004904
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joseph Ruane
Lead inspector:	Jillian Connolly
Support inspector(s):	Brid McGoldrick; Raymond Lynch
Type of inspection	Announced
Number of residents on the date of inspection:	10
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 inform a registration decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
22 September 2015 10:30	22 September 2015 18:00
23 September 2015 09:30	23 September 2015 17:30
24 September 2015 09:30	24 September 2015 11:00

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 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

Inspectors undertook ten inspections in eight centres operated by the Health Service Executive (HSE) through St Peter's Services in Westmeath in 2015, four of which were announced and six unannounced.

These inspections found evidence of poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued immediate actions and

warning letters. Regulatory and escalation meetings were also held with the provider and members of senior management of the Health Service Executive.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to refuse the registration of one of the centres was issued. Following on from this, the provider informed the Chief Inspector of their intention to cease the operation of four houses within the region. The purpose of this was to consolidate the staffing levels in the remaining twelve houses.

HIQA has been informed by the provider that the process for assuming operational and governance responsibility is now complete and the contract has been awarded to another service provider.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection was conducted following an application by the Health Service Executive to register one designated centre under the Health Act 2007. The application was for the designated centre to provide services to ten individuals. The designated centre consists of two community houses located on the outskirts of a town in Co. Westmeath. One of the community houses had been inspected in December 2014. At this time the two community houses were part of a larger designated centre which consisted of eight houses. Following on from the inspections in 2014, the service was restructured and the two houses referred to in this report became a standalone designated centre.

The second community house had not been inspected prior to this in 2014.

Significant failings were identified in December 2014 and inspectors followed up on the actions the provider had stated would occur to address regulatory failings.

Inspectors met with residents and relatives, spoke with staff, observed practices and reviewed documentation. Relatives stated that they were in the main happy with the service provided to residents and spoke very positively about staff involved in the provision of direct care to the residents. However, inspectors found that a common theme arising from relatives was a concern regarding an absence of continuity of care to the residents due to the absence of regular, consistent staffing. Inspectors also found that whilst relatives stated that communication from staff within the designated centre was very good, improvements were required in the consultation by people participating in management with family members, particularly regarding the operation of the designated centre.

These areas of concern were confirmed by inspectors during the course of the inspection, which identified that significant improvements were required in the governance and management arrangements to ensure that services were safe, effective and continuity of care was provided to residents. The person in charge was absent for the inspection, therefore the inspection was facilitated by front-line staff.

Feedback was provided to the individuals participating in management on the third day of inspection.

Inspectors informed management at this meeting that the Chief Inspector had significant concern regarding the safety and quality of service being provided to residents. Management were further informed that the Chief Inspector was not assured of the ability to improve or sustain improvement going forward, due to the failure to progress actions following the inspection in December 2014.

Inspectors found a core factor involved was staffing and continuity of care together with a disproportionate response to risk by the provider. Inspectors reviewed the roster for the coming week and found that staff had yet to be identified to work for three of the seven days. An immediate action was also issued in respect of staffing levels on the first day of inspection as inspectors found there were insufficient staff in one of the community houses after 20.00 hours. The provider responded by 18.00 hours on that day to commit to two staff being on duty. At 15.00 hours on the second day of inspection, the provider had yet to identify a second staff member for the shift commencing at 20.00 hours. This had been rectified by 16.00 hours. A second immediate action was issued in respect of Regulation 26 (2) and is included in the action plan at the end of this report.

Of the 18 outcomes inspected, major non-compliance was identified in 11 outcomes. Moderate non compliance was identified in five outcomes. Outcomes in relation to the absence of the person in charge and communication were found to be compliant. Of the 37 regulatory failings identified, 28 are the statutory responsibility of the registered provider and nine are the responsibility of the person in charge.

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

Findings:
The organisation had policies and procedures in place regarding the management of complaints. Information was also displayed in an accessible format to inform residents and staff regarding the actions to be taken to make a complaint. There was a register of complaints maintained in the designated centre. Inspectors reviewed the record and found that there were no complaints recorded. There were records of conversations maintained in the register which highlighted family members' views on the service, which, although were in the main positive did include a comment that relatives "would welcome the presence of permanent staff". There was no evidence that this had been addressed in line with Regulation 34 or if any action had been taken as a result of this comment or if the family member had been consulted with regarding this matter at any later date. The lack of permanent staff was a concern identified to inspectors throughout the inspection by relatives and staff. Inspectors were not assured that there was a comprehensive understanding of what constitutes a complaint and the necessity to record complaints to ensure improvement in the service provided.

During the course of the inspection, inspectors observed the staff on duty to be knowledgeable of the needs of the residents and to engage with residents in a respectful and dignified manner. However notwithstanding this, practices which were described to inspectors were not indicative that the rights of residents were maintained and that the dignity of residents was preserved. For example, inspectors were informed that due to the presence of one staff member from 20.00 hours, residents' bedroom doors were left ajar to ensure that when the one staff member was supporting a resident with personal care they could be aware of the other residents. There were also

documented incidents of 'near misses' for a resident who had slid out of bed in the middle of night. In each incident the staff member was able to support the resident before the resident fell to the floor. Inspectors queried this practice as there had been no manual handling assessment completed for the resident. They were informed that there had been a hoist present which had been removed due to the absence of assessment and in the interim the informal arrangement would be to contact the neighbouring house to seek assistance. Due to the absence of risk assessments, and considering the number of 'near misses' inspectors determined that this was not only a disproportionate management of risk but also compromised the dignity of the resident who could potentially have to lie on the floor for an undetermined period of time.

