Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004645
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Deborah Harrington
Lead inspector:	Julie Hennessy
Support inspector(s):	Louisa Power; Carol Maricle
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:	To:
26 May 2016 09:00	26 May 2016 16:00

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

Outcome 05: Social Care Needs
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 third inspection of the centre. As outlined in the published report for the inspection of this centre from September 2015, eight of 11 outcomes were found to be at the level of major non-compliance at that inspection. The purpose of this inspection was to determine the level of improvement in key areas of quality and safety of care and support provided to residents in the centre.

Description of the services
The centre comprises three community houses. According to the statement of purpose, the service was available to 18 adult men and women who had a diagnosis of an intellectual disability and/or autism. The person in charge told inspectors that some residents required minimal support and were very independent while others required higher levels of support and assistance. Residents ranged in age from 40 to 80 plus years of age.

How we gathered out evidence
Inspectors spoke with seven residents between the three houses over the course of the inspection. Residents with whom inspectors spoke said that they were very happy with the service they received, they were comfortable, they knew who was in charge and they enjoyed going into the nearby town and going to their place of work

on weekdays. Some residents chose to show inspectors around their house and described to the inspectors who lived there, the day to day arrangements such as who was responsible for what household chores. They spoke about what they did each day, the holidays that they had been on, their family and friends.

Inspectors had also met residents from this centre at a service user forum in February 2016. At that forum and again at this inspection, a number of residents expressed that they wished to live more independently with fewer supports. In one of the houses, a resident said that they would like the access and egress to their house to be made more accessible.

Overall judgment of our findings
Overall, inspectors found that significant improvement had been made in the centre since previous inspections.

Over the course of the previous number of months, a new person in charge had commenced in the centre and this change had been supported with staff training in some key areas, staff changeover and the recruitment of new staff, including social care workers in some houses within the centres. Inspectors found evidence that these combined changes had led to demonstrable improvements in the quality and safety of care and support to residents and in quality of life outcomes for residents. For example, residents' had received occupational therapy assessments to support independent travel and exercise, activities in the community were promoted and new ideas were being explored on an on-going basis and residents' healthcare needs were being met. Where residents wished to live more independently with fewer supports, this wish was being actively supported by the person in charge.

One outcome was found to be at the level of major non-compliance at this inspection as a result of three different failings. Under Outcome 7; Health safety and risk management, an immediate action plan was issued to the provider in relation to fire safety arrangements in the centre. The provider and person in charge responded adequately to the identified failings within an acceptable timeframe. The second failing related to the excessively hot temperature of the water in the main bathroom and kitchen of one house, which was rectified without delay by the person in charge. The third failing related to ensuring that residents could safely access and egress their house.

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

Theme:
Effective Services

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

Findings:
Overall, improvement had been made in relation to personal planning and supporting residents' goals as they related to living more independently. Improvement was required in relation to review of the personal plan and ensuring that each centre was suitable to meet residents' abilities, wishes and assessed needs.

A comprehensive assessment of residents' health, social and developmental needs had not been completed in this centre. However, the person in charge told the inspector that multi-disciplinary assessments were scheduled to commence the following month (June 2016) for all residents, which would also serve to inform and support decisions around more independent living. The person in charge told inspectors that this assessment would help him and staff further understand residents' needs and assist with setting personal goals.

A new format of personal plan had been introduced across both centres since the previous inspections and was in the process of implementation. Personal plans had been developed with input from residents themselves, their key workers and their family members or representatives. Personal plans reflected information specific to individual residents, their likes and dislikes, who was important in their lives, how they chose to spend their days and how to support residents to communicate, make choices and participate in activities in accordance with their wishes.

Due to the fact that personal plans were being rolled out, some were more developed than others. For example, a part of the personal plan that related to healthcare (the epilepsy management plan) did not identify all known triggers for epileptic seizures. Staff told inspectors that they were continually working to improve the setting of residents' goals in both centres. Progress had been made however and many goals were meaningful to residents and made a demonstrable difference to their quality of life. For example, a resident's personal goals had identified a wish for a shed in the garden for their own individual use and this goal had been realised.

However, there was no system in place that ensured that the review of the personal plan would be multi-disciplinary, as required by the regulations.

