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:	Ash Services
Centre ID:	OSV-0004055
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Ability West
Provider Nominee:	Frances Murphy
Lead inspector:	Thelma O'Neill
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
15 September 2016 10:30	15 September 2016 17:30
16 September 2016 09:30	16 September 2016 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the second inspection of this designed centre. This follow-up registration inspection was carried out to monitor compliance with the regulations and to review the management of safeguarding plans recently submitted to HIQA. In addition, the inspector reviewed the actions taken to address the non compliances identified on the last inspection.

How we gather our evidence:
The inspector spent time with the 11 residents living in this centre. The residents whom the inspector met with were unable to verbalise their opinion about the quality of the service received, but generally appeared relaxed and staff told the inspector that residents were happy in the centre.

The inspector also met the person in charge, staff members and senior managers. The inspector also reviewed documentation such as personal plans, fire records, risk management documentation, policies and procedures, and residents' health and medication records.

Description of the service:
This centre comprised of two purpose built houses and was located in a small town in Co. Galway. Five residents resided in one house and six residents resided in the other house. In addition respite services were provided for up to 12 residents. There was also a vacant apartment in house one that was used occasionally by one respite resident.

Each house contained adequate communal and private accommodation and the centre had been designed around the needs of residents'. Each resident had an individual bedroom and access to shared bathroom facilities. Bedrooms were suitably decorated and some residents had personalised their rooms for the duration of their stay.

The individuals living in or receiving respite in this service had a daily routine Monday to Friday that involved attending day services or work placements. The residents participated in social activities and goals as they wished and were well supported by day and residential staff. Each resident had a separate bedroom and had keys to their bedroom doors which ensured their privacy and dignity.

Overall judgment of our findings:
Ten of the previous fourteen actions were not complete. Failings were identified on this inspection in relation to safeguarding vulnerable adults, health and safety and risk management, medication management practices and governance and management. For example, frequent use of seclusion and restrictive practices were used as means of managing behaviours that challenge. These practices were not managed in compliance with organisational policies, procedures or national guidelines. The inspector also found that there was inadequate supervision provided to residents in this centre at night.

Two immediate actions were issued on the day of inspection. The first immediate action issued was in relation to the use of restrictive practices in the centre such as seclusion. The second was issued in relation to fire safety and evacuation procedures in the centre. Restrictive practices and fire safety management were found to be inadequate and put residents at risk. The provider was given five working days to put in place a safeguarding plan for all residents using this service. This was completed by the provider.

The findings of this inspection are discussed in more detail in each of the outcomes in the report. The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The inspector saw that some residents were encouraged to maintain their own dignity and privacy. For example, some residents had keys to their bedroom doors which were locked to maintain privacy and to ensure the safety of all residents' personal possessions. This was an action completed from the last inspection.

It was evident staff and residents knew each other well and staff were able to describe individual residents likes and dislikes to the inspector. They spoke about residents with respect and discussed positive aspects of the service provided in the centre.

However, some of the routines and practices in the centre did not promote residents' independence and choice. For example, the inspector observed residents whose choice and freedom of movement was restricted as a means of safeguarding residents from each other. The impact of such restrictions on all residents were not assessed which resulted in the residents' quality of life and choices being significantly reduced. This is discussed in more detail under Outcome 8.

There was a policy on maintaining residents' personal property and personal finances and possessions. Previously, at the last inspection, the inspector had found that improvement was required to the system in place for ensuring residents' money was kept safe through appropriate practices and record keeping. This action was reviewed on this occasion and found to be compliant.

There was an organisation advocacy service and external advocacy service available from the national advocacy service. However, there was no evidence that residents had

accessed these advocacy services, despite restrictions on residents' freedom within the house.

The inspector reviewed the management of complaints and found that the details of investigations, the outcomes of the complaints and whether the complainants were satisfied with the outcome of the complaints were not recorded. For example, in June 2016, a complaint was made by a family member regarding a safeguarding concern and the complainant was advised that a safeguarding plan was implemented and the complaint was closed. However, on review of the safeguarding plan the inspector found that some elements of the plan were not being implemented, as had previously been advised. This is discussed in more detail under Outcome 8.

The inspector found further evidence where complaints were not being appropriately managed. For example, there was a lack of written evidence of consultation with families where complaints were raised about the provision of equipment for their family members. Some of these complaints were on-going for a number of years and this was impacting negatively on the residents concerned.

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

Findings:
The inspector followed up on the two actions from the previous inspection and found that these remained outstanding.