An action arising from the previous inspection was that staff were utilising the en suite of a resident for their own use. Inspectors found that this practice had yet to cease, as inspectors were informed on inspection to use the en suite for their personal use.

Inconsistent staffing and an absence of appropriate action following incidents of behaviours that challenge also impinged on the rights of residents. For example, inspectors reviewed documented incidents in which residents had become physically assaultive towards other residents due to infringement of their personal space. This was a documented trigger for the resident to engage in assaultive behaviour. Staff described to inspectors their methods to try manage the behaviour, however the challenges posed by environmental factors and insufficient staffing diminished their ability to adequately manage the situation. This resulted in the incidents reoccurring. There was no evidence that an assessment had been conducted to ascertain if the residents residing together was appropriate and inspectors were informed that whilst not ideal, the residents would be going on holiday together due to an absence of resources.

There had been an increase in the activities available to residents since the previous inspection in December 2014. Inspectors reviewed a sample of activity records and found that in the main, residents were supported to engage in activities on a daily basis. However the evidence did not support that the activities in place were in line with the interests and the capabilities of residents. For example, inspectors observed residents being supported to collectively go for a walk/drive based on the staff present as opposed to an assessment of their interests. Inspectors observed that the absence of consistent staff was a fundamental factor that prevented advance planning which resulted in activities being planned on a day-to-day basis as opposed to inline with the assessed needs of residents.

Judgment:
Non Compliant - Major

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:
There was a policy in place regarding communication as required by Schedule 5 of the regulations. Residents residing in the centre each had unique communication needs which included verbal and non verbal methods. Staff were familiar with the needs of the residents and assisted inspectors to communicate with residents. There was also a communication profile in place which assisted inspectors in engaging with residents regarding their likes and dislikes. The absence of continuity of care due to inconsistent staffing levels was identified as a concern by family members as knowledge of the residents' means of communication was essential to meeting their needs.

Inspectors observed a television and radio in the designated centre.

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:
Family members stated that they were always welcome in the designated centre and inspectors observed that a record of visitors was maintained in the designated centre. A policy was also in place as required by Schedule 5. There was a record in place which evidenced that families were informed of changes to the care of their loved one such as hospital appointments.

Inspectors reviewed the links that residents had with the local community and found that whilst improvements had been made since the last inspection, further work was required to ensure that residents had the opportunity to actively engage in their local community based on their interest levels. This was further confirmed by speaking to relatives regarding the interests of their family members.

Judgment:
Non Compliant - Moderate

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):
No actions were required from the previous inspection.

Findings:
There was a corporate policy on the admission and discharge of residents within designated centres. However inspectors found that this did not provide sufficient information on the standard operating procedures in place in the centre. There was also evidence that residents were admitted to a house based on vacancies arising as opposed to if the assessed needs of the resident could be met in line with the Statement of Purpose of the designated centre. Family members stated that they were included in the decision making process regarding the admission of their loved one.

Written agreements had been issued as required by Regulation 24 to be signed by family members and had been returned signed. However from a review of a sample of the agreements, inspectors found that this exercise had been task orientated as opposed to actively ensuring that compliance with Regulation 24 was achieved and that the agreements adequately addressed the care and support to be provided to residents. There was also an absence of the additional fees and charges that may be applied to a resident. In some instances the name of the resident was absent from the contract and there was no signature of a representative of the Health Service Executive present, which invalidates the document.

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

Findings:
Inspectors reviewed a sample of personal plans of residents, and found that whilst improvements had been achieved since the last inspection, non-compliance remained with Regulation 5. Assessments had been completed for residents. Subsequent plans of care/person-centred plans were developed depending on if it were aimed at addressing a health or social care need. The person-centre plans of residents were presented through pictures. Inspectors found that the effectiveness of the documents were reduced, however, as they were in the main, based on available resources as opposed to a comprehensive assessment of the needs/wants of residents and their families, or led by expectation and lifelong learning and development.

There was also evidence that personal plans were not working documents as in some instances they had not been updated annually as required by regulation. Some personal plans had been completed one week prior to inspection by staff on days when they were not due to be working. This was due to an absence of capacity to complete same during their standard working hours. A further risk identified by staff was that due to the absence of a clear system, personal plans contained numerous documents. Inspectors experienced that it took two hours to read the documents in order to understand the needs of residents. Considering the absence of permanent and consistent staffing, the information was not presented in a manner to ensure consistency of approach and fundamental assurance of safe care. Efforts had been made to provide additional information in a concise format as staff recognised this risk. However this information lacked sufficient detail.

Access of allied health professionals for residents had improved. There was evidence that referrals had been made by staff as a need arose. However, there was a lack of documentary evidence to support that the recommendations were consistently implemented in practice and the effectiveness of same. This is further evidenced in Outcome 11.

The procedures in place regarding the temporary absence of a resident were inadequate and did not promote safe practice. For example, if a resident who was prescribed medication as required in the event of a seizure, was not provided with this medication if they were out with family and friends. There was an absence of rationale/risk assessment to support the practice. Therefore inspectors identified non-compliance with Regulation 25 (1).