There was a range of activities located in the community for residents to attend and also a day activation unit based at the campus under the auspices of the provider. Some residents were described by the staff as needing minimal supports and accessed public transport independently and visit friends and family. Residents were facilitated to meet their family members and the residents confirmed same.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Overall, there were a number of measures in place to protect the health and safety of residents and staff. However, significant improvement was required in terms of fire safety arrangements in the centre. The provider and person in charge responded promptly to this failing. Other key non-compliances related to water temperature control and safe access and egress to two of the houses in this centre.

An immediate action plan was issued to the representative of the provider in relation to fire safety arrangements. Fire safety drills did not simulate all likely scenarios and situations, such as night-time conditions, times during the day when some residents were alone in their houses or different staffing arrangements. Inspectors met a resident who was alone in their house and said that they would not know what to do if the fire alarm was activated and said that they did not understand what the pictorial fire evacuation procedure on display was all about. Also, fire drill records did not demonstrate that residents could evacuate independently from the centre during such

times. In addition, improvement was required to ensure that documentation arising from fire drills reflected any issues identified during practice fire drills and what action was required to address any identified deficiencies. The representative of the provider and the person in charge responded appropriately to the immediate action plan issued and undertook to ensure that adequate practice fire drills were completed without delay in all three houses in this centre.

A risk register was in place in both centres. Inspectors reviewed the risk registers and found that the persons in charge had appropriately escalated risks to the risk register.

Some inconsistencies were found in risk assessments in both centres that indicated that on-going support to the staff team was required to ensure that staff understood how to implement risk assessments. For example, two falls risk assessments for the same resident assessed the risk as being medium in one assessment and low in the other assessment. In addition, challenging behaviour risk assessments did not always identify triggers known to staff. When asked, staff were however able to clearly articulate this information to inspectors. The person in charge outlined a system that had been introduced to identify any such gaps in practice or documentation that involved reviewing in detail each resident’s personal plan on a rotating basis with the staff team.

In one of the community houses, an inspector found that the water temperature in the main bathroom was unacceptably hot. The person in charge acted promptly to address this. The temperature reading was confirmed as being too hot at 63°C and was adjusted by the maintenance staff. The person in charge arranged for water temperature readings to be checked in all three houses in light of this finding and to be monitored on a regular basis. The person in charge also completed an incident investigation and provided a copy of the investigation report to HIQA.

Inspectors noted that there was a system in place for the identification, recording and investigation of incidents, including medication-related incidents. With respect to medication-related incidents, for two of the three incident forms reviewed, the control measures to prevent recurrence and learning from medication-related incidents were clearly identified. However, for the third medication-related incident, the control measures to prevent recurrence and learning from this incident were not recorded on the incident form.

Residents in one of the community houses told inspectors that they had difficulty leaving the house during icy weather as they required a handrail to descend the steep driveway. Inspectors viewed a quote for required works that had been sent to the estates department, which included the installation of concrete steps and a handrail.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Overall, while a positive approach was demonstrated by staff to supporting residents with behaviours that may challenge, improvement was required. In addition, it was not demonstrated that the processes in place to manage allegations were adequate.

There were policies and procedures in place in the organisation for the safeguarding of vulnerable adults, in relation to the protection of residents' finances and personal belongings, supporting residents' during intimate care, supporting behaviours that may challenge and restrictive practices.

Staff members and persons in charge were observed to support and interact with residents in an appropriate and warm manner. Residents told inspectors that they were happy and knew how to make a complaint, should they have one.

Behaviour support plans were in place for residents who required such plans. Behaviour support plans had been developed by the staff team. However, there was no system in place to ensure that the effectiveness of the interventions in place were reviewed by appropriate multi-disciplinary team members.

Risk assessments had also been completed for behaviours of concern and an assessment of how residents demonstrate their distress or other emotions. Some inconsistencies were found in the documentation. For example, a threat made by a resident to harm themselves was not included in the risk assessment nor was the source of a resident's anxiety. However, staff members were able to articulate this information to inspectors, as it related to key triggers, how those emotions may manifest themselves and how to respond in order to support residents.

A positive approach to restraint was demonstrated and alternatives were explored to the use of restraint. Inspectors spoke with members of the staff team, who were aware of what to do in the event of an allegation, suspicion or allegation of abuse. There was a designated person within the service to whom any concerns were reported.

