

**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-0004649
Centre county:	Wexford
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Brigid Murphy
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was unannounced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 05 July 2016 09:30 To: 05 July 2016 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was the third inspection of this service and had two purposes. It was informed by unsolicited information received by HIQA. The information received was not directly related to the service but did indicate concerns as to the safeguarding measures and response to concerns if they arose. The inspection was also required to ascertain the provider's adherence to the actions identified in the registration inspection of 20 October 2015 so as to proceed with the registration of the centre. An update on the actions following that inspection was requested and forwarded to HIQA in January 2016. That update indicated that the actions were being addressed satisfactorily.

Residents from this centre had been transferred to another location on a temporary basis while building and fire upgrading works were taking place, and had relocated back to the centre in April 2016.

How we gathered the evidence:

The inspection took place over one day and was unannounced. The inspector reviewed all notifications and information received since the previous inspection. The inspector met with all of the residents and staff members, the acting person in

charge and the provider nominee.

The inspector reviewed the premises and observed practices including mealtime and relaxation for residents. Documentation related to risk management, residents' records, accident and incident reports, medicines management, staff supervision records, policies and procedures were reviewed. The person in charge was on annual leave during the inspection and the inspector was assisted by the clinical nurse manager (CNM) who fulfils the role of person in charge in her absence.

Description of the service:

The statement of purpose describes the service as providing care for 11 residents, both male and female with severe to profound intellectual and physical disabilities, behaviours that challenge and autism. Practices were found to be in accordance with this statement. The centre consists of a large detached house in its own grounds in a large town. The residents attend day services provided by the organization and other agencies.

Overall judgement of the findings:

Having undertaken this inspection in relation to the unsolicited information, the inspector was satisfied that the provider had not been in receipt of information regarding potential neglect on which they had not taken action. The provider had however, put further protective systems in place to ensure the residents' wellbeing. The inspector reviewed the 26 actions required following the registration inspection. Almost all of these had been satisfactorily addressed or were in process of being addressed. The significant matters of the availability of a suitable number of staff and access to behaviour management supports had been satisfactorily resolved.

Overall, the inspector was satisfied that the provider had put effective governance systems in place to ensure that the regulations were being met. This resulted in positive outcomes for residents, the details of which are described in the report. Good practice was found in :

- Consultation with residents and their representatives and access to independent advocates which promoted residents' rights (outcome 1)
- Promotion of privacy and dignity by the reconfiguration of the premises (outcome 1)
- Access to external advocates which promoted residents' rights (outcome 1)
- Access to multidisciplinary clinicians, healthcare services and medicines management which promoted residents' wellbeing and safety (outcomes 5 and 11 and 12)
- Increased access to socialization and external activities which enhanced residents' quality of life (outcome 5)
- Sufficient staffing and skill-mix which ensured care was provided in accordance with the residents' assessed needs and preferences (outcome 17).

Some improvements were required in:

- Development of personal plans based on assessed needs (outcome 5)
- Holding of regular fire drills (Outcome 7)
- Safeguarding plans (outcome 8)

- Communication between other agencies that provide care to the residents
- Systems for the management of residents' finances.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The action from the previous inspection including the management of complaints, and the lack of privacy and dignity due to a number of unsuitable issues in the premises had been satisfactorily addressed. From a review of the complaints register and related documentations a small number of complaints had been made in relation to care provision. These had been reported, recorded and there was evidence that the person in charge and the provider had taken steps to address the issues to the satisfaction of the complainant in a timely manner.

Staff were also seen to make complaints on behalf of residents where internal issues impacted on their quality of life.

Issues in the layout of the premises which impacted on this were also addressed. The design and layout of an unsuitable bathroom had been addressed and the matter of having to access a double bedroom via another double bedroom had also been addressed.

The second toilet had been removed from the bathroom and an unsuitably placed window had been removed. One of the double bedrooms had been converted into office storage and a suitably wide corridor was created to access the second bedroom.

However, the inspector found that information of a sensitive and very personal nature was detailed and conveyed to the centre from another agency via a notebook which was carried by the resident. While this was not the provider's responsibility directly it was not a suitable manner of communicating such information between agencies. The notebook

could easily be mislaid which would impact significantly on the privacy of a resident and family. The details of this are further outlined under Outcome 8 Safeguarding and Safety and the provider was already aware of the inappropriateness of this system.

Taking the residents' assessed needs into account, there was a significant emphasis on relatives and or representatives to speak on behalf of the residents. There was evidence of regular communication and consultation with relatives.