Judgment:
Non Compliant - Major

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

Findings:
The designated centre consisted of two community houses located on the outskirts of a town in Westmeath. Each house is a bungalow which had five bedrooms, a kitchen/dining room and sitting room. One house had two communal bathrooms and the utility room was an outside storage area. The second community house had one communal bathroom, an en suite off one bedroom, a utility room and a small conservatory area. Inspectors observed the two community houses to be clean and suitably decorated, and reflective of a home environment. The kitchen facilities were adequate to meet the needs of the residents residing in the centre. Residents' bedrooms were personalised. There was also adequate heating and lighting on the days of inspection.

Each house also had external grounds which had been adapted for accessibility.

Inspectors were not assured that the layout and communal space within one of the community houses was sufficient to meet the needs of the residents. For example, in one of the community houses one sitting room posed a challenge in supporting one resident to access media of their interests. In the second community house, inspectors were informed that a resident often chose to be alone within the sitting room which resulted in limiting access of other residents to that room.

Inspectors reviewed a sample of assistive equipment and found that they were well maintained.

Judgment:
Non Compliant - Major

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

Findings:
The designated centre had policies and procedures in place regarding the health and safety of residents, staff and visitors. The centre had a risk management policy in place and a risk register. Inspectors noted that improvements had been achieved in the documentation of risk, however further work was required to ensure that the documentation demonstrated that identified controls were measurable and promoted accountability. Notwithstanding the improvements identified in the documentation, the cumulative findings of this inspection demonstrate that there was an absence of proportionate actions in place to effectively manage the safety and welfare of residents and staff. In the main, any actions in place were reactive and task orientated as opposed to a proactive systematic approach to risk management. Examples of this included:

•An absence of appropriate risk management in place to respond to staff absenteeism
•An absence of assessment to support staffing levels and skill mix in the context of residents' individual and collective needs
•An absence of robust policies and procedures and actions to support staff lone working
•An absence of risk assessment and appropriate concomitant control measures regarding the administration of medication

As a result of this, an immediate action was issued on the first day of inspection to the provider nominee in respect of Regulation 26 (2). The regional director of nursing responded by 18.00 hours to state that an additional staff had been allocated in response. However inspectors were not assured by the sustainability of this action going forward, as there remained an absence of staff allocated to support residents in the coming weeks without considering the additional staff member committed by the provider in response to the immediate action.

There were policies and procedures in place regarding infection control. As stated previously, inspectors observed the designated centre to be clean. There were cleaning schedules in place and of the sample staff training records reviewed, staff had received training in infection control. One area requiring review was the use of a commode and the systems in place to ensure appropriate cleaning of same.

The designated centre had procedures in place for the prevention and management of fire. Inspectors reviewed records which confirmed that fire equipment inclusive of emergency lighting and fire extinguishers were serviced and checked at appropriate intervals. In recent months, refurbishment works had taken place in both community houses to ensure that the appropriate mechanisms such as fire doors with self closers had been installed. This also included the adaptation of fire exits to ensure that they promoted safe accessibility of all residents. Inspectors found however, that there was a risk present on the day of inspection. For example, in one of the community houses a resident's bedroom was off a utility room which contained the expected utilities such as a washing machine and dryer. The self closer to the resident's room was broken, which

resulted in the door remaining ajar. Inspectors queried how long this had been broken and were informed that staff had escalated the issue to the appropriate department two weeks prior to inspection. Considering the location of sleeping accommodation to a high risk area in respect of fire management, inspectors found that this timeframe was inadequate and did not demonstrate appropriate fire management practices. Inspectors also observed that the front door in one community house, which was a primary final exit for evacuation from four bedrooms, was key operated. There was a break glass unit beside the front door however the key was missing therefore invalidating the control measure.

Of the sample of staff records reviewed, inspectors confirmed that staff had received training in the prevention, detection and management of fire. Fire drills were also conducted on a regular basis in the designated centre. However, inspectors were not assured of the effectiveness of the fire drills. This is as, they did not demonstrate that the highest number of residents could be evacuated with the lowest complement of staff to an area of safety within an appropriate time frame. This concern was one piece of evidence which contributed to the immediate action being issued in respect of Regulation 26 (2) on the first day of inspection.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Relatives interviewed stated that they felt that their loved ones were safe and well cared for. The organisation had policies and procedures in place for the safeguarding of vulnerable adults and staff had signed to state that they had read the national policy launched in December 2014 by the registered provider.

An absence of appropriate systems to safeguard residents was a finding on the inspection which involved one of the community houses that was conducted in December 2014. At that time, the provider responded by stating that all staff would

receive training in the protection of vulnerable adults by 31 December 2014. Inspectors requested the training records in respect of same and found that this action had not been implemented, with records stating that training had been provided to two staff employed in the designated centre since the last inspection. Inspectors determined that this was a disproportionate response and management requesting that staff read the policy was not adequate. There was evidence of one resident who regularly presented with bruising. Inspectors reviewed the records in respect of same and staff stated it was their considered opinion that this was due to the manual handling needs of the resident. Inspectors were not assured, however, that this had been appropriately investigated to confirm that this was the rationale and that the appropriate control measures had been implemented to reduce the number of incidents documented.

