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:	Edel Quinn House
Centre ID:	OSV-0001814
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Joseph's Foundation
Provider Nominee:	Catherine O'Connell
Lead inspector:	Mary Moore
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
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:
30 November 2016 10:30	30 November 2016 20:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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 inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA) and was undertaken to monitor ongoing compliance with regulatory requirements. The last inspection of the centre was undertaken on 14 and 15 October 2014; that inspection was a registration inspection and those inspection findings were satisfactory.

How we gathered our evidence:
The inspectors prior to the inspection reviewed the information held by HIQA including the inspection findings from October 2014 and notifications submitted in the interim by the provider in line with its regulatory obligations.

The inspectors reviewed and discussed with staff records including fire safety and health and safety records, staff related records, records of complaints received and records pertaining to supports delivered to the residents living in the house.

The inspectors met with the frontline staff on duty, with the person in charge and the manager for adult services; the provider's nominated representative and the

chief executive officer of the organisation also attended the verbal feedback provided at the conclusion of the inspection.

The inspectors were in the centre when the residents returned in the evening from their respective day services. The inspectors observed the delivery of supports to residents and staff resident interactions. The inspectors met and interacted with the six residents living in the centre. Five of the residents communicated non-verbally and showed the inspectors their rooms, items of interests to them including music and table-top activities and communicated activities that they enjoyed including their love of animals and horse-riding.

One resident told inspectors that they liked the house but also liked going home to their family. The inspectors saw that staff created a homely and welcoming environment, were attentive to residents and that the residents appeared to be relaxed both in the house and with staff.

Description of the service:
The inspectors reviewed the document titled the statement of purpose and saw that while it was undated it had been reviewed and updated as required. Residential and respite services were provided to a maximum of six adult residents in a pleasant purpose built single storey residence conveniently located in the local village.

Overall Findings:
The overall inspection findings raised concerns in relation to the governance of the centre and the monitoring of the quality and safety of care and supports provided to residents.

The governance structure did not support achieving and maintaining compliance with regulatory responsibilities including those of the person in charge; failings identified included the submission of notifications, individual assessment and personal planning, the investigation of any alleged abuse and the administration of medicines.

Inspectors were advised that there were no incidents of alleged, suspected or reported abuse in the centre. Records subsequently reviewed by inspectors confirmed that this was incorrect and that an allegation had been reported in August 2016. Inspectors asked for explicit evidence to support that this allegation was appropriately escalated and investigated; this evidence was not available.

Failings were identified in evacuation procedures as while evacuation plans outlining prompts to be used by staff to promote resident co-operation and successful evacuation were in place, these were not used and their effectiveness was therefore not tested and established during simulated evacuations.

Of the ten Outcomes inspected the provider was judged to be compliant with one, staffing and in substantial compliance with one other Outcome healthcare. The provider was judged to be in major non-compliance with five Outcomes; Individualised Assessment and Personal Planning for residents, Safeguarding, Health and Safety, the submission of Notifications to the Chief Inspector and Governance and Management. Given the significant level of non-compliance evidenced in these

core Outcomes the provider was requested to attend a provider meeting with HIQA as part of HIQA's escalation process. Subsequent to this meeting the provider submitted an explicit plan for the review of and amendment to its governance and safeguarding structures and processes.

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 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
This Outcome was not inspected in full but while following up on an action from the previous inspection it was noted that, although the contracts for the provision of services in place were signed by the provider and representatives of residents, two contracts did not state the names of the residents which the contract related to. In addition the contracts in place were generic in nature and did not adequately distinguish and establish the basis on which residents were residing in the centre, that is, on a permanent or respite basis and the terms and conditions applicable to both. For example, the requirement for and understanding of the sharing of bedrooms used for the purpose of respite.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Based on the sample (50%) of personal assessments and support plans seen by inspectors the following failings were identified.

A comprehensive assessment of each resident's holistic needs had not been completed as required to reflect changing needs and circumstances and at a minimum on an annual basis; the assessments seen were dated September 2014.