To this end, the make-up and function of the residents' representative group included parents and an external advocate, as well as residents from this and other centres. The records seen indicated that the meetings focused on development of quality systems to improve residents' access to the community and provide different experiences for them. Requests had also been made to the national advocacy services for individual supports for residents.

On a day-to-day basis the key workers used communication cards and their knowledge of the residents to help them make choices and express their wishes. It was apparent from the personal records and from observation that the staff knew the residents' preferences very well and also understood the residents' means of expression and communication. Residents' privacy was respected in the provision of personal care with thumb locks on bathroom doors and it was observed that even in the double bedrooms, personal care was carried out in private. The three double bedrooms were spacious, with suitable screening and ample room for personal possessions. Staff were observed to be respectful in all interactions with the residents, including when supporting them with meals.

There were detailed and updated personal property lists maintained. Systems for the management of residents' finances within the centre and on a day-to-day basis were transparent and the inspector saw that detailed records were maintained locally of all spending. There was an assessment undertaken to ascertain the capacity of the residents to manage their own money with supports.

The policy on financial management states that a 'best interest' approach would be taken by staff to decisions regarding spending of monies on residents' behalf. There was no clarity however, as to how this process would be undertaken, overseen and who it would be in consultation with.

Residents' monies were currently lodged into a HSE personal property account. The inspector was informed that plans were in process to address the matter of the residents' own accounts.

Judgment:
Substantially 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):

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

Findings:

The actions from the previous inspection in relation to the content, effectiveness and review of the personal plans had been partially resolved. A revised system for assessment, documentation and implementation of residents' support plans had been introduced.

A review of four of the residents' records found that the quality and detail of the personal and support plans differed; however, and the correlation between assessment, clinical interventions and the personal plans was not consistently evident. A number of the plans were very comprehensive and could be seen to be reflective of the assessed needs and aspirations of the residents with regular updates on progress and implementation of the plans evident.

This was not a consistent finding. Some of the personal plans did not detail the goals or the agreed strategies to achieve them. There were specific support strategies identified following assessments, for example, a resident with significant and complex needs required a specific strategy to encourage leaving the unit which was a vital goal for their wellbeing. The plan did not include this strategy.

In other instances smaller, though no less important, goals for life skill development were not included in the plans. Some plans referred the staff to a policy. For example, where a resident required a specific management strategy for road safety and use of the vehicle, the plan referred to the transport policy. Given the dependency levels of the residents, knowledge of and adherence to the specific strategies and plans are crucial to residents' development, consistency of care and to assessing the effectiveness of the agreed strategies.

There was evidence of a significant level of multidisciplinary assessment and interventions. There was regular access to speech and language therapy, physiotherapy, psychiatry and psychological supports. There were records of multidisciplinary reviews of residents having taken place and ongoing strategies agreed on. Multidisciplinary reviews were attended by the residents' representatives. However, due to how documentation

was being used in the centre, the link between the assessment, planning, implementation and reviews could not be clearly ascertained to ensure residents' needs were being met.

Some, but not all, of these findings can be attributed to the use of the documentation available and staff on the day were able to inform the inspector of the actual strategies being implemented and their effectiveness. The inspector acknowledges that the documentation is relatively new and the process of review is also new. On discussion with the provider, the inspector found that training had been provided and further training was planned for staff to ensure they understood the process.

Both the transfer to the temporary premises and the return to the centre were seen to be managed in a planned way with transitional plans implemented to support the residents. There were significant improvements evident in access to individual, community and social supports. This was facilitated by the increase in staffing made available by the provider.

The residents attended day care on different occasions. This meant that there were usually four to five residents who remained in the centre on various days. The inspector saw that the additional staffing provided scope for activities and ongoing interactions with the residents which were not task focussed.

Activities included massage, sensory therapy, music, playing on the garden swing, minding the vegetable patch which had recently been completed and access to the local town, seaside and community events. There were toys and other sensory equipment including music available and used with the residents. Staff stated how the increase in staffing numbers had made a significant difference to the attention and time they could give to the residents.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:
Effective Services

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

Findings:

The actions required by the previous inspection had been satisfactorily addressed. The unsuitable bathroom had been renovated and one of the twin bedrooms had been relocated to the first floor. A staff office and file storage room was now situated in a more suitable location, with easier access for supervision purposes. The alterations also provide an additional and quiet seating space for residents.