Inspectors found that improvements were required to safeguarding procedures as they related to the management of allegations. The process in place was not sufficiently robust to ensure that all allegations were appropriately screened and managed in a consistent way. The person in charge reviewed the procedure in place and addressed this gap in a prompt manner.

Inspectors reviewed a sample of residents' intimate care protocols in both centres and found that they outlined the supports each resident may require while also supporting and promoting independence.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

Findings:
Inspectors found that overall, residents' healthcare needs were met by access to medical, nursing and allied healthcare and supported by staff.

Residents had access to their own general practitioner (GP) and consultants where required. Residents had access to allied healthcare professionals, including speech and language therapy, occupational therapy, physiotherapy, dietetics and dentistry.
Where residents had been recently discharged from hospital, care and support was delivered by staff in accordance with clinical recommendations and guidelines.
Residents' wound care, nutritional and hydration needs, skin integrity and continence was all promoted and maintained by staff.

Based on a sample of healthcare plans reviewed, residents changing healthcare needs were met. For example, where residents were at risk of developing pressure ulcers, there was a care plan in place and guidelines for pressure ulcer management developed by the occupational therapist were being followed. There was evidence of effective wound management resulting in wounds that had healed or were healing. Any required monitoring was completed and recorded. For example, where residents had diabetes, all complications of diabetes were being monitored and residents were supported to exercise and eat healthily.

Based on the sample reviewed on the day of inspection, the required healthcare plans were in place to support residents identified and readily identifiable healthcare needs, for example in relation to their mental health, mobility, circulatory problems, chronic conditions and skin integrity.

There was evidence that relevant risks, such as the risk of choking, were monitored and any incident recorded. Input from allied health was sought in relation to preventing related incidents. Staff members were able to articulate that they were aware of and understood how to implement the recommendations made by allied health professionals.

Breakfast and tea were prepared and served in the houses. A hot meal was prepared in the central kitchen and residents ate that meal in the main dining room on the campus. While this was an institutionalized practice, inspectors observed an example in the community houses where residents were unable or chose not to go to the campus for their meal and the meal was instead delivered to the house.

Where residents had difficulties with swallowing, an assessment had been completed by a speech and language therapist. Where residents had dietary requirements or nutritional needs, assessments had been carried out by a nutritionist and other healthcare professionals as indicated. Weight was monitored and food diaries maintained where indicated.

Each resident had an individual 'hospital passport' that contained key information should a resident be admitted to the acute hospital sector. Information contained in the hospital passport was specific to that resident and included information about allergies, their medication, communicating with the resident in relation to healthcare matters and any relevant risks. Information was kept in the kitchen about any dietary requirements or supports around mealtimes.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Medicines management practices were examined by a medicines management inspector.

There was a medicines management policy in place. Medicines for residents were supplied by a local community pharmacy. 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. The inspector saw that the pharmacist had undertaken a review of residents' medicines in March 2016.

However, it was not demonstrated that the recommendations made by the pharmacist had been discussed with the multidisciplinary team and implemented as appropriate.

The inspector observed a robust system for checking of compliance aids on receipt every week against the resident's prescription to ensure accuracy. Compliance aids were clearly labelled to ensure identification of each individual medicine within the compliance aid.

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. However, the inspector identified five gaps on a medication administration record where a medicine was due to be administered. Therefore it could not been confirmed that the medicines had been administered as prescribed.

Residents' medicines were stored securely. Staff with whom the inspector spoke confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection.

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 outlined that a resident managed inhaled medicines with support from staff. The resident carried and stored the inhaled medicines independently. Staff confirmed that the resident had administered the inhaled medicines and signed the medication administration record. An assessment of capacity to self-medicate was available for this resident and was reviewed by the inspector. However, the assessment tool was not adequate as it did not take into account an individualised assessment in relation to inhaled medicines. In addition, the controls and oversight in place to promote the resident's independence whilst ensuring compliance and concordance with prescribed medicines were not clearly outlined in the resident's personal plan.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors found that overall, it was demonstrated that there were effective management arrangements in place. as evidenced by significant improvements since previous inspections.