Two actions had been identified in December 2014 in respect of positive behaviour support. Inspectors reviewed a sample of residents' records and identified improvements in service provision for individual residents that inspectors had identified on previous inspection. However actions from a governance and management approach were inadequate to ensure sustained improvements and positive outcomes for all residents. For example, as stated in the action plan response, residents had received support from allied health professionals and in some instances there had been a reduction in the number of incidents recorded for individual residents. However notwithstanding this improvement, inspectors identified other residents who engaged in incidents of behaviours that are challenging. Factors had been identified which could trigger socially inappropriate behaviour and proactive and reactive strategies identified for individual residents. However there was an absence of evidence to support that fundamental actions which could assist with improving the quality of life of residents had occurred, inclusive of the living environment and the actual staff supports the resident required. Staff had also not received the training as stated in the action plan response from the failings identified in December 2014.

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:
Safe Services

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

Findings:
There was an accident/incident log maintained in the designated centre. However, notifications were not submitted to the Authority as required. On the first day of inspection, the Authority received notifications as required by Regulation 31 in three

working days. However the incidents had occurred a minimum of two months prior to the inspection. Notifications required to be submitted on a three monthly basis had also not been submitted.

Judgment:
Non Compliant - Major

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
As stated in Outcomes 1 and 5, there had been improvement identified in the opportunities residents had to access activities in the local community. There had also been improvement in the development of goals for residents. Inspectors found, however, that in the main they were not reflective of lifelong learning. Inspectors further found that of the individual goals identified for residents, the supports required to achieve the goals were absent due to staffing levels and the subsequent lack of capacity to proactively plan with residents.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Residents had regular access to their general practitioner and if a need was identified for further intervention it was provided. There was a record maintained of all medical interventions provided to residents and families stated that they were informed and involved in the decision making process in respect of same. However, inspectors found facilitation of healthcare needs was due to frontline staff facilitating appointments outside of their contracted working hours, as opposed to the registered provider having the appropriate mechanisms in place to ensure that the healthcare needs of residents were being met. Inspectors also found that a risk was in place to residents who required nursing care, as per the internal policies of the registered provider. In response to the failings identified in December 2014, the registered provider had stated that a risk assessment had been conducted in respect of staffing levels in one of the community houses. No actions arose following this assessment. However on this occasion, inspectors issued an immediate action in respect of staffing levels. There was also a risk identified as nursing staff from one community house was leaving every evening to administer medication in the other community house. This resulted in staff who were not trained in the administration of medication as required in the event of a seizure supporting five residents. Two of who had received medication as required on numerous occasions due to the frequency and severity of their seizure activity. No risk assessment had been conducted in respect of this matter. Inspectors were also concerned regarding the supports to residents who were temporarily absent from the designated centre, in respect of their healthcare needs, as stated in Outcome 5.

Inspectors observed the mealtime experience and found it to be very pleasant. However they did observe one resident choosing to eat outdoors. Staff stated that this was the resident's decision as they enjoyed the outdoors and sometimes they found it too noisy in the kitchen/dining area. Staff were observed to be respectful of the needs of residents and attended to their needs in a timely and appropriate manner. There was also evidence to support that residents were included in the preparation of meals.

There were residents who were identified as requiring supports to ensure that their nutritional needs were being met. There had been referral and assessment by the appropriate allied health professionals in respect of this. However, as stated in Outcome 5 improvements were required in the evidence to support that the recommendations were consistently implemented in practice and that the interventions were effective. Records of the food residents received were maintained in the centre; however, on review inspectors found that they did not adequately reflect the nutritional intake of residents as per the recommendations of allied health professionals. There were also inadequate parameters in place to guide staff on the action to be taken in the event of a further deterioration or absence of improvement in residents' conditions.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The centre had policies and procedures in place regarding medication management, however, they were dated 2010 and did not reflect the practice of the designated centre.

Inspectors reviewed a sample of the prescription and administration records for residents' medications and found that they contained all of the necessary information inclusive of name, date of birth and a photograph of the resident. There was also a signature of the prescriber present for each individual medication and for medication which had been discontinued. The designated centre had a system in place in which medication is collected on a weekly basis from the pharmacy. Inspectors were informed that the medication is counted by the receiving nurse as a safeguarding measure. The practice within the designated centre is that medication can only be administered by a registered nurse. In one of the community houses there is no nursing staff on duty from 20.00 hours. Therefore medication prescribed to be administered at 21.30 hours is administered by the nursing staff on duty attending from the other community house. Inspectors found that this presented a risk, as stated previously, as it resulted in one staff member who had not received training in the administration of medication as required being responsible for residents who had a frequent history of requiring same.

Inspectors conducted a stock check of a sample of medication during the course of the inspection and found that there was an overstock of one medication for an individual. In conjunction with the nurse on duty, inspectors compared this with a record of medication received and found that on one day a resident had received half of the prescribed dosage of that medication. The nurse on duty took the appropriate course of action once the medication error had been identified by the inspector.

