<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Hazel Grove</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004638</td>
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<tr>
<td>Centre county:</td>
<td>Clare</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Brothers of Charity Services Ireland</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Eamon Loughrey</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Louisa Power</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>6</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a change in person in charge. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 04 August 2016 09:35  
To: 04 August 2016 17:45

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 17: Workforce</td>
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**Summary of findings from this inspection**
Background to the inspection
This monitoring inspection was carried out to monitor compliance with specific outcomes. A new person in charge had been appointed to the centre on 31 March 2016 and the inspection provided an opportunity to interview the new person in charge. The previous inspection was on 7 October 2014 and, as part of the current inspection, the inspector reviewed the actions the provider had undertaken since the previous inspection.

How we gather our evidence
As part of the inspection, the inspector met with four residents. Residents with whom the inspector spoke were very complimentary of staff and the person in charge. Residents described that their independence was promoted at all times and they were facilitated to make choices in all aspects of their lives. Residents reported that they were especially pleased with having an apartment where they lived alone or with one other person. The inspector observed that residents were comfortable in the presence of staff. Assistance and support was provided in a dignified and respectful manner. Residents were observed to be offered meaningful choice and their choices were respected. Independent living skills were promoted.
The inspector met and spoke with staff members. The inspector observed practices and reviewed documentation such as plans of care, medical records, accident logs, policies and procedures.

An interview was carried out with the person in charge. The person nominated on behalf of the provider and the regional manager attended for the feedback meeting at the close of the inspection.

Description of the service
The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that the service was being provided as it was described in that document. The centre comprised four apartments which each had two bedrooms. One of the bedrooms in each apartment was en suite and an additional shower room was provided in each apartment. A maximum of two residents lived in each apartment. An open plan living, dining and kitchen space was provided in each apartment. The centre was located in a suburban location close to a large town. The service was available to adult men and women with mild to moderate intellectual disabilities. The centre supported residents with a variety of health care needs.

Overall findings
Overall, the inspector found that residents had a good quality of life in the centre and the provider had arrangements to promote the rights of residents and the safety of residents.

The inspector was satisfied that the provider had put systems in place to ensure that the regulations were being met. The provider and person in charge did demonstrate adequate knowledgeable and competence during the inspection and the inspector was satisfied that both were fit persons to participate in the management of the centre.

This resulted in positive experiences for residents, the details of which are described in the report.

Good practice was identified in the following areas:
• residents' rights were promoted (outcome 1)
• robust governance and management systems (outcome 14)
• safe and suitable staffing (outcome 17).

Improvements were required in the following areas:
• personal planning (outcome 5)
• risk assessment (outcome 7)
• oversight for restrictive practices (outcome 8).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.
**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:**

Residents with whom the inspector spoke with stated that they felt safe and spoke positively about the care and consideration they received. Interaction between residents and staff was observed and the inspector noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

Residents and their representatives were actively involved in the centre. Residents were consulted about, and participated in, decisions about their care and the organisation of the centre. Regular residents' meetings took place every month and were attended by all residents. Items discussed included social outings, holidays, local cultural events and upcoming discos/parties. The meetings were also used as a forum to educate residents in relation to safeguarding and their rights. Minutes indicated that the house meeting was a meaningful and effective forum with each resident given the opportunity to communicate their views.

Staff were observed providing residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals, assisting residents in personalising their apartments and their choice of activities. Residents were encouraged to choose their activities for the day. The inspector saw that steps taken had been taken to support and assist residents to provide consent and make decisions about their care and support.

The inspector observed that residents were supported in a dignified and respectful manner. Residents' capacity to exercise personal independence was promoted. For example, residents' ability to perform tasks in relation to personal hygiene and dressing
was identified and residents were encouraged to perform these tasks.