There was some but ultimately insufficient evidence of the updating of personal plans and given that there had not been a comprehensive assessment of needs, the plans that were in place did not adequately and accurately reflect residents' needs as described by staff. For example, an epilepsy support plan was last updated in April 2016 but significant changes to supports had been made following neurological review in November 2016. A further record seen indicated that a resident had required mental health support for the first time in 2016 but this was not reflected in the support plan. The assessment that informed the support plan stated that the resident required no mental health supports. Support plans put in place based on risk assessment, for example the risk of choking, were not linked or reflected in the overall assessment and support plan and were not reviewed and updated since 2015.

One assessment and personal plan dated as commenced in July 2015 was still substantially incomplete and did not offer any guidance to staff as to the resident's needs and required supports to so as to maintain their safety and well-being.

Four personal plan reviews had taken place and family members had been invited to attend; minutes of the review meetings were in place. However, there was no record of the identification, agreement, progress and achievement or not of residents' personal goals and objectives since 2014. For example, one education and learning goal was the sourcing of and the use of a computerised tablet "to improve my communication skills". There was no evidence of what action was taken to progress this goal or what barriers there may have been to its achievement; staff spoken with confirmed that a computerised tablet was not in place.

The records were poorly maintained.

An internal unannounced visit that included the review of a sample of residents' assessments and personal plans had been undertaken in July 2016. That internal audit had identified significant deficits in these processes including the failure to review and update; no review of personal goals since 2014 and absence of support plans for two residents receiving support and services. These HIQA inspection findings confirmed that these failings had not been addressed in the intervening period.

Judgment:
Non Compliant - Major

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:
While there were measures in place to protect the health and safety of residents, inspectors found inadequacies regarding the fire drills carried out, evacuation plans and the risk management processes in operation in the designated centre.

A fire detection system and emergency lighting was present in the designated centre. However, inspectors were not provided with copies of maintenance certificates of the fire alarm system and emergency lighting at the prescribed intervals by a competent person. An internal log was maintained and available but indicated that the fire detection system was last inspected in April 2016. Fire fighting equipment was seen to be serviced on the day of inspection. Following the inspection explicit evidence was submitted by the provider to HIQA of the inspection and testing of both the fire detection system and the emergency lighting in July and October 2016.

Fire doors were also present in the designated centre. However, inspectors noted that when closed there were evident gaps between some of these doors and the floor. A health and safety audit carried out by the provider during 2015 had raised an issue regarding the amount of space between the bottom of a fire door and the floor. Inspectors measured this gap on a sample of fire doors within the centre and found this to be in excess of the recommended space.

The provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire. The procedures to be followed in the event of an evacuation were displayed throughout the designated centre. All staff had undergone fire safety training and staff conducted regular internal checks on the fire alarm and emergency lighting. Fire drills were carried out on a monthly basis and documented. Upon review of the drill records it was noted that during four drills carried out in 2016, two residents had refused to leave the centre. Despite this an evacuation time of the centre was recorded.

Inspectors reviewed the personal evacuation plans for these two residents which were last reviewed in November 2016. One of the personal evacuation plans did outline ways to encourage the resident to leave the centre in the event of an evacuation. Staff members spoken to were aware of such methods but these were not used during the course of fire drills. The second resident's personal evacuation plan did not contain details on specific ways for evacuating the resident in the event of a fire which were referenced by the Person in Charge. In addition inspectors saw a risk assessment for this resident which outlined a method of evacuating the resident in a specific set of

circumstances. This information was not included in the personal evacuation plan.

A centre specific safety statement was in place along with a risk management policy. Inspectors reviewed the risk register in place and found multiple copies of risk assessment for some risks. In addition some risk had not been reviewed in over a year while other risks, as identified by inspectors, had not been risk assessed, for example the use of manual locks in addition to keypads on the fire exits. It was also noted that information contained in some residents' personal plans did not correspond with the information contained in the risk register. In training records seen by inspectors it was noted that no member of staff within the designated centre, including the Person in Charge, had undergone any specific risk management training.