A new person in charge had commenced in the centre six months previously and worked in this centre only. The person in charge also provided cross-covered for the person in charge in another designated centre during times of leave (that centre comprises two houses and can accommodate 18 residents).

The person in charge was suitably qualified and experienced to fulfil the role of person in charge. The person in charge demonstrated that he knew residents, their needs and abilities well. Inspectors met with a number of staff who spoke positively of the person in charge and the changes that had taken place over the previous few months and described the person in charge as being both "approachable" and "empowering". The person in charge was supported in his role by a CNM1, who visited each house within the centre daily, a clinical nurse manager (CNM2) (who also worked in another designated centre) and a night supervisor.

The change to the person in charge arrangements had been supported training in some key areas, staff changeover and the recruitment of new staff, including social care workers in some houses within the centres. Inspectors found evidence that these combined changes had led to demonstrable improvements in the quality and safety of care and support to residents and in quality of life outcomes for residents. For example, residents' had received occupational therapy assessments to support independent travel and exercise, activities in the community were being promoted and new ideas were being explored on an on-going basis and residents' healthcare needs were being met. Where residents wished to live more independently with fewer supports, this wish was being actively supported by the person in charge.

Audits viewed in different centres included audits of care plans, unit meetings, incidents, complaints, dining experience, personal care and medication management. With respect to medicines management, inspectors saw audits had been undertaken to review and monitor safe medicines management practices in the centre on a monthly basis by the person in charge. However, the audits were limited in scope and did not cover all aspects of the medicines management cycle including ordering, receipt, disposal, monitoring and staff training.

HIQA had required the provider to carry out two unannounced visits within the previous six months and submit reports on the safety and quality of care and support provided in the centre, as part of an escalation process of all of the provider's centres in this region. The audits for this centre were completed in October 2015 and March 2016.

An inspector reviewed the audits and found that actions were traced and tracked for completion between the two audits. For example, the auditors tracked whether staff were knowledgeable regarding safeguarding procedures, residents' level of involvement in activities both inside and outside the home, the management of complaints and cleanliness of the centre. Where healthcare actions were identified as outstanding, they were brought to the attention of the clinical nurse manager (CNM1) during the audit.

The inspector followed up on a sample of actions from the most recent audit and found that they had been completed. However, some further improvement was required to demonstrate that such audits adequately assessed the quality and safety of care and support being provided in the centre. For example, a number of key failings identified on this inspection had not been identified such as, the need for a formal system of staff supervision and appraisal, gaps in fire safety drills, the need for a comprehensive assessment of needs for all residents, improvements required to the accessibility of the driveways of two houses and the lack of multi-disciplinary review of the personal plan. In addition, a number of residents clearly expressed their wish to live more independently to inspectors both at this inspection and to inspectors at a service user forum in February 2016. This key wish that had been well articulated by residents should have been reflected in the audits with an associated action plan. In addition, the inspector noted that of 18 residents, the views of only four residents were sought on the first audit and three residents on the second audit.

Judgment:
Non Compliant - Moderate

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:
Overall, improvements had been implemented since the previous inspection in order to support residents' needs and abilities and promote community inclusion. Improvements were required in relation to the full implementation of a formal system for staff appraisal, staff training, the checking and recording of information required as part of the recruitment process and ensuring that staffing arrangements reflected residents' actual assessed needs.

There was a staff rota in place in the centre. However, the rota did not fully reflect planned and actual staffing arrangements as it also contained the arrangements for other centres. In addition, the actual hours scheduled or worked were not always included on the rota. While the clinical nurse managers were supernumery, their hours were not included on the rota itself.

Based on observations, discussions with staff, a review of the roster and these inspection findings, it was demonstrated that in both centres, the staff numbers were appropriate to meeting the number and assessed needs and abilities of residents at the time of inspection. Changes to the staff team had taken place since previous inspections, including an increase in social care workers in some houses in this centre, in order to promote a social care approach and increase the variety and type of activities for residents. Staff demonstrated that they were constantly exploring opportunities for residents in the community, including residents who were retired.

A sample of staff files was reviewed against the requirements of Schedule 2 of the regulations and gaps were found in staff files. For example, three of four files viewed had gaps in employment history and two of four files did not contain a job description.