The outstanding actions related to the lack of written agreements between the residents and the provider which detailed the support, care and welfare of the residents in this service. Despite written confirmation that this action was complete since the 22 December 2015 the inspector found on this inspection that not all residents had written agreements in place.

Furthermore, on the previous inspection, the inspector had identified that the residents' written agreements did not accurately detail the number of nights they were entitled to avail of the service. This had not been completed.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Each resident attended daily meaningful activities that were appropriate to his or her interests and preferences. Staff also told the inspector that some residents attended a local community gathering once a month where they enjoyed meeting their friends. Residents also attended bowling and socialising in the local community during respite admissions. One resident owned their own car and staff told the inspector that this vehicle had allowed them and other residents to socialise more frequently.

There were two actions issued following the last inspection that had now been addressed. These included the implementation of medical screening tests for some residents and the monitoring of residents weights regularly.

However, further areas for improvement were identified. The inspector found that the centre was not meeting the needs of all of the residents. For example, not all residents had up-to-date assessments to reflect their changing needs such as appropriate multidisciplinary assessments, such as physiotherapy, occupational therapy, and psychology reviews recorded in their personal plans. Furthermore, the compatibility of individuals living together was not reviewed following recent safeguarding incidents and appropriate safeguarding plans implemented to protect and safeguard residents.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
This centre comprised of two purpose built houses and was located in a small town in Co. Galway. Each house contained adequate communal and private accommodation and the centre had been designed around the assessed needs of residents. Each resident had an individual bedroom and access to shared bathroom facilities. Bedrooms were suitably decorated and some residents had personalised their rooms for the duration of their stay.

Two actions were issued following the last inspection. These related to the lack of appropriate assistive equipment to meet the needs of the residents and a lack of suitable storage in the centre. The storage issue had been resolved, the second action related to a specific floor level bed that was trialled and found suitable to meet the needs of the resident by the physiotherapist. However, this equipment was not supplied due to the lack of resources and concerns raised by family members. This issue remains outstanding.

On this inspection, the inspector noticed on entering one of the premises a strong odour around the house. There was also stain marks on the hallway carpet throughout the house. The person in charge acknowledged the odour and stains on the carpet and advised the inspector that they were seeking funding to replace the flooring.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There was one action relating to fire evacuation procedures to be addressed following the last inspection. The non compliance identified the lack of staff participation in fire evacuation procedures and the lack of evidence that residents could be evacuated in the event of a fire at night. This action was not complete.

On this inspection the inspector completed a review of the fire and individual evacuation procedures in the centre. Due to the seriousness of the findings an immediate action was issued to the provider on the first day of inspection. This was with regard to the risks identified in the procedures for evacuating residents. The inspector found that the most recent night evacuation had taken over six minutes to evacuate five residents, and two of the residents had refused to evacuate. This resulted in one resident being left in their bedroom to wait on emergency services as per their emergency evacuation plan In addition, there were no contingency plans put in place following the fire drill to ensure all residents could be evacuated safely in the event of a fire.

Furthermore, although residents had individual personal emergency evacuation plans (PEEPs) in place, some residents PEEPs did not outline their individualised support requirements in the event of an emergency evacuation of the centre. For example, residents' with a visual impairment or mobility difficulties evacuations plans did not specify all options available to assist them evacuate the premise in the event of an emergency evacuation.

Some residents required assistance with mobilising in this centre. The centre had policies and procedures in place to advise staff on safe moving and handling practices. Appropriate equipment was available such as ceiling hoists in each bedroom. During the inspection the inspector found improvements were required regarding the safe moving and handling techniques. The policies and procedures in place to promote safe moving and handing were not being implemented. In addition, the inspector observed poor moving and handling practices when staff were supporting a resident. Furthermore, the manner in which the resident was mobilised was not in compliance with a recent safeguarding plan submitted to HIQA.

The organisations' risk management policy on managing individual risks was not implemented adequately in the centre. For example, not all residents' risks were individually risk assessed or actions put in place to mitigate the identified risk. This was a requirement of a previous action plan response that remained outstanding.

The previous inspection found that there was significant restrictive equipment used in the centre. At the time of this inspection this equipment was still in use and the risks had not been risk assessed. For example, a resident's profiling bed had a steel frame with Perspex glass surrounding the four sides of the bed. The frame of the bed could be opened through two gate style side opening on the bed. Staff told the inspector this purpose made bed was for the resident's safety due to a medical condition. The inspector observed the resident in the bed and they appeared relaxed and were smiling. However, there was no evidence of a risk assessment to support the use of this restriction in terms of the resident's needs.