A record of accident and incidents was maintained in the designated centre. All such records where referred to the provider's Health and Safety Officer and there was an annual review collectively and as specific to each centre of accidents, incidents and adverse events. What was not clear was the learning from such adverse events for example incidents relating to medication. It was noted that during 2016 there were regular instances of recording errors, residents getting medication at the wrong time or residents receiving the medication of another resident.

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):
No actions were required from the previous inspection.

Findings:
There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, and staff training; however, concerning failings were identified in these measures.

The person in charge told inspectors that the majority of the residents by virtue of their disability were limited in their capacity to protect themselves from abuse or to make a report of abuse or harm. The person in charge described how staff would monitor residents for cues, that is, a change in demeanour or behaviour.

In response to direct questioning on the safeguarding of residents inspectors were told that there had been no incident of alleged, suspected or reported abuse in the centre. However, subsequent to this conversation inspectors discovered a record of a complaint made in August 2016 of alleged physical abuse by a staff reported by the resident to a family member. The complaint was made by the family member and was received and recorded by the person in charge who deemed that the allegation was "too serious" a matter to be dealt with locally.

There were safeguarding policies and procedures dated June 2016 and referenced to relevant national guidance that clearly set out unequivocal reporting, action and oversight responsibilities of all grades of staff including the explicit records to be completed and submitted by front line staff in receipt of such an allegation. It was the responsibility of both the relevant line manager and the designated person to inform the chief executive officer of all allegations, suspicions or reports received.

Inspectors asked for evidence of how this allegation was reported and investigated. Explicit evidence as required by the above policy was not available. Over the course of the inspection conflicting evidence was provided as to who and to whom the allegation was verbally reported; inspectors were initially told that it was reported to a line manager but not reported to the designated officer; inspectors were subsequently told that it was reported to the designated officer. The person in charge said that she had no knowledge of the investigation of this allegation of abuse.

Further records seen by inspectors including minutes of a staff meeting held on 18 August 2016 chaired by the person in charge made reference to this allegation and staff concerns with regard to it. A multi-disciplinary team referral dated July 2015 made reference to "spurious" allegations made of physical and psychological abuse by staff.

There was no safeguarding plan (the personal plan was substantially incomplete). The Chief Inspector had not been notified within three days as required by Regulation 31 (1) (f) of any of these allegations. At verbal feedback no member of the senior management team present had knowledge of the complaint of alleged abuse made in August 2016.

Staff spoken with said and records of incidents seen confirmed that residents did present at times with behaviours of concern and risk to themselves or others. There was evidence of interventions such as modified tableware, restricted access to items of concern such as disposable gloves, seating arrangements while in the transport vehicle, referral to the psychiatrist and regular and p.r.n medicines (a medicine taken only as required). However, there was no clear multi-disciplinary approach to the assessment and management of behaviours of concern or risk including the role and use of medicines. Plans seen were signed off by the person in charge, one behaviour support plan was relevant to and imported from the day services and staff spoken with had not seen the plan.

There was evidence of some restrictive practice, for example restricted access to foodstuffs. While there was a rationale for these restrictions (the safety of the resident), there was no clear process for the planning, agreement, implementation and ongoing review of the requirement for a restrictive practice.

Training records indicated that one staff member required safeguarding training and two staff required training in responding to behaviour that was challenging including de-escalation and intervention techniques.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
Notifications had not been submitted to the Chief Inspector as prescribed by Regulation 31; this included an allegation of abuse that should have been notified to the Chief Inspector within three working days.

Inspectors also found records of a loss of water, a loss of heating and three power cuts which had not been notified to the Chief Inspector as required. In addition matters which should be notified at quarterly intervals such as non serious injuries had not been submitted to the Chief Inspector.

Judgment:
Non Compliant - Major

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:
As assessments had not been updated since 2014 and support plans were sporadically

reviewed and updated or were incomplete, it was difficult for inspectors to establish the robustness of the systems that were in place for supporting residents to maintain their health and wellbeing. However, having spoken with staff and reviewed the records that were maintained, overall and on balance, while there were gaps, inspectors were reassured that staff did monitor and support residents.