Residents were encouraged to maintain their own privacy and dignity. Staff were observed to knock before entering residents' apartments. Each resident had their own bedroom. Suitable locks were provided on the doors of sanitary facilities. One bedroom in each apartment had an en suite shower room. Where two residents occupied an apartment, the main shower room was used by the resident who did not have en suite facilities. Intimate care protocols were reviewed and the inspector saw that the measures to promote resident's privacy and dignity were clearly documented.

Residents' personal communications were respected and residents had access to a telephone. Wireless internet was provided throughout the centre. Residents with whom the inspector spoke reported that they had their own personal mobile telephone. Residents reported that they used the internet regularly on their own tablet or personal computer to use social media and to maintain family links.

There was a complaints policy which was also available in an accessible format and had been reviewed in June 2015. The policy was displayed prominently at the entrance to the centre. The complaints policy identified the nominated complaints officer and also included an independent appeals process as required by legislation.

The inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints form included whether the complainant was satisfied. The inspector noted that residents were encouraged to make complaints by the person in charge and staff. Residents reported that support from staff was readily available, if required, to make a complaint. The investigation undertaken in response to complaints was thorough, comprehensive and prompt. Learning from complaints to prevent recurrence was seen to be implemented such as purchasing an additional vehicle.

Residents were encouraged and facilitated to retain control over their own possessions. There was adequate space provided in each apartment for storage of personal possessions. Records in relation to residents' valuables were maintained and updated regularly in line with the centre-specific policy reviewed in February 2015. Residents were supported to do their own laundry if they wished and adequate facilities were provided in each apartment.

Residents had easy access to personal monies and, where possible, control over their own financial affairs in accordance with their wishes. Money competency assessments were completed annually for each resident which outlined the supports and training needs, if any, required. Staff outlined a transparent and robust system for the management of residents' finances who required support in this area. An itemised record of the all transactions with the accompanying receipts was to be kept. A daily check of residents' finances was undertaken.

Residents were facilitated to exercise their civil, political and religious rights. Easy read information was provided to residents in relation to their rights. Residents were afforded the opportunity to vote. Residents were supported to access religious services in line with their wishes.
Residents reported that they were facilitated and supported to participate in external activities that are meaningful and purposeful to them. Residents outlined that they enjoyed going to a local community day centre one to two mornings per week where they met with their friends, participated in activities and had a meal. Residents went to yoga, knitting groups and other exercise classes in the local area. Some residents confirmed that they had paid employment in local businesses whilst other residents had secured volunteer positions locally. Residents enjoyed visiting friends and family in the local community. Residents were supported to use services locally such as public transport, shops, hairdressers, beautician and restaurants. Residents stated that the local area was safe and they liked to walk down to the shops or into town.

**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):**
No actions were required from the previous inspection.

**Findings:**
A sample of residents' plans was reviewed. A discovery document was used to assess the health, personal, social care and support needs of the resident annually and the information contained was individualised and person centred. The discovery document formed the basis of an individual personal plan (IPP). The inspector saw that the discovery documents contained comprehensive and individualised information.

An IPP had been developed for each resident which included a comprehensive life story, family support network and important background information. The IPP outlined residents' needs in many areas including nutrition, home, work, finance, rights, community inclusion, healthcare, leisure, communication, spirituality, education, spirituality, relationships and life transitions. The IPP was made available to each resident in an accessible format in line with their needs. Staff with whom inspectors spoke confirmed that the resident signed the IPP to confirm that they were consulted with and participated in the development of the IPP. However, one IPP reviewed was not signed by the resident to demonstrate consultation in line with the centre's policies and procedures.
The person in charge confirmed that the IPP was made available to each resident in an accessible format in line with their needs including pictorial and electronic formats. The inspector noted that format in which the IPP was made available to residents was to be outlined on the front page of the IPP.