The bedrooms were suitable and spacious and there was sufficient communal and personal space available. The inspector saw that assessments and consultation had been undertaken to decide which residents should share the double rooms. Consideration had also been given to mobility and safety when deciding which residents should relocate to the double rooms upstairs.

The long-term plan for the centre as part of the overall reconfiguration of the service is to reduce the number of residents living together in the centre. The inspector was informed that this was under consideration at the time, taking location, compatibility and age into account. Discussions were taking place with relevant agencies to progress this.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The actions required from the previous inspection had been satisfactorily resolved. The policy on risk management had been revised to include the risks as specified in the regulations, and supporting policies were in place including an appropriate emergency plan and on the risk of residents absconding.

While the inspector found that safety was prioritised, some improvements were required in the holding of fire drills, clarity of information in the residents' personal evacuation plans and in the details to mitigate some risks identified for residents. The residents had returned to the centre in April 2016. Some alterations had been made to the premises and with the alterations, three residents were now accommodated upstairs.

The records showed that one fire safety training session had been undertaken with some staff on return to the centre to simulate night time conditions and staffing levels. All other staff, including new staff members, had basic fire safety training in the day centre. No fire drills had been undertaken since the return to the centre which would

ensure staff were familiar with the revised layout, residents' sleeping arrangements and the correct use of equipment such as the ski sheets. However, staff spoken with were aware of the evacuation arrangements and what to do in the event of a fire.

The personal evacuation plans required review to accurately reflect the residents' individual physical capacity, support needs and location of bedrooms, and were in a more easily accessible location.

There were risks assessments undertaken for individual residents for pertinent issues including self-harm, falls and unauthorised absence and evacuation of the residents.

Some of the management plans were very specific and provided staff with clear directions as to how to keep the resident safe. However, a small number were generic. This is actioned under outcome 5 Social Care Needs.

There was evidence that incidents which occurred were reported and reviewed at senior management meetings as part of the incident management process. This included analysis of data which contributed to any untoward events and decisions taken to mitigate the risks.

The risk register detailed both clinical and environments risks pertinent to the centre. Staff either carried or had easy access to emergency alarms. Infection control systems were satisfactory and a system for the maintenance of equipment including hoists used by residents was evident.

The residents had been relocated temporarily in order to facilitate fire safety upgrading works. This included the installation of new fire doors, fire alarm and emergency lighting systems. Documentary evidence of the servicing of the fire alarm and the fire fighting equipment was available. The emergency lighting was present and could be seen to be active but the commissioning documentation was not yet available from the contractors. Daily checks on the alarm and exits were carried out. A number of safety audits of the premises and work practices in the centre had been undertaken by the person in charge on a regular basis. Emergency phone numbers were readily available to staff.

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):

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

Findings:

The inspector was satisfied that residents' safety and welfare was prioritised but some improvements were required in the procedures for the sharing of information between external services and details of safeguarding plans.

Concerns had been raised for residents' welfare in circumstances external to the centre. This had resulted in a significant and very serious intervention being taken to safeguard the residents concerned. This intervention had been reviewed by the Health Service Executive (HSE) and at the time of this inspection had been withdrawn following a review with ongoing monitoring in place.

Some alterations to the residents' plans had been made to provide support to these residents in the external environment. This matter was initially reviewed by HIQA in two other services and the inspector found that there was no evidence that the person in charge had received information suggestive of neglect and had not acted upon it.

However, the inspector found that while systems for communicating between an external agency and the centre had improved, systems were still not sufficient to ensure either effective monitoring or clarity of information. There was sufficient evidence available to indicate that both the provider and the person in charge had requested a more structured communication system be used. Some of the information was communicated to the centre in an inappropriate manner as detailed in Outcome 1 Privacy and Dignity.

This lack of adequate sharing and recording of information is contrary to the HSE's national policy.

There was ongoing review of this concern via the statutory agency. However, the details of the safeguarding plan implemented as seen were not sufficient. The plans identified the risk and the primary actions taken only.

The plans did not detail the protective factors including additional supports facilitated by the provider, actions taken to promote wellbeing, prevent a re-occurrence of the initial concern and assist future decision making. This would also facilitate better review of the outcome and ensure that any additional supports could be considered. The details were, however, recorded in other records pertaining to the residents.

The Health Service Executive (HSE) policy on the protection of vulnerable adults was in place in the centre. There was a designated person assigned to manage any allegation should one arise. Nine of the staff and the person in charge had undergone training in the revised policy. There was a schedule of training in place for the remainder of staff. The inspector found that staff were familiar with their responsibilities in terms of acting to protect residents and in recognition of actions or behaviours which were abusive.

