

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	No.4 Seaholly
<b>Centre ID:</b>	OSV-0004573
<b>Centre county:</b>	Cork
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Brothers of Charity Services Ireland
<b>Provider Nominee:</b>	Una Nagle
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	6
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

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

From: 05 September 2016 09:30 To: 05 September 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

**Background to the inspection:**

This was the second inspection of this designated centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 21 July 2015 and was a registration inspection. Following that inspection, a certificate of registration was granted.

This inspection was a triggered inspection in response to two areas of concern. The first related to an increase in notifications to HIQA for incidents of behaviour that challenges which had raised concerns regarding the safety of residents in the centre. The second related to an anonymous complaint that had been brought to the attention of the provider by the public accounts committee (PAC) and in turn, reported by the provider to HIQA. This complaint related to an incident of misappropriation of funds that had taken place in 2014, which had been appropriately investigated. Inspectors followed up on the implementation of systems in place for the protection of residents from financial abuse in the centre.

How we gathered our evidence:

Inspectors met with three residents on the day of inspection. While residents present were non-verbal, they appeared comfortable and content with staff and were involved in making choices and decisions with the support of key workers. Other residents were either away from the centre on the day of inspection or choose not to meet inspectors. Inspectors met with the person in charge of the centre, the unit leader and members of the staff team over the course of the inspection. Inspectors also reviewed and discussed residents' personal plans, behaviour support plans, healthcare plans, communication supports and documentation as it pertained to restrictive practices.

Description of the service:

The centre was located on a larger campus and provides a service for residents with severe intellectual disability, autism and behaviours that may challenge. Inspectors found that the service provided was as described in the statement of purpose for the centre. In relation to the premises itself, the centre had been re-configured since the previous inspection and now comprises a four-bed single-storey house and two adjoining separate single-occupancy apartments. While the centre was an older premises, it was bright and spacious and decorated in a homely way.

Overall judgment of our findings:

Overall, there was evidence of person-centred practices that supported residents' choices and participation in the wider community and that facilitated quality of life outcomes to be met. A high level of compliance was demonstrated with previously identified actions either completed or substantially progressed. One moderate non-compliance was identified under Outcome 7: Health, safety and risk management.

With respect to the protection of residents from injury or harm arising from behaviours that may challenge, re-configuration of the centre had resulted in a significant decrease in such incidents.

With respect to the management of residents finances, the provider had taken steps to ensure that there was a system in place to protect residents from financial abuse. Since 2014, the provider had introduced or strengthened systems relating to financial management including the sharing of financial duties, recording of financial transactions, receipts for donations to residents and transparency in relation to monies for housekeeping and weekly use. In addition, relevant policies had been reviewed and updated, training had been provided to managers in identifying misappropriation of funds and a system of staff rotation had been introduced across the service. Finally, unannounced external financial audits had been introduced and were being implemented across the service. A recent external financial audit of this centre had taken place.

Findings are detailed in the body of this report and should be read in conjunction with the action plan at the end of this report.

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

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

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

At the previous inspection, it had been identified that the complaints log was inadequate to record all information and the outcome of whether or not the complainant was satisfied was not always recorded.

Inspectors noted that the layout and content of the complaints log had been reviewed since the previous inspection to ensure that all information could be recorded. The complaints log recorded whether or not the complainant was satisfied for all complaints since the previous inspection.

**Judgment:**

Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

At the previous inspection, it was not evidenced that personal plans had been updated at least within the previous 12 months or that they reflected current and relevant information to guide residents' care and support.

At this inspection, inspectors reviewed residents' personal plans and found that they were all within date. Comprehensive assessments had been completed of residents' personal and social care needs, for example, independent living skills, intimate and personal care, money skills, leisure activities, interaction in the community and safety awareness.

Personal plans reflected residents' current likes and dislikes and included other relevant support plans, for example to support communication, behaviour support, safety and healthcare needs.

Residents either attended a day service off-campus or an individualized service was provided by staff. Staff clearly articulated how they supported residents to have a meaningful day, based on their individual abilities, needs, wishes and preferences.