Goals and objectives were outlined. There was evidence of resident involvement in agreeing/setting these goals. There was also evidence that individual goals were achieved. A number of goals would improve the residents’ personal development such as accessing exercise classes in the community, attending a course in baking/cookery/jewellery making, nights away, day trips, using public transport, participating in healthy lifestyles training and work experience. A goal tracking sheet had been used to track these goals in one IPP seen. The goal tracking sheet clearly identified the person responsible for supporting the resident in pursuing these goals and the timeframe for completion. The goal tracking sheet was regularly reviewed and updated. However, the inspector noted that a number of the goals outlined in the other IPPs focussed on staff continuing to support the residents in activities of daily living and meeting healthcare needs. The person responsible for supporting the resident in pursuing these goals and the timeframe was not always clearly identified in these IPPs. The lack of definite goals could lead to residents not maximising their personal development.

The person in charge and staff outlined that the IPP was subject to a review on an annual basis or more frequently if circumstances change with the maximum participation of the resident. The inspector noted that the review did assess the effectiveness of the plan and reviewed the goals/aspirations that had been identified. Changes in circumstances and new developments were included in the IPP and amendments were made as appropriate.

The IPP also contained domains in relation to healthcare and nutrition. The information in these domains reflected the information gathered in the discovery document. Many of the IPPs seen contained comprehensive guidance to staff in relation to each resident’s healthcare needs which included arthritis, mental health, diabetes, underactive thyroid and constipation. However, some IPPs in relation to healthcare and nutrition contained information that was not comprehensive or easy to retrieve. For two residents with healthcare needs that require dietary modifications, the dietary modifications were outlined in the healthcare domain and not in the nutrition domain which could lead to staff not supporting the resident to implement these modifications. For a resident with healthcare needs that require ongoing daily monitoring, the healthcare domain did not contain information to guide staff in relation to the response if results of monitoring are outside the recommended range. For a resident with complex healthcare needs, the information contained in the IPP was not accurate in relation to the indication of some medicines prescribed.

There was evidence of multi-disciplinary team involvement for all residents, in line with their needs, including psychiatry, speech and language therapy, general practitioner (GP), optical, audiology and psychology services.

A booklet was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The booklet was completed in advance
and many booklets contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare.

Judgment:
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<tbody>
<tr>
<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
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<thead>
<tr>
<th>Theme:</th>
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<tbody>
<tr>
<td>Effective Services</td>
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<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>The action(s) required from the previous inspection were satisfactorily implemented.</td>
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</tbody>
</table>

Findings:
Overall, the provider was committed to protecting and promoting the health and safety of all in the centre. A proactive approach had been implemented in relation to risk management. However, some improvement was required in relation to risk assessments, implementation of fire safety checks and infection prevention and control practices.

There was a health and safety statement, dated September 2014, in place which outlined general aims and objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk.

The inspector reviewed the risk register attached to the risk management policy and saw that there was a system to identify and review hazards on an ongoing basis. However, some risks identified specifically in the regulations were not included, namely the unexplained absence of any resident and self-harm. In addition, the inspector noted that an individualised risk assessment was not completed where a resident had been identified as being at high risk of choking by the speech and language therapist.

The controls in place to manage the risks identified were outlined. The inspector confirmed that the controls were implemented. The level of risk associated was to be assessed before and after the implementation of controls to ensure that the level of risk had reduced.

A comprehensive emergency plan was in place which covered events such as natural disasters and utility failure. Provision was made to cover an event where the centre may be uninhabitable.
Arrangements were in place for the identification, reporting, investigating and learning from accidents and incidents. The person in charge demonstrated a proactive approach to risk management. An online system for incident reporting was in place allowed for the timely investigation of all incidents, identification of any trends and review of the effectiveness of preventative actions. The system allowed for the information to be collated into a report which was to be reviewed quarterly by the regional manager and every six months by the service leader.

Suitable fire equipment was provided throughout the centre. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation of residents and staff in event of fire was displayed in a number of areas. The fire panel and emergency lighting were serviced on a quarterly basis, most recently on 19 May 2016. Fire safety equipment is serviced on an annual basis, most recently in July 2016. Fire drills took place regularly and a detailed description of the fire drill, duration, participants and any issues identified were made available to the inspector. Records of daily and monthly visual fire checks for each apartment were made available to the inspector. These checks included inspection of the fire panel, escape routes, emergency lighting and evacuation procedure. However, the inspector noted a total of 14 gaps over a three month period across three of the apartments in the daily fire checks. For fourth apartment, the resident independently completed the daily fire checks and no gaps were present.