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

Findings:
There were two actions required following the last inspection, one was complete and the second action remained outstanding. The outstanding action related to the management of restrictive practices in the centre. The inspector found on this occasion, significant safeguarding risks remained and an immediate action was issued to the provider to ensure that appropriate action was taken to safeguard the residents in this centre from abuse.

The inspector found the provider had failed to implemented measures to ensure residents were free from all types of abuse. There was a policy and procedures in place for responding to allegations of abuse and staff spoken with were knowledgeable of the types of abuse. However, staff did not identify continuous peer to peer abuse or the fear and intimidation displayed by some residents towards their peers as abuse. This was evidenced from a review of the incident and accident logs in the centre. The inspector found that the provider had failed to safeguard the residents from further potential incidents reoccurring.

There were 28 incidents of behaviours that challenge from January to June 2016. The inspector reviewed residents' personal files such as the positive behaviour support plans in place to support staff when the resident presented with such behaviours that challenge. The inspector found that the behaviour support plans in use for some residents did not promote the least restrictive measures. In one residents file, seclusion was recommended as the first course of action when a resident displayed behaviours that challenge.

Furthermore, the practice of seclusion, where a resident was locked into a room alone, was regularly used in the centre. This was done so in the absence of appropriate guidelines or protocols in place to protect the resident's rights and dignity. The inspector reviewed documentation which stated one resident was frequently put into seclusion for periods of between five to 45 minutes. In some of these incidents no dates or times

were recorded or the reason why these restrictions were necessary.

The inspector found the use of restrictive practices were not proportional to the risks and were not subject to regular multi-disciplinary review. Restrictions were used in this centre as a means of managing behaviour that challenge. For example, locks were used on the doors into a sitting room, dining room, kitchen, utility, and staff office. The inspector was told that these doors were locked to ensure residents' safety, primarily from their peers that presented with behaviours that challenge. This was further evidenced by one resident who refused to walk down the hallway in their house without staff presence as this resident had experience several previous assaults by their peer and was fearful of another similar incident occurring.

Visual and audio monitors in residents' bedrooms at night were not risk assessed or identified by staff, management or internal auditors as the least restrictive option for residents. Staff spoke with regarding the use of these audio and visual monitors described the rationale for using such equipment. However, it was evident that the use of audio and visual monitors required a review as staff stated they may not be necessary.

There was evidence that the staff members and the person in charge had escalated their concerns about inadequate staffing levels to senior management on a number of occasions following some safeguarding incidents occurring. Despite this, the inspector found that no compatibility assessments or updated assessments of need were completed to review the suitability of the residents living in the centre together.

In addition, there were two safeguarding issues reported to HIQA in July 2016 that had not been adequately managed. The incident related to a lack of appropriate supervision at night. For example, one resident had disturbed another resident's sleep and frightened them by entering their bedroom. The resident sought assistance of staff as they were fearful of the visitor entering their room at night. In response a door alarm was placed on the resident's bedroom to alert the sleepover staff when the resident was awake and mobilising around the house. Furthermore, staff had recorded 37 hours of sleep disturbance over one month period when residents required additional assistance at night. The inspector found that the safeguarding plan put in place did not adequately address the impact it had on residents.

Judgment:
Non Compliant - Major

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:
A record of all restrictive practices occurring in the designated centre was not maintained and all incidents had not been notified to HIQA as required. However, the provider has since submitted the appropriate documentation following the inspection.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There was a policy and procedure in place relating to the ordering, prescribing, storing and administration of medication to residents. All staff administering medication had received training in safe medication practices. However, the inspector found that a medication prescribed fifteen days previously on the 31 August 2016 had not been administered to the resident.

Furthermore, the inspector viewed a sample of residents' prescription sheets and administration records. There was a system of transcribing the prescription from the general practitioner (GP) medication sheet to another printed prescription sheet. This was carried out by pharmacist. However, there was no oversight arrangement in place to ensure that all medication prescribed by the GP's were appropriately transcribed. For example, in one incident staff were administering medication using the transcribed sheet and errors on the transcribed sheets were identified by the inspector. The inspector identified that staff were administering a medication to a resident daily, but it was not documented as prescribed by the GP. This was brought to the immediate attention of the person in charge and the person participating in management. Furthermore, there was no signature by either the GP or the pharmacist on the transcribed medication sheets.