Inspectors reviewed what residents did on a day-to-day basis and found that a varied and active programme was in place for each resident. There was evidence of active participation in the community and daily access to community facilities and services, including going bowling, to the gym or cinema, horse-riding, eating out, going to the shops, going for walks and visiting a local wildlife park.

Personal plans were reviewed by a multi-disciplinary team on a regular basis. The review process was comprehensive and considered all aspects of residents' lives. For example, reviews considered residents' health, communication supports, daily schedule, weekly activities, interactions, positive behaviour support, skills teaching, training for staff to support individual residents and opportunities for new experiences.

**Judgment:**

Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

At the previous inspection, it was identified that further review of the design and layout of the centre was necessary. The re-configuration of the centre formed part of the safety plan for this centre and will be discussed under Outcome 8 as it relates to safeguarding and safety.

In relation to the premises itself, the centre had been re-configured since the previous inspection and now comprises a four-bed single-storey house and two adjoining separate single-occupancy apartments. The completion of one of those apartments was a recent development. As a result, works were yet to be fully completed. The person in charge confirmed that outstanding works would either be completed by the service's maintenance team (e.g. electricians) or where larger works were involved (painting, plastering), these had gone out for tender.

Further adaptations were required to meet residents' needs, including the creation of a shared kitchen between the two apartments and creation of access to the garden from one apartment. The person in charge confirmed that these works would be completed by the end of September 2016 and the inspector viewed the floor plan for these works.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

Certain aspects of this outcome were inspected at this inspection due to environmental changes that had taken place since the previous inspection, including risk management and fire safety evacuation procedures. Improvements were required to infection control and fire safety procedures.

There was a risk register in place that addressed most key risks in the centre, including accidental ingestion of chemical agents, unsupervised access to the kitchen and

potential excess consumption of liquids. However, a risk assessment had not been completed for an identifiable infection control risk in the centre.

In addition, the training matrix indicated that nine staff had not completed the organization's initial training session in infection prevention and control. This was discussed with the person in charge who stated that the training need had been identified and the staff members were booked on upcoming training.

Inspectors found that a risk assessment had not been completed for a trip/fall hazard associated with a step leading from the main living/TV room to the garden. Also, the garden furniture was in a poor state of repair presenting a risk to residents.

The procedures to be followed in the event of a fire were prominently displayed. Arrangements were in place for detecting, containing and extinguishing fires including emergency lighting, a fire detection and alarm system, fire equipment and fire doors installed throughout the centre. While the person in charge confirmed that keypads on final exit doors were connected to the fire alarm in most parts of the centre, it was not confirmed whether the keypad on the final exit door of the new apartment had yet been connected to the fire alarm system.

Fire safety drills indicated that residents could be safely evacuated from the centre. Each resident had a personal emergency evacuation plan (PEEP) that contained specific and detailed information in relation to how to support residents individually to evacuate from the centre.

However, the training matrix indicated that all staff required refresher training in relation to fire safety. This was discussed with the person in charge who stated that the training need had been identified and the staff members were booked on upcoming training.

**Judgment:**

Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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



**Findings:**

As mentioned in the introduction of this report, this was a triggered inspection in response to two areas of concern. The first related to an increase in notifications to HIQA that related to incidents of behaviours that may challenge that had raised concerns regarding the safety of residents in the centre. The second related to an anonymous complaint that had been forwarded to HIQA about the management of residents finances. Inspectors found that overall, the provider demonstrated that systems and safeguarding measures in place were now substantially in compliance with the regulations.

As previously mentioned, the centre had been re-configured since the previous inspection and now comprises a four-bed single-storey house and two adjoining separate single-occupancy apartments. Re-configuration of the centre formed part of the safety plan to address the frequency and nature of significant incidents of behaviours that may challenge in the centre. This re-configuration had resulted in a significant decrease in peer-to-peer incidents. Residents living in their own separate apartments still socialized with their peers in order to prevent unnecessary social isolation and to maintain social skills.

