Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Suaimhneas
Centre ID:	OSV-0001749
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Bernadette Donaghy
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
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 compliance with National Standards. 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:
12 June 2017 10:30	12 June 2017 15:15

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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) CHO Area 1, the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and on-going levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to the Authority which described the actions the HSE would take, in order to improve the quality of life for residents living in the services in CHO Area 1, the overall safety of the services operated by the HSE in that area and to improve and sustain a satisfactory level of compliance across the five core outcomes of concern.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by the 13th June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential

Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

The inspector met with three staff members, the acting clinical nurse manager and the person in charge during the inspection process. The inspector did not meet with residents upon this follow-up inspection. A number of practices and documents were reviewed as part of this inspection including two residents' files, three staff files, risk assessments, health and safety, fire procedures, improvement plans and staff training records.

Description of the service:

This centre is managed by the Health Service Executive (HSE) and provides residential services to people with moderate to severe intellectual disability, autism spectrum disorder and complex behaviours that challenge, who have been identified as requiring medium to high levels of support. The service can accommodate male and female residents, from the age of 18 years upwards. At the time of inspection, there were three male residents and one female resident living at the centre. All four residents were identified for transition to the community in the last quarter of 2017.

The person in charge has the overall responsibility for the centre and is supported in his role by a recently appointed acting clinical nurse manager and the provider. The acting clinical nurse manager is present in the centre on a full-time basis and works in a supernumerary administrative capacity. The person in charge is not based the centre on a full-time basis but is in the centre on a fortnightly basis to meet with staff and residents. The house is a large two-story dwelling which has a kitchen area, dining area, two sitting rooms, a utility, relaxation room, bathroom and bedroom spaces for residents. All bedrooms are single rooms and have en-suite facilities.

Overall judgment of our findings:
This was a follow-up inspection to identify if actions the provider said they would complete following the inspection on the 10th of April, 2017, were satisfactorily implemented. Overall, the inspector found a significant improvement was made to the service being provided to residents. Improvements were found in areas such as residents' personal planning, governance and management arrangements, risk management systems, staff training and to the management and review of restrictive practices.

There were twelve actions issued to the provider following the last inspection, eight of these were due to be completed at the time of this inspection. The inspector found two of these eight actions were not satisfactorily completed in line with timeframes given by the provider. These actions related to social care needs and governance and management. The findings of this inspection identified two outcomes to be substantially compliant and three outcomes in moderate non-compliance.

The findings and their actions are further outlined in the body of the report and the action plan at the end.

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:
Three actions were required from the previous inspection, the inspector found significant improvements had been made to personal plans and to the availability of these plans to residents. However, further improvements were found still required to the provision of information on the services and supports available for residents preparing for transition.

Since the last inspection, the provider had implemented a new personal plan system. Personal plans and personal goals were recently revised by residents and their key workers. The inspector found personal goals were concise and reflected the interests of residents. Action plans were clearly documented and detailed the actions required by staff to support residents to achieve their goals. The named persons responsible for supporting each resident to achieve their goals was clearly documented, with the date of when the next review of the action plan was due. The completion of personal goals was also monitored on a regular basis, which supported the progress made by residents to achieve their goals. Documented evidence of these reviews was available to the inspector to review on the day of the inspection.

Personal plans were now available to residents in picture and word format. Staff who spoke with the inspector said that some residents in the centre liked to read their personal plans, while photo trails were more effective for other residents in understanding the content of their personal plans. Staff also told the inspector that they were in the process of trialling an audio-visual version of personal plans to see if it would be an effective format to make available for residents with specific behaviours that challenge.

Since the last inspection, no residents transitioned from the centre. All residents were still planned for transition from the centre in quarter four of 2017; however, the person in charge told the inspector that exact dates for when this would occur were still not determined. Staff informed the inspector that houses were selected for each resident to transition to, and compatibility assessments were completed. Staff also said they had begun some life-skill sessions with some residents to familiarise these residents with the area of where they are planned to transition to. However, there was still no information available on the services and supports required by each resident in preparation for their transition from the centre to the community.

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):
No actions were required from the previous inspection.

Findings:
Two actions were required from the previous inspection, although these actions were not yet due for completion, the inspector reviewed the progress made by the provider towards completing the actions.