Staff demonstrated good knowledge in relation to fire safety and the procedure to follow in event of a fire and the training matrix indicated that all staff had received mandatory fire safety training. Residents had also attended fire training with staff.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEP took into account the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident. The inspector noted that the PEEPs were kept under regular review and changes were made in line with the changing needs of residents.

An infection prevention and control policy was available, dated May 2015 and contained information in relation to the management and disposal of sharps, hand hygiene, waste disposal, food safety and the management of an outbreak of norovirus. The centre was visibly clean, personal protective equipment (PPE) was provided and there were adequate hand sanitising and washing facilities. However, the inspector observed that the storage arrangement for mops was not adequate to prevent cross-contamination. In addition, the training matrix indicated that one staff member had not completed infection prevention and control training. Furthermore, the inspector noted and the person in charge confirmed that there was no cleaning schedule in place for the fridge used to store medicines requiring refrigeration and the fridge was not clean on the day of inspection.

Two vehicles were available to transport residents. Records made available to the inspector confirmed that the vehicles were roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained. Quarterly checks of the interior, exterior and equipment were completed and the inspector confirmed that any issues identified were remedied in a
timely fashion.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There was a policy and procedure in place in relation to the safeguarding of vulnerable adults, reviewed in February 2015. The policy identified the designated safeguarding officer and their deputy. The policy and procedure were comprehensive, evidence based and would effectively guide staff in the reporting and investigation of incidents, allegations or suspicions of abuse. The policy included a reporting pathway if the allegation was made against a member of the management team. The policy was also available in an accessible format.

The intimate care policy, reviewed in May 2015, outlined how residents and staff were protected. Each resident had an intimate care plan which was reviewed on a regular basis. The plan outlined in detail the supports required, resident's preference in relation to the gender of staff delivering personal care.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff with whom the inspector spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom the inspector spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse.

The provider and person in charge monitored the systems in place to protect residents and ensure that there are no barriers to staff or residents disclosing abuse. A robust recruitment and selection procedure was implemented, all staff received ongoing training in understanding abuse and staff stated that there was an open culture of reporting within the organisation.
The person in charge confirmed that staff routinely worked alone in the centre and robust measures were in place to safeguard residents including unannounced visits from the person in charge, an open visiting policy and mandatory staff training. The contact details for the designated safeguarding officer and the confidential recipient were displayed prominently in the centre. Measures were in place to assist and support residents to develop the knowledge, self-awareness, understanding and skills needed for self care and protection.

The inspector noted that all incidents, allegations and suspicions of abuse since the last inspection were appropriately and comprehensively recorded, investigated and responded to in line with the centre’s policy, national guidance and legislation.

A policy was in place to support residents with behaviour that challenges, reviewed in October 2014. The policy was comprehensive and focussed on understanding the function of the behaviour, responding and communicating appropriately and identifying triggers for the behaviour. Training records confirmed that training was provided to staff in the management of behaviour that is challenging including de-escalation and intervention techniques. However, confirmation was not available that agency staff had completed this training. The roster indicated that agency staff worked in the centre alone with a resident who required support in this area.

The inspector reviewed a selection of individualised plans for support behaviour that challenges and spoke with staff. Specialist input from a psychologist and behavioural specialist team had been sought to support a number of residents. Residents and their representatives were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour. Clear strategies were in place to support residents to manage their own behaviour and staff were able to describe the strategies in use. Antecedent Behaviour Consequence (ABC) charts were used to validate that the strategies outlined were effective and the charts were reviewed regularly by the person in charge and the regional manager. However, a positive behaviour support plan dated August 2015 had been developed by the team for a resident. The person in charge outlined that the team and the resident required additional support as the behaviours that challenge had reoccurred recently. The positive behaviour support plan in place at the time of the inspection was not adequate and required the input of the behavioural specialist team. This was acknowledged by the person in charge who confirmed that the behaviour support team had commenced working with the resident and the team to develop an effective plan.