Chemical restraint was in use in this centre. However, there was no protocol in place to guide staff in the appropriate use of such medication. Furthermore, no reviews as to the need or rationale for administrating such medication or audits had taken place to ensure that chemical restraint was being prescribed as recommended by the psychiatrist.

There was a lack of robust oversight of the medication management practices in the centre and the risks identified by the inspector had not been identified prior to the inspection. A medication audit was completed on 28 August 2016 and no issues of concern were identified and the medication practices were deemed safe in this centre.

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 provider failed to ensure that the actions identified on the previous inspection were addressed. The actions related to the failure of management to ensure the service provided was safe, appropriate to residents' needs and effectively monitored. The provider had confirmed that this action was completed in December 2015. However, on this inspection the inspector found ten of the previous 14 actions were not complete. Significant and sustained improvements regarding the overall entity and the governance and management of the centre were required.

Two new managers took up post in this centre in 2016. The local management team consisted of a person in charge who was responsible for the designated centre. The area manager of the centre had responsibility for 11 designated centres in Galway city and county. The inspectors found that the governance and management arrangements failed to ensure oversight, accountability and responsibility in managing risks in this centre such as risk of fire, peer to peer abuse, overall management of risk and medication management amongst other areas as outlined in the report.

The provider had nominated a Unit Director of another service to complete the six monthly unannounced visit to assess compliance with the regulations. The inspector found this unannounced visit failed to identify the deficits which the inspector identified on inspection. The audit system was also ineffective in ensuring the service provided was safe, appropriate to residents' needs and consistent. For example, the inspector

found that audits were being conducted in relation to medication administration. However, the audits failed to identify serious risks in relation to the practices and procedures in administrating and transcribing medications.

The inspector, through conversations with staff was not assured that staff concerns, such as inadequate staffing levels, were being heard or acted upon.

Significant improvements were required to ensure the governance and management arrangements ensured that a safe and effective service was being delivered.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
The inspector found there was inadequate staff support with the appropriate skill mix to safeguard residents. Improvements were also required regarding the frequency of mandatory training.

The inspector was advised that there was a three year cycle of staff training in a number of areas including fire prevention, safeguarding vulnerable adults, safe moving and handling and the safe administration of medication. The inspector found that based on the findings of this inspection the staff team, including the managers, required refresher training all of these areas.

The designated centre had a staff allocation of 12.3 whole time equivalent (WTE). This included staffing for two houses which accommodated up to eleven residents. In one house, one resident had received a one-to-one staff support. This had demonstrated a positive improvement for this residents and their peers' quality of life. The inspector saw documented that a decline of 62% in incidents of behaviour that challenge in the past year occurred for that resident as a direct result of the one-to-one staffing. Furthermore, staff spoke positively of how the familiarity and consistency of staffing for this resident had such a positive impact on their behaviour and had reduced the risks of behaviours

that challenge.

However, in the other house there was inadequate staff support or supervision provided to residents. This resulted in seclusion and significant restrictive practices in place. Furthermore, staff were constantly changing and some staff spoke of the need for consistent staffing to ensure positive behaviour support was being maintained for residents. This requirement was also documented in residents' behaviour support plans. In addition, a safeguarding plan submitted to HIQA had identified that a waking night staff was required to protect residents at night from disturbances and to meet residents' healthcare needs. However, at the time of inspection this was still not in place.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Ash Services
Centre ID:	OSV-0004055
Date of Inspection:	15 September 2016
Date of response:	21 October 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 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:
Residents' choice, freedom of movement and behaviour was limited in this centre through the use of physical, environmental and chemical restraints.

[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 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
Safeguarding Process for all service users instigated, with completion of Preliminary Screening, Interim Safeguarding Plans put in place within five working days of the inspection. In line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedure, the Safeguarding Plans were submitted to the HSE Safeguarding Team. The Safeguarding Team were invited by the Registered Provider to visit the service and they visited on 13/10/2016 and reviewed the plans. The Safeguarding Plans included the impact of restrictions on other residents. Review of roster and additional staffing assigned to facilitate greater choice and greater accessibility throughout the service.

Proposed Timescale: 23/09/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The investigations and outcome of complaints were not available to review.

There were two open complaints not resolved to the satisfaction of the complainants.

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

Please state the actions you have taken or are planning to take:
At the time of the inspection, there was one complaint logged on the complaints management system, this complaint was closed out, noting that the family were satisfied with the outcome.

A second complaint was logged on the complaints management system and is now closed off to the satisfaction of the complainant.

Proposed Timescale: 17/10/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The terms on which residents' shall reside in the designated centre was not agreed in writing between the provider and the resident's.