Records seen supported that staff monitored resident well-being and sought medical review by the General Practitioner (GP). Records of reviews were maintained and reflected a pro-active approach including medicines review, blood-profiling and seasonal influenza vaccination. Staff said and records seen indicated that residents had access to other healthcare services including psychiatry, neurology, physiotherapy, occupational therapy and speech and language (SLT).

However, a complete and comprehensive review of healthcare assessments, needs, supports, treatments and recommendations was required to ensure that healthcare support plans were current, appropriate to residents' needs, accurately reflected all recommendations and ensured that all and any healthcare related supports were implemented in a timely manner. For example, the person in charge said that residents were weighed monthly but there were significant gaps in the records seen by inspectors. Further discrepancies included the ongoing requirement for modified fluids; SLT had in 2014 said that that these should be phased out, the last review of the associated support plan was in July 2015; records pertaining to the frequency of optical review as required needed review.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Arrangements were not in place that ensured that each resident could and did receive all medicines that were prescribed.

Medicines were seen to be supplied to residents by a community based pharmacy in a compliance aid or in the original container. Medicines were seen to be securely stored and appropriately labelled by the pharmacist for individual resident use.

A refrigerator for medicines was also in place; this was secure and staff monitored its

temperature.

Each resident was seen to have a signed and dated prescription and a corresponding administration record. Prescription records were current and legible, the maximum daily dosage of medicines prescribed on a p.r.n basis (a medicine administered only if required) was stated. The medicines administration record completed by staff was seen to reflect the instructions of the prescription.

Residents were not participating in the management of their medicines; there were clinical records in place supporting this decision.

Staff described systems to support the safety of medicines management practice included the checking of medicines delivered. There was a monthly audit of the administration and stock balance of medicines administered on a p.r.n basis.

However, a record seen by inspectors stated that staff had in September 2016 requested on-call advice on the administration of a medicine that was prescribed to be administered by a route that non-nursing staff were not permitted to administer. Nursing support was not provided and the medicine was not administered. Inspectors saw that the resident still had a current prescription and requirement for this medicine. An alternative but not as effective format was prescribed on this basis (that staff were not permitted to administer the medicine in a particular format) and was seen to be administered in the alternative format regularly by staff. Other records seen indicated that non-nursing staff were permitted and did administer other medicines via this route. There was no learning from these events to ensure that appropriate and suitable practices were in place so that residents could receive any and all prescribed medicines in the most therapeutically effective format for their assessed needs.

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):
No actions were required from the previous inspection.

Findings:

These inspection findings did not support governance and management systems that monitored, supported, ensured and promoted the quality and safety of the supports and services provided to residents in this centre. The provider had, further to other recent concerning inspection findings, submitted to HIQA a revised governance structure and plan for the organisation.

The person in charge had been in that role since October 2015 and described her role as the "acting person in charge". Acting arrangements and extended deputising arrangements and the requirement to formalise them had been discussed previously with the provider.

The person in charge had appropriate management and social care qualifications and established experience of providing supports to persons with a disability. However, the person in charge worked exclusively on sleepover duties six nights per fortnight and was effectively on duty from 16:00hrs to 23:00hrs and from 07:00hrs to 09:00hrs. The person in charge said that is was a constant challenge to strike a balance between attending to residents needs and maintaining "paperwork". Inspectors did identify core failings in areas of regulatory responsibility attributed to a person in charge of a designated centre including failings in; the submission of notifications, individual assessment and personal planning, the investigation of any alleged abuse, the administration of medicines and the supervision of staff.

There was a formal staff supervision process but the person in charge said that due to time constraints these had not been completed at the prescribed frequency for 2016.

While the provider had systems for reviewing the quality and safety of the care and services provided they were not robustly applied to this centre and did not promote improvement as evidenced throughout the findings of this inspection. There was an agreed schedule of internal audits to be completed and responsible persons but records seen indicated that these reviews were not undertaken at the prescribed frequency. Where reviews had been undertaken including an unannounced visit in July 2016 there was no evidence of the progress to completion of actions required.