The policy in relation to restrictive practices was made available to the inspector. The policy had been reviewed in October 2014, was comprehensive and was in line with evidence-based practice. The use of restrictive practices was guided by a centre-specific policy and followed an appropriate assessment. A risk balance tool was used prior to the use of restrictive practices, less restrictive alternatives were considered and signed consent from residents was secured where possible. A number of environmental restrictive practices were in place at the time of the inspection. However, multi-disciplinary input was not in place to oversee the restrictive practices. This was confirmed with the person in charge and had been identified at the most recent unannounced visit by the provider but no action had been taken to put appropriate systems in place.
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:
Residents’ healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical practitioner of their choice was available to each resident and an "out of hours" service was available if required. The inspector saw that residents were reviewed by the medical practitioner regularly. Medical advice and consultation in the event of clinical deterioration was seen to be sought in a timely fashion. There was clear evidence that there treatment was recommended and agreed by residents, this treatment was facilitated. Residents’ right to refuse medical treatment was respected.

Where referrals were made to specialist services or consultants, the inspector saw that staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including speech and language therapy, psychiatry, psychology, chiropody, dental and optical.

The inspector saw that end of life plans for some residents had been developed which recorded residents' wishes. However, much of the information contained in the plans related to care after death. The person in charge also confirmed that an individualised plan of care had not been developed in relation to care at times of illness for each resident in line with the centre's policy. Therefore, information would not be available to guide staff in meeting all residents’ needs whilst respecting their dignity, autonomy, rights and wishes.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Residents' weights were monitored on a monthly basis and residents' weights were stable and within a healthy range. The recommendations from the speech and language therapist were seen to be implemented. Residents were encouraged to be active through going for walks and exercise classes.

Residents were encouraged to be involved in the preparation and cooking each meal. Residents reported that they enjoyed preparing meals or baking with staff. Residents confirmed that staff offered a choice for all meals. The meals outlined by staff and
Residents were nutritious and varied. The inspector saw that there were ample supplies and choice of fresh food available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks; residents prepared snacks and small meals in their apartments. The inspector observed that residents were encouraged to prepare their own refreshments and snacks. There was adequate provision for residents to store food in hygienic conditions.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents’ needs was available in an easy read format.

**Judgment:**
Substantially Compliant

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

**Theme:**
Health and Development

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

**Findings:**
Medicines for residents were supplied by local community pharmacies. Staff confirmed that the pharmacist was facilitated to meet his/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 had been reviewed in January 2016. The policy detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. The training matrix indicated that medicines management training was mandatory for staff and all staff had attended recent training.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. The inspector noted that medicines, including medicines requiring refrigeration, were stored securely. The temperature of the fridge used to store medicines was recorded daily, when appropriate, to confirm the reliability of the fridge. The inspector saw and staff confirmed that medicines requiring additional controls were not in use at the time of the inspection.

A sample of medication prescription and administration records was 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 medicines were administered as prescribed.
Some residents with whom the inspector spoke confirm that they took responsibility for their own medicines. A comprehensive and individualised risk assessment was completed which took into account cognition, communication, reception and dexterity. Safe and secure storage was provided for residents and adequate oversight was in place to ensure compliance and concordance.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are 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. Stock levels were checked and reconciled on a daily basis to identify any errors or discrepancies. A system was in place for reviewing and monitoring safe medicines management practices on an annual basis. The results of the most medication management audit in May 2016 were made available to the inspector. The audit identified pertinent deficiencies and the inspector confirmed that actions had been completed.

When residents left the centre for holidays or days out, a documented record was maintained of the quantity and medicines given to the resident and/or their representative. This record was signed by staff and the resident and/or their representative. A similar record was maintained when the resident returned to the centre and the quantities were reconciled by staff.