Judgment:
Non Compliant - Major

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:
As part of the application to register the designated centre, the provider was required to submit a Statement of Purpose to the Chief Inspector. Inspectors reviewed the Statement of Purpose and found that whilst it contained all of the necessary information as required by Schedule 1, the information was not reflective of the practice of the designated centre. For example, the Statement of Purpose states that there are 25 staff employed to provide direct support to residents. However from a review of the roster and training records, inspectors found that there were 19 staff employed. The Statement of Purpose also stated that the person in charge was an individual who was no longer employed in the service. The governance structure referenced an individual who was no longer involved in the service. The cumulative evidence of this inspection also demonstrated that the service was not meeting their aim 'to respond to the evolving needs of individuals in a safe and positive environment' as stated in the Statement of Purpose.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge commenced their post in the designated centre in June 2015. The person in charge had the necessary experience and qualifications to fulfil the role of person in charge as required by Regulation 14. The person was absent on the days of inspection, therefore inspectors were not in a position to assess their knowledge of the regulations and their statutory responsibility. However inspectors were informed by staff that as the person in charge was included in the compliment of staffing for one of the community houses, their engagement in the governance and management of the second community house was negligible.

The person in charge reports to the assistant director of nursing, who in turn reports to the regional director of nursing. The regional director of nursing reports to the general manager. The general manager is the person nominated by the provider for the purpose of engaging with the Authority.

There were two actions arising from the previous inspection. The first failing of regulation was that inspectors determined the management systems were ineffective and did not ensure safe and quality services for residents. Based on the cumulative findings of this inspection, inspectors determined that this action had not been adequately addressed. Inspectors found that when the person in charge was not on duty, there was no procedure in place for management to be assured that the care provided to residents was safe and effective.

There was also an absence of a review of the quality and safety of care in the designated centre. Whilst some audits had been done, they were completed at a local level and did not account for the findings of this inspection. In the main, consultation between the person in charge and provider was done during a collective person in charge meeting each week in which management directed all persons in charge in the region on actions to be taken. There was evidence of inadequate supervision or support provided to the person in charge to ensure their understanding of regulation or the quality of care received. Inspectors found that the risk was compounded by the absence of standard operating procedures in all areas to guide practice and ensure accountability. Furthermore family members had not been informed of changes to the management team and were not clear on the members of management team.

There had been no annual review of the safety and quality of care which had been identified as a failing in December 2014.

Judgment:
Non Compliant - Major

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:
The person in charge had not been absent for more than 28 days since they commenced their post. Therefore there was no requirement to notify the Chief Inspector as required by Regulation 32.

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:
Major non-compliance was identified in the use of resources on the last inspection, as the evidence did not support that the skill mix and competency was adequate to meet the needs of residents. There was also a delay in referrals to the appropriate allied health professionals for residents in respect of positive behaviour support. As stated previously the action in respect of support from allied health professionals had been adequately addressed. In response to the action plan response from the last inspection, the provider stated that following the inspection, an assessment of need had been conducted. There had been no changes to staffing following on from that assessment in respect of this designated centre. On this inspection an immediate action was issued due to inspectors identifying insufficient staff. In conjunction with this, the total number of staff employed in the centre was less than that required to meet the needs of residents. Therefore the failing is repeated at the end of the report.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors confirmed that there was an actual and planned roster in place in the designated centre. However on review of the roster, it was apparent that the centre did not have sufficient regular staff in active service and as a result relied on the provision of staff who were employed by external companies. This resulted in inspectors identifying that in the coming weeks there were multiple days in which the core staffing had yet to be determined due to insufficient staff. As stated previously, five hours prior to a shift commencing a second staff member had yet to be secured for a shift which had been committed by the provider to the Chief Inspector in response to an immediate action the day previous. The immediate action was a failing of Regulation 15 (1) and is included in the action plan at the end of this report.

There were five failings identified in respect of this outcome in December 2014. Due to the cumulative findings of this inspection, four of the failings are repeated at the end of this report as:

-There remained an absence of risk assessments to evidence that the staffing levels and skill mix were appropriate to meet the needs of residents
-Due to the internal policies of the centre nursing care was not always available if required
-Inspectors were not assured that agency staff and staff deployed from other designated centres had the necessary knowledge to provide safe and effective services for residents
-There was no evidence of staff supervision

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed the documents in respect of Schedule 3 and Schedule 4 and found that whilst they were maintained, improvements were required to ensure that compliance with the regulations was achieved. For example, information held in respect of care provided to or required by residents had not been reviewed within an appropriate time frame. Medication records stated medication had been administered which had not been. There were also insufficient records maintained to evidence that the food provided to residents was in line with their nutritional needs.

A review was required of the policies as required by Schedule 5 in the designated centre. The medication management policy had not been reviewed since 2010. The policy in respect of the admissions, discharge and transfer of residents did not sufficiently inform of the practice to be implemented in the designated centre. The policy for the creation, access to, retention of, maintenance of and destruction of records did not relate to the designated centre.

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:

Jillian Connolly
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-0004904
Date of Inspection:	22 September 2015
Date of response:	20 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:
Due to environmental factors and staffing levels, situations which were known to trigger assaultive behaviour were reoccurring.