Residents behaviour support needs were met by staff that were supported by the multi-disciplinary team (MDT), psychiatrist, behaviour support professionals and their general practitioner (GP). The team met regularly (monthly or more frequently if required). Reviews were multi-factorial, were based on comprehensive assessment and considered all aspects of an individual's life.

Proactive and reactive strategies were outlined in behaviour support plans and clearly articulated by staff. A positive approach to behaviour support was demonstrated by staff. Staff were experienced and knew residents well, including how to identify and respond to triggers and behaviours that may challenge. Staff demonstrated that they supported residents in a person-centred way.

Inspectors reviewed the use of seclusion rooms in the centre. Where seclusion was used, it was demonstrated that it was used in line with national policy and evidence-based practice. The service's behaviour standards committee was responsible for approving the practice and where applicable, residents had an individualized seclusion protocol. A clear rationale was provided and oversight and regular monitoring of the practice was demonstrated by the behaviour standards committee.

Any occasion where seclusion was used was reviewed by a behaviour support professional and the person in charge. Attempts had been made to replace the practice with less restrictive practices. Staff demonstrated that they followed seclusion protocols in place for individual residents.

However, inspectors found that the use of seclusion was not adequately addressed in an organizational policy. The person in charge told inspectors that there was a new draft policy in place that would address all aspects of the use of seclusion. A copy of the draft policy was provided on the day of inspection.

With respect to the management of residents finances, the provider had taken steps to ensure that there was a system in place to protect residents from financial abuse. Since 2014, the provider had introduced or strengthened systems relating to financial management including the sharing of financial duties, recording of financial transactions, receipts for donations to residents and transparency in relation to monies for housekeeping and weekly use.

In addition, relevant policies had been reviewed and updated, training to managers to identify misappropriation of funds had been provided and a system of staff rotation had been introduced across the service. Finally, unannounced external financial audits had been introduced and was being implemented across the service. A recent audit of this centre had taken place.

At the previous inspection, it was identified that all staff, including non-core relief staff, had access to residents' finances. An inspector reviewed the arrangements for residents' finances. The person in charge outlined a number of additional safeguards that had been put in place since the last inspection. There were a number of levels of access for staff in relation to residents' finance. The storage location had been reviewed to prevent unnecessary access. An annual internal audit had been completed of residents' finances within the centre. Inspectors saw and senior staff confirmed that residents had easy access to personal monies. A money competency assessment was completed annually for each resident which outlined the supports and training needs, if any, required.

The inspector saw and senior staff outlined that all residents required full support to manage their finances. An individual and itemised record of each resident's transactions was kept, in line with the centre's local procedures for the management of residents' finances which had been reviewed in September 2015. The policy outlined that transactions should be countersigned by a second staff. However, the inspector saw that the receipt or transaction record was not countersigned by a second staff member for two expenditure transactions, of €100 and €58.80 respectively.

Receipts were kept for every item of expenditure. Where no receipt was available, an explanation for the money spent was to be entered in the transaction record and the fact that no receipt was available was to be noted as per the centre's local procedures. However, the inspector saw that this procedure was not followed for fifteen relevant transactions for two residents from 1 to 31 August 2016.

A recent notification to HIQA indicated that two residents had been administered chemical restraint in the period April to June 2016. One resident received chemical restraint on eight occasions during this period and the other resident received chemical restraint on two occasions. An inspector reviewed the management of chemical restraint within the centre and saw that the administration of chemical restraint was, for the most part, in line with each resident's individual protocol in relation to the use of chemical restraint. The majority of the protocols reviewed guided staff to identify and alleviate the underlying cause, if any, and to use less restrictive measures where possible, in line with guidance issued by HIQA.

However, the inspector saw that one protocol did not include this information and records reviewed did not reflect that the underlying cause had been identified and

alleviated or that less restrictive measures had been considered or used. In addition, the documentation following the administration of chemical restraint did not record or evaluate the resident's physical, psychological and emotional wellbeing during the use of chemical restraint, in line with guidance issued by HIQA.