There were detailed personal care plans available. A body chart was used to indicate any areas of bruising or skin damage which may occur, and these were found to be completed by staff and monitored.

There was a policy on the management of behaviours that challenge and the use of restrictive practices. A number of residents presented with behaviours that challenge and self-injurious behaviours. There was evidence of good and prompt access to psychiatric supports and psychology services. There were detailed behaviour supports plans in place but in some instances these did not sufficiently outline the precise recommendation made by the specialists. However, from a review of documentation and from speaking with staff the inspector was able to ascertain that the interventions were known and were implemented by staff.

Where specific triggers had been identified, which in one instance had resulted in assault on peers, the staff roster was altered to ensure the contributing factors were minimised and this was seen to have a good effect. Safeguarding plans had been implemented where behaviour impacted on other residents. A resident's sleeping accommodation had been changed to avoid the previous negative impact of their behaviour on peers. All such incidents were recorded, reported and reviewed.

One to one support and supervision was also made available where this was deemed necessary. Activity object identification cards were used to help aid communication and to avoid anxiety. A review of a number of residents' records indicated that p.r.n medicine (a medicine taken as the need arises) was used appropriately to manage behaviours. There was a protocol for its use which staff were familiar with. Documents reviewed indicated that the protocol was adhered to. This medicine was regularly reviewed by the psychiatric service and staff also noted the effectiveness or side effects of the medicine.

There were a number of restrictive practices used. These included key pad locks on certain doors, including the kitchen. There were evidenced-based assessment tools used to assess the need for and the safety of these restrictions and given the vulnerability of the residents these were satisfactory.

However, there was insufficient evidence of regular review of these restrictions. The provider was aware of this and had set up a rights review committee which would be responsible for undertaking such reviews. The members and terms of reference had been agreed. The committee consisted of suitably qualified people with external members to overview such strategies in the future.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector was satisfied that the healthcare needs of residents were identified and supported. The daily records maintained by staff were comprehensive and demonstrated that staff noted any changes in a resident's health. There were regular reviews of residents' healthcare undertaken and good access to healthcare supports evident. Evidenced-based tools were used to determine risk including skin integrity and dietary requirements.

There were support plans in place for all identified healthcare needs including nutrition, skin integrity, epilepsy and risk of aspiration. Fluids and food intake were monitored. Vaccinations were administered as deemed necessary and agreed. The inspector saw that medical interventions were undertaken in consultation with the resident's representative and agreed or not in conjunction with the resident's GP. Where residents were unable to cooperate with required medical treatments or assessment there was evidence of full consultation with all clinicians involved to monitor healthcare status.

The main meals were prepared off site and delivered in thermally insulated food trolleys. Staff in the centre altered or pureed the food delivered for the residents who required this. This strategy was undertaken as a precautionary measure to ensure each resident's nutritional needs were met. Additional foods or supplements could then be added to supplement the meals provided. Prescribed supplements were also administered as required. Pictorial menus were used to offer residents choice.

The inspector observed the meal time. The meals were in accordance with the directions of the dieticians and speech and language therapists and staff supported residents in a respectful, calm and unhurried manner.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The policy on the management of medicines was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory although none were being used at the time of this inspection. There were appropriate documented procedures for the handling, disposal of and return of medication.

The inspector saw evidence that medication was reviewed regularly by both the residents' GP and the prescribing psychiatric service. All medication was safely stored and there were systems for checking-in and receipt of medication. Regular audits of medication administration and usage were undertaken by the person in charge. Additional food supplements were used only if prescribed by the GP. There was a protocol in place for the use of emergency medication. No medication errors were noted and the systems for administration were seen to be safe.

Judgment:

Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

This outcome was not reviewed in its entirety due to the absence of the person in charge and subsequent lack of access to some documentation and information. However, there was sufficient evidence available to ascertain that suitable and effective governance systems had been implemented as required by the previous inspection. Although not available during this inspection, the person in charge was suitably qualified and experienced.

The provider nominee was responsible for five other designated centres under the umbrella of this organization in her role as director of nursing. She had suitable experience for the role, was clear on her responsibilities and was found to be very involved in the governance and development of the services, and very knowledgeable of the residents.

The findings on this inspection showed that a number of actions required from the previous inspection had been satisfactorily resolved. This demonstrated a commitment to ensuring that the care provided was suitable to meet residents' needs.