3. 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:
The contracts for residents were reviewed and amended and sent to families. The contracts include the quantum of residential placement offered to residents.

Proposed Timescale: 22/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A residents' written agreement did not accurately detail the number of nights they were entitled to avail of the service.

4. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
The contracts for residents who avail of residential placements were reviewed and amended and sent to families. The contracts include quantum of residential placement offered to residents.

With regard to residents availing of respite in addition to their residential placement, contracts have been issued in this regard.

With regard to the one resident who avails of respite and did not have a contract in place, a contract was issued on a number of occasions to the family, however, this was not returned by the family. A further copy of the contract of care has been issued, and a Social Worker has been requested by the Person in Charge to visit the family in order to get same completed.

Proposed Timescale: 15/11/2016

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:
Assessments were not complete to reflect the changing needs of residents.

5. 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:
Annual Health Care checks are carried out with residential residents and are completed by their GP and case reviews are held annually. Each resident has a person centred plan in place. An Assessment of Needs template has been implemented in the organisation. Assessment of Needs template has been completed for all residents with input from multi-disciplinary staff. The assessment of needs process involved review of current, future needs and compatibility of residents.

Proposed Timescale: 21/10/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Equipment recommended by members of the multi-disciplinary team was not provided to residents in the centre.

6. Action Required:
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

Please state the actions you have taken or are planning to take:
The resident avails of non-overnight respite at the service at present and does not require specialised equipment. A business case has been designed for submission to the HSE reflecting the persons support needs going forward, including overnight respite and related equipment.

Proposed Timescale: 17/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The carpet flooring in the centre was not clean or in a good state of repair internally.

7. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The hallway carpet has been replaced with Marmoleum flooring.

Proposed Timescale: 28/09/2016

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:
1. Individual risk assessments were inadequate and did not identify all of the risks posed to the residents'.
2. Individual risk assessments were not reviewed regularly.
3. The risks associated with moving and handling of residents had not been assessed.

8. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
1. Residents' individual risk assessments are being reviewed to ensure that they include all potential risks and safety measures.
2. Timescale for risk assessments is on an annual basis or more frequently if required, this is now included on the risk assessment tool.
3. Individual risk assessments are being reviewed to ensure that risks associated with moving and handling of residents are included on the risk assessment tool.

Proposed Timescale: 15/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate arrangements in place for the safe evacuation of residents.

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

Please state the actions you have taken or are planning to take:
A further night time fire evacuation was carried out on 16/09/2016 and results indicate that no issues occurred; this was submitted to the Health and Safety Manager and a response received, noting satisfaction with the outcome. Following this, Personal Emergency Evacuation Plans for each resident have been reviewed and updated. The Centre Emergency Evacuation Plan was also reviewed.

The Person in Charge has a schedule in place for completion of fire evacuations, to ensure all residents and all staff in each location are involved in at least one fire evacuation annually. Fire evacuation is also a standard agenda item for the staff meetings.

Proposed Timescale: 23/09/2016

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:
There were multiple restrictive practices in use in this centre. It was not evidenced that the restrictions in place were the least restrictive measures or used for the shortest time necessary. For example, restrictive practices such as seclusion were used in the absence of appropriate assessments, follow-up or reviews.

10. 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:
The Safeguarding Process for all service users instigated, with completion of Preliminary Screening, Interim Safeguarding Plans put in place within five working days of the Inspection. In line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedure, the Safeguarding Plans were submitted to the HSE Safeguarding Team, who visited the service to review the plans on 13/10/2016. The Safeguarding Plans included the impact of restrictions on other residents. Review of roster and additional staffing assigned to facilitate greater choice and greater accessibility throughout the service.

The behaviour support plan for one resident has been reviewed with regard to promoting the least restrictive measures, now contained on the updated behaviour support plan. This has been signed off by the Behaviour Support Manager.

Proposed Timescale: 20/09/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have the appropriate skills, guidance, or knowledge to respond to some residents behaviours that challenge, or appropriately support residents that expressed fear towards their peers.

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

Please state the actions you have taken or are planning to take:
All staff have completed training and Client Protection/Safeguarding Vulnerable Adults Training. Further training for the staff team is planned with regard to positive behaviour support, strategies and techniques.

Proposed Timescale: 15/12/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Restrictive practices, seclusion and peer on peer abuse were not investigated.

12. Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The Safeguarding Process for all service users instigated, with completion of Preliminary Screening, Interim Safeguarding Plans put in place within five working days of the Inspection. This was completed in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures. The organisation's policy and procedure in this regard was followed, including completion of incidents/accidents on Quality Management Information System and instigation of processes in this regard (Client Protection/Safeguarding); and statutory bodies notified.

Proposed Timescale: 20/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Residents were not protected from abuse.
2. Some residents were in fear of physical and psychological abuse living with other residents.

13. 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:
The Safeguarding Process for all service users instigated, with completion of Preliminary Screening, Interim Safeguarding Plans put in place within five working days of the Inspection. This was completed in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures. The organisation's policy and procedure in this regard was followed, including completion of incidents/accidents on Quality Management Information System and instigation of processes in this regard (Client Protection/Safeguarding); and statutory bodies notified.

The Safeguarding Policy and Procedure was reiterated at a staff meeting, and is a standard agenda item going forward.

'Right to Feel Safe' guidance for residents is available in the service, and is being reiterated at the next house meeting for residents on 23/10.2016.

Letters have been sent to families outlining the concerns and the Safeguarding processes instigated and being followed by the service.

Proposed Timescale: 23/10/2016

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:
Medications were not administered as prescribed.

14. 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:
All medications administered are now transcribed appropriately as per procedures. The issue identified during the inspection was addressed and rectified during the inspection

on 16/09/2016, i.e. medication documented as prescribed by the G.P., and signed off appropriately on transcription.

A protocol is in place, signed by mental health services, outlining rationale, and is now available in the service with regard to the use of PRN Medication (chemical restraint) for one resident.

Medication Audits have been carried out by health care professionals independent of the designated centre.

Proposed Timescale: 23/09/2016

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:
Management systems in place did not ensure that the services provided were safe, effective and met the needs of residents.

15. 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:
An action plan has been developed with regard to areas identified for action and progress in this regard, with oversight by the Person Participating in Management, Quality and Compliance Manager and Director of Client Services, and involves the Person in Charge.

The introduction of a scheduled system of conducting frequent support meetings has been put in place, including a review of ongoing support, supervision and training and support needs.

A mentor has been put in in place to support the Person in Charge for a duration of time.

Proposed Timescale: 23/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The written report on the safety and quality of care and support provided in the centre did not identify or address areas of concerns regarding the standard of care and support provided in the centre.

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

Please state the actions you have taken or are planning to take:
An Information session on relevant topics has been scheduled for 20/10/2016, for members of the internal audit team who carry out the Provider Led Audits. This will include a revision for the audit team with regard to Regulations, identification of risk and Safeguarding Policy and Procedures.

Proposed Timescale: 20/10/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff concerns regarding the quality and safety of care provided was not appropriately managed by the provider.

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

Please state the actions you have taken or are planning to take:
Approval was granted for the provision of additional staffing resource for the service, from 19/09/2016, this included the provision of night duty in one location, previously having sleep in duty. Following the logistics of putting the resources in place, the additional evening and weekend staffing commenced on the 23/09/2016 and the night duty element commenced on 17/10/2016.

A meeting was held between the Director of Client Services, Person Participating in Management, Person in Charge, Quality and Compliance Manager and the staff team on 20/09/2016 with regard to overall service provision. Additionally, approval has been granted for the commissioning of a review of the services at the designated centre, to be carried out by external parties, with completion date of 30/11/2016.

The Person Participating in Management has schedule in place at attend specific number of staff team meetings at the service.

Proposed Timescale: 30/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate staff support or supervision provided to residents in the centre.

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

Please state the actions you have taken or are planning to take:
Approval was granted for the provision of additional staffing resource for the service, from 19/09/2016, this included the provision of night duty in one location, previously having sleep in duty. Following the logistics of putting the resources in place, the additional evening and weekend staffing commenced on 23/09/2016 and the night duty element commenced on 17/10/2016.

Proposed Timescale: 17/10/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have appropriate training to manage risks in this centre. For example:
1. Managing behaviours that challenge
2. Fire evacuation management
3. Safeguarding vulnerable adults
4. Safe moving and handling
5. Safe medication practices
6. Risk management.

19. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
A schedule of training for the staff team has been developed with regard to the six areas identified above. This includes the completion of a competency tool for each of the elements identified.

Proposed Timescale: 15/12/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff practices in relation to managing residents' behaviours that challenge were not appropriately supervised.

20. 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:
All staff have completed training and Client Protection/Safeguarding Vulnerable Adults Training. Further training for the staff team is planned with regard to positive behaviour support, strategies and techniques.

Proposed Timescale: 15/12/2016