The training matrix made available to inspectors indicated that two staff members required refresher training in the management of behaviour that is challenging including de-escalation and intervention techniques. This was discussed with the person in charge who stated that the training need had been identified and the staff members were booked on upcoming training.

**Judgment:**  
Substantially Compliant

### **Outcome 11. Healthcare Needs**

*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**  
Health and Development

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

No actions were required from the previous inspection.

#### **Findings:**

Aspects of this outcome were inspected for the purposes of monitoring on-going compliance in meeting residents' healthcare needs. Overall, inspectors found that residents' healthcare needs were supported by staff and by timely access to medical, nursing and allied healthcare services.

Residents were supported by a multi-disciplinary team, who met regularly and reviewed residents' healthcare needs. Residents had access to a GP, psychiatrist and medical and surgical consultants as required. Residents and/or their representatives were involved in decisions about their care and support from social work was sought as required.

A new assessment template had been recently introduced in the centre and the inspector reviewed a sample of a completed assessment, which was comprehensive and identified the resident's healthcare needs. Each resident had a hospital passport, to inform about residents' key care and support requirements in the event of an admission to the acute hospital sector.

Where daily recordings, checks or diagnostic tests were required to meet or monitor identified healthcare needs, these were being completed, for example in relation to dietary or fluid intake, weights, blood levels or diagnostic scans.

Residents on special diets were supported to follow those diets and staff were aware of how to implement instructions from speech and language therapy or medical/nursing professionals.

There was evidence of choice being offered during mealtimes and communication aids (such as objects of reference and pictures) were used to support residents to make choices.

**Judgment:**  
Compliant

## **Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**  
Health and Development

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

No actions were required from the previous inspection.

### **Findings:**

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. There was a medicines management policy which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Inspectors noted that medicines were stored securely. The inspector saw and staff confirmed that medicines requiring refrigeration or additional controls were not in use at the time of the inspection.

A sample of medication prescription and administration records was reviewed by an inspector. Medication prescription records contained many of the required elements under the relevant legislation to be complete authorisation for staff to administer prescription only medicines. However, the date of the prescription was not present on a number of prescriptions on every medication prescription record reviewed.

Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. The inspector saw that the medication administration records indicated that the majority of medicines were administered as prescribed. However, the inspector noted that one prescription was ambiguous and had not been clarified by staff. The prescription stated that the medicine was to be administered at 2pm but the prescriber had ticked the box in the time to be administered section for noon. The medication administration record

indicated that the medicine was administered at noon. This was brought to the attention of unit leader who undertook to clarify the prescription with the prescriber.

One resident was managing their medicines at the time of the inspection. The medicines management policy outlined that residents were encouraged to take responsibility for their medicines, in line with their wishes and preferences. A comprehensive and individualised risk assessment was available which took into account cognition, communication, reception and dexterity. Appropriate controls were outlined in the policy to ensure that the practice was safe.

Staff outlined the manner in which medications which were out of date or dispensed to a resident but were no longer needed were stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. Many medicines were supplied in monitored dose systems and references were available to ensure timely identification of each medicine contained. Stock levels of medicines not supplied in monitored dose systems were checked and reconciled on a daily basis to identify any errors or discrepancies.

A sample of medication incident forms were reviewed and inspectors saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented.

An inspector examined the medicines management audit reports and saw that practices were reviewed by the night supervisor every three months. The results of the medicines management audits completed since the last inspection were made available to inspectors. However, the audits were limited in scope and did not examine a number of areas of the medicines management cycle including ordering, review and disposal of medicines. This action is included under Outcome 14: Governance and management.

Training had been provided to staff on medication management and the administration of 'rescue medicine' for seizures.

**Judgment:**  
Substantially Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Overall, the provider had ensured that there were systems and arrangements in place for the effective governance and management of the centre.

The person in charge of the centre was supported in his role by a unit leader. It was demonstrated that the systems in place ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

At the previous inspection, it was identified that the unannounced visits carried out at least every six months did not consider all key aspects of quality and safety of care provided in the centre.