There were systems for monitoring and review of the service evident. While all audits were not available at the time of inspection, the schedule included medication, personal planning, risk assessments, residents' finances and access to activities.

A number of unannounced safeguarding visits also took place at various different times of the day and night. These focused on the safety and wellbeing of residents at these times. Reports of the findings were maintained. This system had been used to good effect in other centres belonging to the organization.

Thematic unannounced inspections by the provider have been taking place since January 2016. These focused on various outcomes such as consultation, complaints, personal planning and quality of life issues. There was evidence that where issues were identified actions were taken to address the deficits.

The annual leave of the person in charge did not require notification to HIQA and there was a suitably qualified nurse in charge at the time of the inspection. However, there was no protected time available to this person outside of normal nursing duties to oversee and monitor care. This was discussed with the provider who agreed to make suitable arrangements.

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):

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

Findings:

The actions required from the previous inspection including adequacy of the staffing levels, skill-mix and training for staff had been satisfactorily resolved. Two additional staff had been rostered which provided a ratio of three nurses and four care assistant staff from 8am until 8:30pm and three staff until 9pm. All of the residents were assessed as requiring fulltime nursing care and this was provided. A total of 17 staff provided care to the residents with 7 full-time nursing staff and 10 multi-task attendants.

This was seen to have had a positive impact on the residents' primary care needs being satisfactorily attended to and their opportunities to have staff support and activation outside of the centre. It also facilitated behaviour management strategies and safeguarding where separation of functions, activities and adequate supervision could be provided.

The training matrix demonstrated that staff had training in Trust in Care with further training in safeguarding being scheduled. Training in patient handling and infection control was also up-to-date for staff. Training in managing behaviours that challenge was also provided. All staff had mandatory fire safety training but as detailed in Outcome 7 further drills were required to ensure all new staff were familiar with the process in the centre.

While the inspector could not access the recruitment files, assurances were given that all of the necessary documentation and procedures for the safe recruitment of staff were obtained. Some, but not a significant number of agency staff were used in the centre. A staff supervision process was in place at six monthly intervals and records were available.

A number of new staff had commenced just prior to the inspection. While a detailed induction programme was in place and was described to the inspector there was very little supernumery time to ensure new staff were familiar with the residents and their duties.

Staff were observed spending constructive time with the residents either on a one-to-one basis or in small groups and taking residents out of the centre.

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:

Noelene Dowling
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 report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004649
Date of Inspection:	05 July 2016
Date of response:	02 August 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Systems for communicating between services did not ensure that residents' personal information was protected.

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

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Provider has met with the CNM3 of the external agency and formalised a robust communication procedure between the day and residential setting including the elimination of the daily communication books and agreeing weekly email reports, phone call log and follow up while also revised the residents annual review structure

Proposed Timescale: 02/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Not all of the personal plans were informed by the residents' assessed needs.

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:

Educational sessions are scheduled to support all outstanding staff in the implementation and completion of the newly introduced Care Planning system

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The personal plans did not consistently outline the supports or strategies necessary to achieve the aims identified.

3. Action Required:

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

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

The PIC is currently auditing the Care Plans following their recent introduction after which educational sessions are scheduled to support all staff in the correct implementation and completion of the newly introduced Care Planning system. Also to ensure staff apply and implement a consistent comprehensive holistic approach to the completion of residents care plans focusing on the detail of assessments, planning, interventions and the review process. A newly devise performance support format has been devised to assist this process.

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

No fire drills had been undertaken since the return to the centre which would ensure staff were familiar with the revised lay out and residents' sleeping arrangements.

4. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

The PIC has scheduled weekly fire drills to include both day and night time simulation for all staff in the centre to include role play using ski sheets and wheelchairs for the evacuation of residents until all staff have experienced same and are competent in this process. Following this initial plan, three monthly fire drills will be scheduled for all staff

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The personal evacuation plans required some amendments to ensure they were reflective of residents' level of dependency and were easily accessible.

5. 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:

All personal evacuation plans have been reviewed and updated as identified. All plans available in an emergency in each residents bedrooms and a summary document

located at all exits.

Proposed Timescale: 02/08/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Systems implemented to support and protect residents were not detailed in the safeguarding plan as required by the national policy. This could present a risk to residents.

6. Action Required:

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

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

Formal safeguarding plans are been developed and will be placed in individual residents personal file.

Proposed Timescale: 31/08/2016