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

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
Improve staffing levels and consistency of staff to a standard that assists in the prevention of assaultive behaviour reoccurring - 22/09/2015

Training is scheduled for in behaviour management which is specific to individual residents - 26/11/2015

Meetings with behavioural therapists to commence in respect of the care and behavioural needs of individual residents - 09/11/2015

Proposed Timescale: 09/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' privacy and dignity was compromised as:
- residents' bedroom doors were ajar during personal care
- inspectors were instructed to use the private en suite of a resident
- there was an absence of assessment and appropriate control measures to safeguard residents' dignity

2. 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 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:
Manager has advised all staff at staff meeting that it not appropriate to use residents' en-suite bathrooms. Completed 9/11/2015

Doors to residents' rooms are no longer left ajar during personal care times or at night since the appointment of a second healthcare assistant to the night roster. Completed 22/9/2015

Training for staff on HSE Policy in relation to the Privacy and Dignity of Residents has been scheduled for Friday 20th November. Timescale 27/11/15

This issue will now form a core agenda topic at the House meetings which are to be held twice monthly commencing 01/12/15

Risk assessments are in place for all residents.

Manual handling assessments completed for all residents - 24/09/2015

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to an absence of resources, there were inconsistent opportunities for residents to partake in activities in line with their interests and capabilities.

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

Please state the actions you have taken or are planning to take:
Improved staffing levels and consistency of staff has improved the opportunities to support residents to partake in activities. Timescale - 22/09/2015

Key workers are beginning the process of reviewing the needs assessments in line with interests and capabilities in person centred plans, in consultation with resident. Staff will be supported in this through the use of the PAL tool which will identify activities appropriate to each resident based on their individual abilities. Timescale - 15/12/2015

Key workers will review all individual needs assessments in line with interests and capabilities in person centred plans, in consultation with resident and families. 31/03/2016

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Areas of dissatisfaction were not documented as complaints. There was no evidence that potential complainants were supported to familiarise themselves with the complaints procedure.

4. Action Required:
Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
Training for staff in recognising and managing complaints has been scheduled for handling complaints.

Managing complaints will now become an agenda item at the House meetings which are to be held twice monthly - Commencing 01/12/15

A complaints log will be kept up to date in both houses. Immediate

Proposed Timescale: 01/12/2015

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

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Notwithstanding the improvements identified, residents did not have consistent access to the wider community.

5. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
Residents currently have access to the wider community through attendance at religious services, visiting restaurants, local library & shopping trips, swimming pool, cinema, bowling, Bingo.

Two residents now attend local active retirement group which facilitates participation in choir, knitting club.

One resident has commenced work experience in charity shop once per week.

Another resident is attending a resource centre five days a week, another two residents attend twice weekly and another resident has day service three afternoons a week.

It is planned to introduce another two residents to retirement group Art classes.
One resident has planned to go holidays. Date 23rd November 2015.

Agreement has been made with the local GAA club to facilitate activities for 1 resident with a special interest in that field. Have been organised from 1st December 2015.

In other house one resident is attending a resource centre three times a week.

An assessment process in underway for another two residents to facilitate additional day service.

One resident is preparing for mini marathon to raise awareness and support for breast cancer survivors.

While an Out Reach Programme has been in place since September at very low intensity some clients have chosen not to engage with the Out Reach programme on some days.

While a time table of such activity is available at one House it is not formally structured. This will be reviewed by the PIC.

Proposed Timescale: 15/12/2015

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:
Admission to the designated centre appeared to be based on a vacancy as opposed to meeting the assessed needs of residents.

6. Action Required:
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
The policy for admission to HSE ID residential services has been updated and will determine the criteria for admissions to the House in line with an updated Statement of Purpose. Complete 31st October

Changes to contracts of care have been agreed with Finance Manager to include charges following financial assessment. Completed: 13/11/2015

A full review of contracts of care has being carried out to identify gaps in relation to same. Completed: 01/12/2015

Work has commenced to ensure all contracts are signed with the appropriate attachments. We still awaiting signing by a number of families. Contracts of care will clearly outline the financial contribution from each resident as outlined by the Disability Finance Manager to incorporate with charges to add to contract of care (in respect of financial assessment / charges.

Proposed Timescale: 31/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of names and signatures on the sample of written agreements reviewed.

7. 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:
All contracts of care being reviewed.

Proposed Timescale: 01/12/2015

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:
Some personal plans had not been updated annually as required by regulation.

8. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
Care plan training has commenced for nursing staff commenced 19/10/2015

Care plans reviews have commenced and will be updated to reflect best practice commenced 15/12/15

Key worker to review needs assessments in line with interests and capabilities in person centred plans, in consultation with all healthcare professionals commenced 15/12/15

Annual care plan update completed for all care plans commenced 01/12/2015

In another residence the process of individualising needs assessments is ongoing.

This will include updating and refreshing care plans, risk assessments, PCP's.
This process will be finished on 1st December.

Proposed Timescale: 15/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The arrangements to meet the needs of residents were inappropriate.

9. 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:
Care plan reviews have commenced and will be updated to reflect best practice in relation to both health and social care needs. These will include assessment of capabilities to support the residents in achieving individual goals and activities most suited to their abilities. This review will take a multidisciplinary team approach which will ensure that all the residents' needs are identified and will ensure the appropriate involvement of the relevant discipline required. Timescale January 2016

The ID residential service in the Midlands is currently in the process of developing a new format for Care Planning. This will include an index system which will improve the navigation of the individual care plan. Final sign off is awaited prior to print run. Timescale: 28th February 2016.