A sample of medication incident forms were reviewed and the inspector 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. Medication incidents and the use of 'as required' medicines were reviewed by the management team on a quarterly basis to identify any trends.

Training had been provided to staff on medicines management.

**Judgment:**
Compliant

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**Outcome 13: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. The statement of purpose was made available to residents and their representatives.

The statement of purpose had been reviewed since the last inspection and contained all of the information required by Schedule 1 of the regulations. The inspector found that the statement of purpose was clearly implemented in practice.

Judgment:
Compliant

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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):
No actions were required from the previous inspection.

Findings:
There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. Staff with whom the inspector spoke were clear about the management structure and the reporting mechanisms.

A new person in charge had been appointed to the centre on 31 March 2016. The inspector concluded that the person in charge provided effective governance, operational management and administration of this centre. The person in charge had worked with the organisation since 2007 in a social care management role. The person in charge had an undergraduate degree in social care and a Masters degree in family development. The person in charge held a suitable qualification in management. The person in charge was employed full time by the organisation. The person in charge demonstrated a comprehensive knowledge of the residents and their needs. Residents were observed to be familiar with the person in charge and were comfortable in her...
A person participating in management (the regional manager) was appointed in the centre to ensure the effective governance, operational management and administration of the centre. There were established regular monthly management meetings and the inspector saw minutes of these meetings. The person in charge outlined that she had regular informal contact and formal supervision every four months with her line manager who was the regional manager.

The provider nominee had arranged for an unannounced visit to the centre in the previous six months (July 2016) to assess quality and safety. The inspector read a report of the most recent unannounced inspection. The report demonstrated a proactive approach and indicated that many of the deficiencies highlighted during the inspection had been identified during the unannounced visit. A robust action plan had been developed by the person in charge following the unannounced visit and there was evidence of progress against the action plan.

A report of accidents, incidents, medication related incidents and 'as required' medicine administration was prepared and reviewed by the regional manager on a quarterly basis. The provider nominee reviewed the reports every six months. Trends were identified and areas of improvement were identified by the senior management team. An annual audit of medicines management had been completed in May 2016. A review of financial arrangements in the centre had been completed in March 2016. There was evidence that pertinent deficiencies were identified, acted upon and improvements made.

The person nominated to act on behalf of the provider confirmed that an annual review of the quality and safety of care and support in the designated centre had not taken place in the past year.

**Judgment:**
Non Compliant - Moderate

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**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the
There were adequate arrangements in place for the management of the centre when the person in charge is absent. The regional manager was identified to deputise for the person in charge in her absence. The regional manager demonstrated a good understanding of the responsibilities when deputising for the person in charge. The inspector was satisfied that suitable arrangements were in place for the management of the designated centre in the absence of the person in charge.

**Judgment:**
Compliant

### Outcome 17: Workforce

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

**Theme:**
Responsive Workforce

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

**Findings:**

There was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff on duty at night. Sleepover staff were based in one of the apartments where the resident required a higher level of support. Residents demonstrated that they could alert staff at all times using an intercom system. Residents confirmed that staff were very responsive to the system. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. The inspector noted that a regular team supported residents and this provided continuity of care and support.

There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy. A comprehensive induction process was in place which also included job shadowing and the completion of a competency framework for all new staff.

Staff were observed to be supervised appropriate to their role. Regular staff meetings were held and items discussed included personal planning, incident review, health and safety, residents' health and social care needs, complaints, fire safety, training, advocacy, residents' finances and safeguarding. A formal and meaningful supervision and appraisal system was in place for staff.
Staff with whom the inspector spoke were able to articulate clearly the management structure and reporting relationships. The inspector saw that copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge and competencies the programme reflected the needs of residents. Further education and training completed by staff included mandatory training and training in medicines management, epilepsy awareness, occupational first aid and personal planning.