Since the last inspection, the provider has implemented a new health and safety and risk management system. This system was locally managed by the acting clinical nurse manager and staff nurses. The clinical nurse manager and the person in charge met weekly to discuss areas of risk within the centre. On the day of the inspection, the clinical nurse manager told the inspector that some staff had recently received risk management training. The clinical nurse manager and staff nurses who spoke with the inspector, had good understanding of the new health and safety and risk management system, of their role in ensuring this system was regularly reviewed and demonstrated an increased knowledge in how to escalate risk to senior management. However, some actions were still in the process of completion at this time of this inspection, to include the introduction of documented guidance for staff on the escalation process for risk management within the centre.

Some improvements were also found to the fire management systems in the centre. Since the last inspection, the practice of using whistles to alert residents of fire drills had ceased, and staff informed the inspector that the fire alarm was now being used. An additional fire assembly point was allocated to the front of the building, which means a choice of assembly points is now available to staff and residents, depending on the

location of a fire in the centre. Residents' personal evacuation plans were updated since the last inspection and now included specific information regarding residents' use of the centre's bus during an evacuation at night. All staff had now received up-to-date fire safety training. The fire procedure was also updated to reflect the location of the additional fire assembly point. Some actions were in the process of completion at the time of this inspection, to include the updating of the fire procedure on the use of the centre's bus in the event of an evacuation at night. The person in charge also confirmed with the inspector that remedial work relating to fire safety was still scheduled for completion by the 30.7.2017, which was in accordance with the date provided on the previous action plan response.

Judgment:
Substantially Compliant

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

Theme:
Safe Services

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

Findings:
The actions required from the previous inspection were found to be satisfactorily completed. However, upon this inspection, the inspector found improvements were required to the guidance available for residents who were prescribed chemical restraints.

Significant improvements had been made to the management and review of restrictive practices, since the last inspection. There was still a number of restrictive practices in place in the centre; however, since the last inspection some restrictive practices had been discontinued following review. Staff who spoke with the inspector were knowledgeable of all restrictive practices in place, and of when these restrictions were to be applied and released. A log of restrictive practice applications was maintained by staff, and this was available for the inspector to review on the day of the inspection. Since the last inspection, risk assessments were completed on some environmental restrictions, which now considered the impact of these restrictions had on other residents residing in the centre. Staff who spoke with the inspector told of various measures which have been implemented to reduce the impact these restrictions have on the every day life of other residents living in the centre. The inspector found all restrictive practices were recently reviewed and guidance was available to staff on the

correct application of each restrictive practice. However, the inspector found that where protocols were in place to guide on the administration of chemical restraints, these did not guide staff on monitoring residents for specific side effects following administration.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Some actions required from the previous inspection were satisfactorily completed; however, some actions were not yet due for completion at the time of this inspection.

Since the last inspection, an acting clinical nurse manager had been appointed to the centre. The clinical nurse manager is present in the centre on a full time, supernumerary basis and oversees the rostering duties, risk management and general administrative duties. The clinical nurse manager told the inspector that they are is supported in their and that regular communication is also maintained with the person in charge, in between weekly meetings. Staff who spoke with the inspector said that since the appointment of the acting clinical nurse manager to the centre, staff now have increased managerial support available to them which has had a positive impact to the running of the centre. The inspector found improvements were made to the regularity of staff meetings and that weekly conference calls continue to be held with the person in charge and senior managers, to discuss operational related issues.

The annual review report, six monthly provider visits report and quality improvement plan for the service were reviewed by the inspector. Of the 52 actions identified in the quality improvement plan, five actions remained overdue. Of the eleven actions identified in the last six monthly provider visit, two actions were overdue. Of the 25 actions identified in the annual service review, seven actions remained overdue. The inspector observed all these actions were in relation to remedial works required within the centre, with no date available to guide on when these will be addressed. The person in charge informed the inspector that they meet with the clinical nurse manager each week to review the status of overdue actions.

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):
No actions were required from the previous inspection.

Findings:
The actions required from the previous inspection were satisfactorily completed, while some actions were not due for completion at the time of this inspection.