There was evidence of effective induction procedures in line with the policy. Staff who had commenced working in the centre in the previous few months told the inspector that they had received a comprehensive induction to the centre. Staff told the inspector that while a changeover of staff in late 2015 had been unsettling for some residents, residents had been supported through this period. A core staff team currently provided continuity for residents.

Weekly staff team meetings took place and minutes were kept of those meetings. The person in charge had also recently introduced meetings between social care workers. Staff told the inspector that they could add to the agenda if they wished to do so. One-to-one staff appraisal had been recently introduced by the person in charge and a number of appraisals had taken place. However, a formal supervision system had yet to be introduced to all of the houses for staff to facilitate staff to raise any concerns and to support, develop and manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

Staff training records indicated that there were gaps in mandatory training and training relevant to their role. For example, two staff required training in relation to safeguarding, two staff had never received training in fire safety and six had never received training in fire evacuation and there were also gaps in relation to hand hygiene training. A detailed staff training schedule was available for review that demonstrated

that training gaps were in the process of being addressed.

Judgment:
Non Compliant - Moderate

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

Findings:
One aspect of this outcome was added on inspection.

The medicines management policy required review as it did not adequately detail the requirements in relation to recording medicines administration and self-administration. It was outlined to an inspector that the policy had been reviewed, was in draft form and was awaiting implementation.

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[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004645
Date of Inspection:	26 May 2016
Date of response:	28 June 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 review of the personal plan was not multi-disciplinary. **1. Action Required:** Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

Please state the actions you have taken or are planning to take:
In light of the regulatory requirement, annual MDT reviews will be scheduled to occur with immediate effect and will be carried out fortnightly. The first review is scheduled for 06/07/2016.

Proposed Timescale: 15/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment of residents' health, social and developmental needs had not been completed.

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

Please state the actions you have taken or are planning to take:
Assessment of needs is to be carried out on 12 residents by an external agent and will be completed by the 01/07/2016 to take account of the above requirements

With regards to the other 6 residents, their assessments will be completed utilising a MDT approach and will be completed by 15/10/2016.

Proposed Timescale: 15/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, personal plans required further development to reflect residents' needs, abilities, wishes and preferences.

3. 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:
This will take priority following the assessment of needs. Personal plans which reflect residents' needs, abilities, wishes and preferences will be completed to demonstrate cognisance of this an as part of the annual MDT care plan reviews.

Proposed Timescale: 15/10/2016

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 control measures to prevent recurrence and learning from medication-related incidents were not always recorded on the incident form.

4. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The risk management policy and the medication policy will be reviewed and updated accordingly to ensure that these policies include arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, the steep driveway presented a hazard during icy conditions for residents. A quote for required works had been sent to the estates department, which included the installation of concrete steps and a handrail. Approval of and a completion date for these works was required.

5. 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:
As per the national regulations, contracts have been sent out for tender and the HSE Estates department are in the process of appointing an engineer for resurfacing parts of St Raphael's. As part of this plan, the driveway of this house will be added to the schedule of works for completion.

Proposed Timescale: 01/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, some inconsistencies were found in risk assessments in both centres that indicated that on-going support to the staff team was required to ensure that staff understood how to implement risk assessments.

6. 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:
Training has been facilitated in this centre for staff with regards to completing and complying with risk assessments.

Further training dates will be arranged so that all staff will have training in this area.

Proposed Timescale: 30/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that fire drills as completed, considered all likely scenarios and conditions. In particular, night-time conditions and actual staffing arrangements in place (both day and night) and recorded findings and any actions required.

7. 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:
Both night and day-time drills were carried out in all three houses immediately following the unannounced inspection in May 2016 with satisfactory results noted. A planned schedule of fire drills is in place going forward. The results of these drills will be reviewed and future learning outcomes developed, as appropriate.

Proposed Timescale: 19/06/2016

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:
Risk assessments for behaviours of concern and behaviour support plans required further improvement to reflect all of the required information to support residents' behaviour that may challenge.

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:
Training on Positive behaviour support will be provided to all staff within the centre facilitated by the Clinical Nurse Specialist in Behaviour Support.

Proposed Timescale: 30/09/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no system in place to ensure that the effectiveness of the interventions in place were reviewed by appropriate multi-disciplinary team members.

9. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
The MDT annual reviews will commence on 06/07/2016 and the recommendations made will be included in the review to ensure that the effectiveness of the interventions undertaken is satisfactory.

Proposed Timescale: 15/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that practices in place to manage allegations of abuse were in line with the relevant Health Service Executive (HSE) safeguarding policies, December 2014.

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

Please state the actions you have taken or are planning to take:
This issue was addressed immediately to the satisfaction of the Inspector on the 26/5/16.

All risk assessments regarding behaviours of concern are to be updated by 31/07/2016.

Proposed Timescale: 31/07/2016

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:
It was not demonstrated that the recommendations made by the pharmacist had been discussed with the multidisciplinary team and implemented as appropriate.

11. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
New Medication Management policy to be fully implemented by 30/09/2016.
The pharmacist has been invited to attend an MDT meeting on the 06/07/16 to formalise the system and agree the process of implementation of any recommendations.
Proposed Timescale:
- Medication Management Policy to be implemented by 30/09/2016.
- The pharmacist invited to attend the MDT meeting on 06/07/2016 and quarterly thereafter.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector identified five gaps on a medication administration record where a medicine was due to be administered.

12. 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:
Medication management system to be enhanced by 30/08/2016 and the introduction of a new medication error system will be implemented giving credence to learning and development of individuals involved in medication administration.

Medication management policy is currently under review by the Policy Review Group. This will be ratified by 15/08/2016. An updated policy will include 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 required to the resident for whom it is prescribed and to no other resident. This policy will be distributed to all staff by 22/08/2016. A series of information sessions will be facilitated by the Policy Review Group and completed by 30/09/2016.

Proposed Timescale: 30/09/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessment tool was not adequate as it did not take into account an individualised assessment in relation to inhaled medicines.

The controls and oversight in place to promote the resident's independence whilst ensuring compliance and concordance with prescribed medicines were not clearly outlined in the resident's personal plan.

13. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
Inhaler use assessment tool put in place immediately on the 26/5/16 and HIQA advised of same.

Proposed Timescale: 26/05/2016

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:
Medicines management audits were limited in scope and did not cover all aspects of the medicines management cycle including ordering, receipt, disposal, monitoring and staff training.

14. 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:
1. A new medication audit tool will be in place following the introduction of the Medication Policy on the 15/8/16.
2. Following the launch of the new Medication policy and the audit tool a schedule of audits will be developed by the 15/9/16.
3. Audits of all designated centres will be completed by 30/10/16.

Proposed Timescale: 30/10/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to the unannounced visits by the provider to ensure that they adequately reviewed all aspects of the safety and quality of care and support being provided to residents in the centre.

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

Please state the actions you have taken or are planning to take:
A new audit template for Regulation 23 inspection was developed on the 2/6/16 and an unannounced inspection of the designated centre will be completed by the 03/09/2016.

Proposed Timescale: 03/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A planned and actual staff rota was not maintained, showing staff on duty at any time during the day and night.

16. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
A new roster format will be developed to reflect the requirements as requested above.

Proposed Timescale: 30/08/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A formal supervision system was not in place to facilitate staff to raise any concerns and to support, develop and manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

17. 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:
A draft policy regarding staff support is currently being finalised. Following this a formal supervision system will be developed to facilitate staff to raise any concerns and to support, develop and manage all staff to exercise their personal and professional responsibility with reference to the quality and safety of the service. Date of commencement of this supervision system is 01/08/16.

Supervision system to commence by 01/08/2016-this process will be ongoing from that date.

Proposed Timescale: 01/08/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff training records indicated that there were gaps in mandatory training and training relevant to their role.

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

Please state the actions you have taken or are planning to take:
A robust schedule of staff training is ongoing in the centre since 01/01/2016 an updated analysis of current staff training needs will be completed by 01/09/2016. A schedule of training dates will be developed by 15/09/2016 address any deficits identified.

Proposed Timescale: 15/09/2016

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An updated medicines management policy was in draft form and was awaiting implementation.

19. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Medication management policy is currently under review by the Policy Review group. This will be ratified by 15/08/2016 and will be distributed to all staff by 22/08/016. A series of information sessions will be facilitated by the Policy review group and completed by 30/09/2016.

Proposed Timescale: 30/09/2016