The roster indicated that agency staff were deployed to the centre. The person in charge confirmed that a regular group of agency staff were used to support residents in order to ensure continuity in care and support. Confirmation was available that agency staff had the required skills and qualifications to meet the needs of residents, had been appropriately vetted and references had been sought from the most recent employer.

Judgment:
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:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Center name: Hazel Grove
Center ID: OSV-0004638
Date of Inspection: 04 August 2016
Date of response: 15 September 2016

Requirements

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

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

Outcome 05: Social Care Needs
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person responsible for supporting the resident in pursuing goals and the timeframe was not always clearly identified in IPPs.

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 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
The person responsible for supporting the resident in pursuing goals and the timeframe will be clearly identified in IPPs. A front page will also be added to plans to guide new staff and supporting staff to sign off when goals have been completed.

**Proposed Timescale:** 07/10/2016  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some IPPs in relation to healthcare and nutrition contained information that was not comprehensive or easy to retrieve to ensure that all staff were aware of the support required in this area.

2. **Action Required:**
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident’s assessed needs.

**Please state the actions you have taken or are planning to take:**  
Healthcare and nutritional domains on all IPP will be updated to clearly inform staff in an easy format what support is required.

**Proposed Timescale:** 28/10/2016

**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 risk of the unexplained absence of any resident was not included in the risk management policy.

3. **Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.
Please state the actions you have taken or are planning to take:
The risk of the unexplained absence of any resident will be included in the risk register as part of the risk management policy.

**Proposed Timescale:** 28/10/2016  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The risk of self-harm was not included in the risk management policy.

4. **Action Required:**  
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:  
The risk of self-harm will be included in the risk register as part of the risk management policy.

**Proposed Timescale:** 28/10/2016  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
An individualised risk assessment was not completed where a resident had been identified as being at high risk of choking by the speech and language therapist.

5. **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:  
An individualised risk assessment for a resident at high risk of choking as identified in Speech and Language Therapist report will be completed.

**Proposed Timescale:** 23/09/2016  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The storage of mops was not adequate to prevent cross-contamination.
The training matrix indicated that one staff member had not completed infection prevention and control training.

There was no cleaning schedule in place for the fridge used to store medicines requiring refrigeration and the fridge was not clean on the day of inspection.

6. **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:**
(1) A new storage system for mops to ensure prevention of cross-contamination will be put in place. 04/11/2016.

(2) Staff has now completed the Infection Prevention and Control Training. 12/09/2016.

(3) A weekly cleaning schedule now in place for the fridge used to store medicines requiring refrigeration. 19/09/2016

**Proposed Timescale:** 04/11/2016

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**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:**
It could not be confirmed that agency staff had received training in the management of behaviour that is challenging including de-escalation and intervention techniques.

7. **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:**
Agency staff will be completing training in MAPA

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

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A positive behaviour support plan in place at the time of the inspection was not adequate and required the input of the behavioural specialist team to ensure that staff had 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.

8. **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:**
Positive Behaviour support currently meeting with the team. A report to be compiled 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.

**Proposed Timescale:** 19/09/2016
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Multi-disciplinary input was not in place to oversee the restrictive practices.

9. **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:**
PIC and Social Care Worker met with psychologist for Multi-disciplinary input to oversee the restrictive practices in place in Hazel Grove on 17 August 2016. A report is now being compiled.

**Proposed Timescale:** 30/09/2016

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Plans in relation to care at end of life and times of illness required development in line with the centre's policy and procedure.

10. **Action Required:**
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.
Please state the actions you have taken or are planning to take:
Ensure adequate information on the hospital passport with an overall view of the health needs and history of each individual. End of life information to be updated in respect of each resident needs. Easy read accessible information around end of life to be made available to residents, theme of End of Life to be brought up at the in house Advocacy meeting.

Proposed Timescale: 30/09/2016

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:
An annual review of the quality and safety of care and support in the designated centre had not taken place in the past year.

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

Please state the actions you have taken or are planning to take:
2015 Annual Review currently underway with final report completed early October.

Proposed Timescale: 07/10/2016