Inspectors reviewed the most recent six-monthly unannounced provider visit, which assessed core outcomes as they related to residents' social care needs, health and safety, safeguarding, healthcare needs, medication management and staffing. The report of the visit was comprehensive and identified any gaps that needed to be addressed, including in relation to residents' hospital passports, fire safety and epilepsy training and the keeping of meeting minutes. An action plan was available and it was evidenced that actions were being progressed.

In addition at this inspection, inspectors reviewed the annual review for the centre dated 17 August 2016. The annual review reflected the reduction in the number of incidents and use of seclusion since the previous year due to the changes in the design and layout of the centre. The annual review considered key areas of the safety and quality of care provided to residents, including the management of concerns and complaints, the findings from six-monthly unannounced provider visits, incidents, restrictions, personal plans and the risk register. As per the regulations, feedback from residents and/or their representatives informed the annual review.

**Judgment:**

Substantially Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

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

**Findings:**

At the previous inspection, training gaps, in line with residents' assessed needs, were identified. The training matrix was made available to inspectors and training had been provided to all staff in relation to epilepsy and food hygiene.

Inspectors noted that not all staff had completed training in relation to dysphagia to support residents with difficulties swallowing and Lámh training (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland) to support residents with who chose to use Lámh signs to communicate.

Staff were supervised on an informal basis by the person in charge and the unit leader. However, a system of formal supervision had not been implemented in the centre. This had been identified by the provider during the most recent unannounced visit.

**Judgment:**

Substantially Compliant

**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):**

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

**Findings:**

At the previous inspection, it was noted that policies in relation to admission, discharge and transfer of residents, complaints and visitors to the centre required review. Inspectors saw that the policies had been updated and reviewed since the last inspection.

Only the area relating to the relevant records and documentation required under the outcomes examined on this inspection were considered. An inspector saw that medication administration records were not always complete. For example, where a range of dose was prescribed (one to two tablets), the medication administration record did not record the actual dose administered to the patient.

The date on one medication administration record was not accurate or clear in relation to the month. One medication administration record was left blank at one time point on one day and a reason was not recorded as to whether the medicine was withheld. The signature of the staff administering the medicines was not recorded at one time point on one day.

**Judgment:**

Substantially Compliant

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority



## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

Centre name:	No.4 Seaholly
Centre ID:	OSV-0004573
Date of Inspection:	5 September 2016
Date of response:	12 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 06: Safe and suitable premises

**Theme:** Effective Services

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

Further adaptations were required to meet residents' needs, including the creation of a shared kitchen between the two apartments, the creation of access to the garden from one apartment and the creation of a seclusion room in one apartment.

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

**1. 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:**

The planned renovation/structural works have been costed as part of the Services tendering process and a commencement date has been agreed.

**Proposed Timescale:** 14/11/2016

**Theme:** Effective Services

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

Works were yet to be fully completed in the centre to ensure that the premises was of sound construction and kept in a good state of repair externally and internally.

**2. Action Required:**

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

Painting and decorating will be completed after the structural works have been finalised.

**Proposed Timescale:** 21/11/2016

**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:**

The arrangements in place for identifying hazards and assessing risks required improvement. For example, a risk assessment had not been completed for a trip/fall hazard associated with a step leading from the main living/TV room to the garden.

Also, the garden furniture was in a poor state of repair presenting a risk to residents.

**3. 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:**

An updated environmental risk assessment will be completed for the renovated premises and garden areas and appropriate control measures put in place. The garden furniture has been replaced.

**Proposed Timescale:** 28/11/2016

**Theme:** Effective Services

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

Procedures in place to protect residents who may be at risk of a healthcare associated infection required improvement.

A risk assessment had not been completed for an identifiable infection control risk in the centre.

The training matrix indicated that nine staff had not completed initial training in infection prevention and control.

**4. 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:**

All identified risks in relation to infection control have been assessed and placed on the risk register [07/10/2016]

Any necessary additional control measures have been put in place.

A hand hygiene Assessor will provide refresher training and discuss Services policy with the Team.

Remaining staff requiring infection control training have been booked into the next available training date.