Judgment:
Non Compliant - Major

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:
Based on the information made available to inspectors and inspectors own observations, staffing levels and arrangements were adequate. The person in charge said that she was generally satisfied with the staffing levels and confirmed that a stable core staff team was in place since April 2016. The night-time staffing arrangement consisted of one sleepover staff and one waking staff. There were three staff on duty in the evening from 16:30hrs to 21:00hrs when residents returned to the house.

The person in charge told inspectors that there was no undue reliance on relief or agency staff and that the same relief staff were utilised as necessary so as to ensure continuity for the residents. A review of the staff rota confirmed the staffing levels described and that a small core group of relief staff was used. Staff spoken with confirmed that they were regular staff.

Staff files were available for the purposes of inspection. The sample reviewed was well presented and contained all of the regulatory required documents such as evidence of Garda vetting, a full employment history and two written references.

Training records were also reviewed and, with the exception of the gaps highlighted in Outcome 8 regarding safeguarding and de-escalation and intervention techniques, all mandatory training was provided for.

Judgment:
Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
This Outcome was not inspected in full. However, inspectors found that the records

pertinent to the Outcomes inspected were not maintained in a manner that ensured completeness, accuracy and ease of retrieval.
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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Joseph's Foundation
Centre ID:	OSV-0001814
Date of Inspection:	30 November 2016
Date of response:	23 December 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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contracts in place were generic in nature and did not adequately distinguish between residents who were residing in the centre on a permanent or respite basis. In addition some contracts did contain the names of residents who the contracts related to.

[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 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
Under Regulation 24 (4) (a) the Registered Provider will review the Terms of Residency (contracts) and ensure that they will be more individual and reflect the type of placement (permanent/respite) being provided to the resident.

Proposed Timescale: 31/01/2017

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:
A comprehensive assessment of each resident's holistic needs had not been completed as required to reflect changing needs and circumstances and at a minimum on an annual basis; the assessments seen were all dated September 2014.

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:
Under Regulation 05 (1) (b) the Person in Charge will 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.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One assessment and personal plan dated as commenced in July 2015 was still substantially incomplete.

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:
Under Regulation 05 (4) (a) The Person in Charge will ensure that a personal plan/assessments for the resident which is incomplete will be completed and will reflect the residents assessed needs.

Proposed Timescale: 13/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was some but ultimately insufficient evidence of the updating of personal plans and given that there had not been a comprehensive assessment of needs, the plan that were in place did not adequately and accurately reflect residents needs as described by staff.

4. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
Under Regulation 05 (6) the Person in Charge will ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances. Following an assessment of needs for all residents, their personal plans will be reviewed and updated to reflect their current needs and any identified emerging need will be addressed.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no record of the identification, agreement, progress and achievement or not of residents' personal goals and objectives since 2014.

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

Please state the actions you have taken or are planning to take:
Under Regulation 05 (7) the Person in Charge will ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the

personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.
A comprehensive review of all residents plans including review & updating of all goals will be carried out. This will involve a consultation process with residents, their families and relevant multi-disciplinary team members.

Proposed Timescale: 28/02/2017

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:
Some risks within the centre were not contained in the risk register.

6. 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:
Under Regulation 26 (2) the Registered Provider will ensure that all risks within the residence will be reviewed, reassessed and any controls identified will be implemented and recorded in the risk register.

Proposed Timescale: 13/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Learning from adverse events particularly in relation to medicines errors was not clearly demonstrated.

7. 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:
Under Regulation 26 (1) (d) the Registered Provider will ensure that there is learning from adverse incidents relating to medication by having a regular review of any incidents occurring and a reflection on these with the Person in Charge and staff. Adverse incidents will be included on the agenda for all staff meetings.

Proposed Timescale: 31/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some risks had not reviewed in over a year while information contained in some residents' personal plans did not correspond with the information contained in the risk register.

8. 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:
Under Regulation 26 (2) the Registered Provider will ensure that all risks within the residence will be reviewed, reassessed and any controls identified will be implemented. As part of the review of the residents personal plans all risks relating to individual residents will also be reviewed to ensure the information contained on the risk register and in the personal plan will correspond.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The space between the floor and fire doors required review.

9. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Under Regulation 28 (3) (a) the Registered Provider will ensure that all fire doors are reviewed any any necessary adjustments carried out.