Since the last inspection, all staff had received up-to-date training in manual handling. Refresher dates were documented on the training matrix to identify when staff were next due for this training.

A sample of staff files were reviewed by the inspector and gaps were found in the maintenance of Schedule two documents including gaps in employment and garda vetting.

Judgment:
Non Compliant - Moderate

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:

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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-0001749
Date of Inspection:	12 June 2017
Date of response:	04 July 2017

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 provider failed to the ensure information was available on the services and supports required by residents who were preparing for transition from the centre.

1. Action Required:
Under Regulation 25 (3) (a) you are required to: Provide support for residents as they

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

transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:
The provider has ensured that transition plans have been updated which includes supports and services required by each resident during the transition period.

Proposed Timescale: Complete

Proposed Timescale: 05/07/2017

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 provider failed to put systems in place for the assessment, management and on-going review of risk to include:
- review of risk assessments in line with their scheduled review dates
- ensure staff were appropriately supported in the on-going review of risks within the centre

This action was previously issued to the provider following the inspection of this centre on the 10th of April, 2017. The provider has provided the Chief Inspector with a response to this action, which was not yet due for completion upon this inspection. The provider told the Chief Inspector that this action will be completed by the 21.6.2017.

2. 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:
The provider will ensure that existing risk management systems are currently being reviewed within the designated centre. The assessment, management and ongoing review of risks, including a clear plan for responding to emergencies is included in the overall health and safety risk management system.

Emergency response alarms have been installed in this community home to respond to emergencies.

The PIC has ensured that staff have accessed training on risk management and risk assessment was provided to staff working in this community home on 15.5.17 & 17.5.17.

Algorithm/Guidance sheet on the risk escalation process has been developed to guide staff on the process involved in escalating risk to senior management through the PIC.

Proposed Timescale: Complete

Proposed Timescale: 05/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider has failed to put in place effective fire systems in relation to:
- adequate fire procedures to guide on the use of the centre's bus in the event of a fire
- put in place adequate arrangements for remedial works to be completed within the centre, in accordance with the findings of the risk safety assessment report.

This action was previously issued to the provider following the inspection of this centre on the 10th of April, 2017. The provider has provided the Chief Inspector with a response to this action, which was not yet due for completion upon this inspection. The provider told the Chief Inspector that this action will be completed by the 30.7.2017.

3. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
The Registered Provider has ensured all PEEP's and fire evacuation procedures have been updated to include the use of the centre's bus in the event of a fire. (Complete 13/06/2017).

The Registered Provider will follow up on remedial works to be completed within the centre in accordance with the findings with the fire risk safety assessment report.

Proposed Timescale: 30/07/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that where chemical restraints were administered, protocols guided staff on the side effects to be monitored for, in accordance with national policy and evidence based practice.

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

Please state the actions you have taken or are planning to take:
The Provider has ensured that all PRN chemical restraints prescribed have individualised protocols identifying rationale for use, alternative strategies to be implemented and possible side effects identified.

Proposed Timescale: Complete

Proposed Timescale: 05/07/2017

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:
The provider failed to put management systems in place in the centre to ensure that the service provided is consistent and effectively monitored to include:
- adequate arrangements to ensure the continuous monitoring and review of action plan deadlines and the completion of remedial works

This action was previously issued to the provider following the inspection of this centre on the 10th of April, 2017. The provider has provided the Chief Inspector with a response to this action, which was not yet due for completion upon this inspection. The provider told the Chief Inspector that this action will be completed by the 30.7.2017.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will ensure management systems are put in place to monitor and review action plans in conjunction with the new management structure (A/CNM1 and PIC) to meet deadlines and make arrangements for completion of remedial works.

Proposed Timescale: 30/07/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all information required of Schedule 2 of the regulations was maintained for all staff

This action was previously issued to the provider following the inspection of this centre on the 10th of April, 2017. The provider has provided the Chief Inspector with a response to this action, which was not yet due for completion upon this inspection. The provider told the Chief Inspector that this action will be completed by the 30.6.2017.

6. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The Provider has ensured that the information and documents as specified in Schedule 2 have been obtained from staff working within the designated centre.
Currently awaiting the return of 2 Garda vetting forms in order the achieve compliance.

Proposed Timescale: 31/08/2017