**Proposed Timescale:** 16/11/2016

**Theme:** Effective Services

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

The training matrix indicated that all staff required refresher fire safety training.

**5. 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:**

All staff will have received fire evacuation training. One of the staff has been appointed as the Fire Warden and will deliver training on a yearly basis or as required to new staff joining the Team.

**Proposed Timescale:** 08/11/2016

**Theme:** Effective Services

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

It was not confirmed whether the keypad on the final exit door of the new apartment had yet been connected to the fire alarm system to ensure that it would be deactivated in the event of a fire.

**6. 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:**

The apartment door has been fitted with a break glass unit with a key in line with Services policy. All other electronic keypad doors are connected to the fire alarm and release in the event of a fire.

**Proposed Timescale:** 14/10/2016

**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:**

Some protocols in relation to chemical restraint did not guide staff to identify and alleviate the underlying cause, if any, and to use less restrictive measures where possible.

**7. 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:**

All protocols and reactive strategies have been reviewed to include underlying cause and least restrictive measures.

**Proposed Timescale:** 14/10/2016

**Theme:** Safe Services

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

The documentation following the administration of chemical restraint did not record or evaluate the resident's physical, psychological and emotional wellbeing during the use of chemical restraint, in line with guidance issued by HIQA.

**8. Action Required:**

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

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

The PRN recording form is currently being reviewed as part of the Services Person Centred Medication Management Policy review. The record will be updated to ensure the record notes the evaluation of the resident's physical, psychological and emotional wellbeing during the use of chemical restraint in line with the guidance issued by HIQA

**Proposed Timescale:** 30/10/2016

**Theme:** Safe Services

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

Two staff members required refresher training in the management of behaviour that is challenging including de-escalation and intervention techniques.

**9. Action Required:**

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

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

Staff are scheduled to receive refresher training on Positive Behaviour Supports.

**Proposed Timescale:** 11/11/2016

**Theme:** Safe Services

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

The local procedures for the management of residents' finances, to protect residents from financial abuse, were not always followed.

**10. Action Required:**

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

The PIC has provided refresher training to staff on the Services Policy and Procedures on the Management of Service Users Monies.

**Proposed Timescale:** 07/09/2016

**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:**

The date of the prescription was not present on a number of prescriptions on every medication prescription record reviewed.

One prescription was ambiguous and had not been clarified by staff.

**11. 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:**

The Medication Administration Records (MAR) charts have been updated by the GP. Staff have been reminded to remain vigilant on this matter and to ensure that any gaps on prescriptions are rectified as a matter of urgency.

**Proposed Timescale:** 06/09/2016

**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:**

As discussed under Outcome 12, the medicines management audits were limited in scope and did not examine a number of areas of the medicines management cycle including ordering, review and disposal of medicines.

**12. Action Required:**

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

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

The audit is being reviewed as part of the Person Centred Medication Management Policy review and will include the areas of ordering, review and disposal.

**Proposed Timescale:** 30/10/2016

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Not all staff had completed training in relation to dysphagia.

Not all staff had completed required training to support residents' communication needs (Lámh training).

**13. 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:**

The speech and language therapist supports the staff team in both dysphagia and communication systems. The Speech and language therapist will attend staff meeting to update staff. Staff have been scheduled to attend the relevant training.

**Proposed Timescale:** 30/12/2016

**Theme:** Responsive Workforce

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

A system of formal supervision had not been implemented in the centre

**14. 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:**

The Services are currently implementing a new policy on supervision. All managers and team members will receive training on the policy and dates for individual supervision sessions will be agreed.

**Proposed Timescale:** 30/11/2016

## Outcome 18: Records and documentation

**Theme:** Use of Information

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

Medication administration records did not always clearly record the dosage, name of the medicine, date of administration and signature of the staff member administering the medicine.

**15. 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:**

The Services are currently rolling out new MARS charts in consultation with the pharmacy. All managers have received awareness training on this new system 24th & 31st/08/2016 in consultation with the GP and Consultant Psychiatrist. As the GP reviews service users the new charts will be implemented.

**Proposed Timescale:** 30/12/2016