An SOP has been developed for when resident leaves the building with either staff or friends or relatives. Timescale 4th January 2016

Proposed Timescale: 28/02/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Plans of care did not consistently outline the necessary supports required to meet the identified/assessed needs of residents.

10. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
The process of reassessing 5 residents is taking place in one community house and is up to date in other community house.

Proposed Timescale: 01/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The appropriate supports were not in place if a resident was absent from the designated centre on a temporary basis.

11. Action Required:
Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

Please state the actions you have taken or are planning to take:
A Communication/Hospital Passport is in place for all residents which identify the needs/likes/dislikes for each resident as well as documenting their care needs.

Proposed Timescale: 13/01/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre did not meet the needs of some of the residents residing there.

12. 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:
A full OT assessment of clients' needs has been carried out to ensure that the facilities in the house appropriately meet their needs. Facilities in house 20th February 2016

Recommendations have been made to identify improvements required. Work has commenced to address these issues. Consideration of alternative accommodation for one resident: 30th Sept 2016

Proposed Timescale: 30/09/2016

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:
Evidence did not support that the practices in place in respect of fire safety, administration of medication and lone working had been adequately assessed. Therefore there was an absence of control measures in place.

13. 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:
Fire drills take place on a regular basis including at night - Complete and on-going
Increased staffing has ensured that medication management Night staff manager administers medication in night - 01/10/2015

Refresher training on the use of Ski sheets has been scheduled - 03/12/2015

Due to the increased staffing levels lone-working is no longer an issue in the centre - 22/09/2015

Risk management training will be provided for the 4 staff that had not completed it - 31/01/2016

System for responding to emergencies is in place in both houses - 30/09/2015

The fire safety issue in relation to the exit door has been addressed - 30/09/2015

Daily and weekly fire checks are carried out in the Houses - Ongoing

Proposed Timescale: 31/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required in respect of the cleaning of a commode.

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

Please state the actions you have taken or are planning to take:
An SOP is now in place to inform staff of the appropriate guidelines in relation to the management and hygiene practices for use of commodes. Timescale: Complete
The OT Assessments of residents will identify the required works in relation to bathroom facilities at the Centre. Timescale: 20th December 2015

Proposed Timescale: 20/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The self closer to the resident's room was broken for a two week period, which resulted in the door remaining ajar.

15. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
The self closer alluded to in the report was repaired on the 23rd September 2015.
All spring closers have also been reviewed.

Both houses have the correct equipment to manage the risk of fire.

Proposed Timescale: 23/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Keys were missing from the break glass units.

16. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Key was returned to the break glass unit from 23rd September 2015.

Emergency lighting is working and in good condition in both houses.

Daily and weekly fire checks are carried out in the Houses - Ongoing

Proposed Timescale: 23/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire drills did not evidence that the residents with the greatest dependency could be evacuated to a place of safety with the lowest complement of staffing.

17. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
Fire drills are carried out in one house every Sunday Night.

They are facilitated with different numbers of staff.

In other house the fire drills are also done and recorded on regular basis with different members of staff involved in conducting them.

Fire drills in both houses have established that staff will be able to evacuate safely in the event of an emergency.

During mock evacuations staff practise using a Ski Mat during day time.

Training on use of Ski Pad took place on 03/12/2015.

A safe venue has been identified for residents in the case of an emergency evacuation**.**

Proposed Timescale: 03/12/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Every effort had not been made to alleviate the cause of a resident exhibiting behaviour that is challenging.

18. 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:
Behaviour Management Support Team provide training in each house.
Training is schedule for 26th November 2015 around individual resident needs in one house.

In other house meeting is scheduled for 9th December 2015 with behaviour therapist. Behaviour plan in place with on-going review.

Proposed Timescale: 09/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received training in the protection of vulnerable adults as stated in the action plan from the previous inspection.

19. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
The training has been completed for all staff with the exception of a member of staff coming back from sick leave. This training will be provided on return from sick leave.

Proposed Timescale: 30/12/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Notifications had not been submitted to the Chief Inspector as required by the regulations.

20. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
Training has been provided for staff in relation to requirements to HIQA
All notifications will be sent to HIQA within the required time.

Proposed Timescale: 18/12/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been improvements in the provision of skills development however it was inconsistent.

21. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
PAL assessment are planned for all residents as part of the updating of Care Plans
In the meantime it should be noted that:
One resident attends work experience in local shop.
A number of residents attend a Resource Centre.
One resident is due to start work experience 1st December.

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that the systems in place to support residents' access to healthcare could be facilitated.

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

Please state the actions you have taken or are planning to take:
All residents are registered with local GP, regular health checks are done annually or as need arise, bloods are done on regular basis if the need arises.

Improved staffing levels has ensured that residents are facilitated with appointments as required by staff on duty.

Medication is reviewed every 6 months. Medication was last reviewed in November 2015.

Proposed Timescale: 30/10/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication management practices were unsafe.

23. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Weekly spot check audits are done by PIC, new audit sheets have been developed by PIC.

In one house there are new MAR sheets in place since 14th October 2015.

All medication is provided by local Pharmacy on weekly basis.

Medication Audit is done by Pharmacist every 6 Months in both houses.

In other house new system of MAR sheets will be in place from Mid December 2015.

Proposed Timescale: 20/12/2015

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:
The Statement of Purpose did not contain accurate information as required in Schedule 1.

24. 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:
The statement of purpose has been reviewed and updated for accuracy as per Schedule 1 and will be submitted to HIQA

Proposed Timescale: 08/01/2016

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:
As of the time of writing this report the application to register the designated centre remained incomplete.

25. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The outstanding fees in relation to the registration of the designated centre to be paid to HIQA. Timescale - 23/10/2015

Proposed Timescale: 23/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of evidence to identify the lines of accountability and responsibility assigned to individuals participating in management.

26. 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:
The governance structure for the Centre identifies that:
There is nominated PIC for the Centre
There is a new nominated PPIM working fulltime in the second house
In their absence the Staff nurse on the day is the person in charge in each house.
Training has been provided on the role and responsibilities of the PPIM on the 4th and 5th November.
Training will be provided for the PIC

Proposed Timescale: 04/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on the cumulative findings identified on this inspection and the repeated failings of regulation identified, inspectors determined that the management systems were ineffective and did not ensure safe and quality services for residents.

27. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
A new governance structure has been put in place both at Regional and local level to support the work in the Centre.

Training is being provided for staff in a wide range of areas where deficits have been identified

Proposed Timescale: 13/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the safety and quality of care provided.

28. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
Audit of care plans has taken place in one centre on 18 November 2015

Further Medication audits planned week commencing 23 November 2015

Full 12 month audit planned before year end

Proposed Timescale: 23/12/2015

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the staffing level, skill mix and competency were appropriate to meet the needs of residents.

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

Please state the actions you have taken or are planning to take:
Rosters are in the houses which now support one Staff Nurse and two HCA during day duty from 08:00am until 20:00pm in both houses.

In one house there is one Staff Nurse and one HCA during night time from 20:00 pm until 08:00am as per residents needs, in other house there are two HCA and medication are given by Night Manager Staff Nurse/CNM.

Newly appointed PPIM is a q qualified nurse with managerial experience.

QQI (FETAC) Training, commencing 27 November 2015 for Care staff.

Two staff members fully trained on Buccal Midazolam (HCA and nursing) at all times day and night. BM training on going all will have received this training by 24th November 2015.

Proposed Timescale: 27/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on the identified need of residents, as evidenced by inspectors through documentation, interviewing staff and observation, there were insufficient staff with the appropriate skills to ensure residents are safe and needs were met.

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

Please state the actions you have taken or are planning to take:
Rosters are in the houses which now support one Staff Nurse and two HCA during day duty from 08:00am until 20:00pm in both houses.

In one house there is one Staff Nurse and one HCA during night time from 20:00 pm until 08:00am as per residents needs, in other house there are two HCA and medication are given by Night Manager Staff Nurse/CNM.

Newly appointed PPIM is a q qualified nurse with managerial experience.

QQI (FETAC) Training, commencing 27 November 2015 for Care staff.

Proposed Timescale: 27/11/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the internal polices of the designated centre, nursing care was not provided when required.

31. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
In two houses there is one Staff Nurse and two HCA during day duty from 08:00am until 20:00pm. In one house there is one Staff Nurse and one HCA during night time FROM 20:00 pm until 08:00am as per residents needs, in other house there are two HCA and medication are given by Night Manager Staff Nurse/CNM.

New PPIM appointed
Two staff nurse due to commence January
Two HCA'S have returned back from sick leave whom were absent during audit.

Proposed Timescale: 04/01/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that staff not employed to work directly in the designated centre had the necessary knowledge to provide safe and effective services for residents.

32. 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:
In both houses there is core staff employed on regular basis including agency staff who are on line system. Staff (including agency staff) are undergoing extensive training since Inspection to be compliant with the regulations and to ensure best practice is in place.

Supervision Meetings with PIC's commencing on 20th November. These meetings will roll out over an 8 week period. At these meetings A/DON will ensure that all PIC's will cascade the practice of supervision to all staff members.

Proposed Timescale: 28/02/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of staff supervision.

33. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Staff supervision will commence in the designated centre with effect from 01/03/2016.

Training in Supervision and Performance Management has been scheduled for the Person in Charge of the designated centre for 24th February 2016.

All staff in the designated centre will have staff supervision completed by 30/04/2016.

Proposed Timescale: 30/04/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Policies did not sufficiently guide practice.

34. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:
Working Group is working on policies and the following have been completed
Medication policy
Admissions discharge policy
Retention of Documents policy

Training will be provided on Schedule 5 policies to all staff

Proposed Timescale: 28/02/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication management policy had not been reviewed within three years.

35. 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:
A new medication management has been be finalised and is in place and being implemented in the Centre.

Proposed Timescale: 04/12/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in the documentation maintained in respect of residents.

36. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
Audit of information currently on file will be carried out by the ADON / PIC and PPIM. Remedial action to be taken where gaps are identified

Proposed Timescale: 15/12/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records maintained in respect of the food offered to residents, did not demonstrate that the nutritional needs of residents were being met.

37. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Menu planning training has been provided for staff in one house and is planned for the staff in the other house.

Food choices and menus are in development in line with residents' preference and health needs.

Dietary intake and times of meals are being recorded in each resident's care plan.

Proposed Timescale: 04/01/2016