Proposed Timescale: 16/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' personal evacuation plans required review.

10. 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:
Under Regulation 28 (3) (d) the Registered Provider will ensure that the Personal Emergency Evacuation Plans for all residents are reviewed and any necessary amendments made to same.

Proposed Timescale: 06/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire drills carried out did not provide adequate assurance that the methods to ensure that all residents evacuated the centre in the event of a fire would be followed by staff or would ensure the effective evacuation of the resident.

11. 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:
Under Regulation 28 (4) (b) the Registered Provider will ensure that that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire through the improvement in the quality of fire drills carried out and the availability of any props required by the resident to assist them in vacating the residence during fire drills.

Proposed Timescale: 06/01/2017

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:
Two staff required training in responding to behaviour that was challenging including de-escalation and intervention techniques.

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

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

Under Regulation 07 (2) the Person in Charge will ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques on the next available training programme. A referral for the required training has been forwarded to the Human Resources Department. Training has been organised for 4th and 5th January 2017.

Proposed Timescale: 06/01/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no clear multi-disciplinary approach to the assessment and management of behaviours of concern or risk

13. 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:
Under Regulation 07 (3) the Registered Provider will ensure that there is a multi - disciplinary approach to the assessment and management of behaviours of concern and risk and this will be addressed through the reviews of the personal plan.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no clear process for the planning, agreement, implementation and ongoing review of the requirement for a restrictive practice.

14. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
Under Regulation 07 (4) the Registered Provider will 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.
The Registered Provider has requested an audit of any practice which may be restrictive in the centre and the result of this audit will be highlighted to the Restrictive Practice Committee for guidance on their appropriateness. Where a restrictive practice is

deemed necessary its use and implementation will recorded and the restriction reviewed on a regular basis.

Proposed Timescale: 31/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training records indicated that one staff member required safeguarding training.

15. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Under Regulation 08 (7) the Person in Charge will ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse and a request for this training has been forwarded to the Human Resource Department to include the staff member in the next available training course re safeguarding which will be held on 18th January 2017.

Proposed Timescale: 18/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of the appropriate management and investigation of an allegation of abuse.

16. 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:
Under Regulation 08 (3) the Person in Charge will ensure that all incidents, allegations or suspicion of abuse are managed appropriately and any investigative processes followed. The Person in Charge will also ensure that appropriate action will be taken in the event of a resident being harmed or suffers abuse.
Additional training to the Person in Charge will be provided by the Registered Provider.

Proposed Timescale: 20/01/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A loss of water, a loss of heating and three power cuts had not been notified to the Chief Inspector.

17. Action Required:
Under Regulation 31 (1) (c) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.

Please state the actions you have taken or are planning to take:
Under Regulation 31 (1) (c) the Person in Charge will give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.
Additional training will be provided by the Registered Provider to the Person in Charge regarding the role and responsibilities of a Person in Charge.

Proposed Timescale: 20/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of abuse had not been notified to the Chief Inspector.

18. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
Under Regulation 31 (1) (f) the Person In Charge will give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Additional training will be provided by the Registered Provider to the Person in Charge regarding the role and responsibilities of a Person in Charge

Proposed Timescale: 20/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Matters which should be notified at quarterly intervals such as non serious injuries had not been submitted to the Chief Inspector.

19. Action Required:
Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

Please state the actions you have taken or are planning to take:
Under Regulation 31 (3) (d) the Person in Charge will provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).
Procedures have been reviewed and amended with regard to reporting of all events to ensure that the Person in Charge and the person within the organisation designated to submit reports are informed of all notifiable incidents within the required timeframe.
Additional training will be provided by the Registered Provider to the Person in Charge regarding the role and responsibilities of a Person in Charge.

Proposed Timescale: 20/01/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As assessments had not been updated since 2014 and support plans were sporadically reviewed and updated or were incomplete, it was difficult for inspectors to establish the robustness of the systems that were in place for supporting residents to maintain their health and wellbeing.

20. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
Under Regulation 06 (1) the Registered Provider will ensure that appropriate health care is provided for each resident, having regard to each resident's personal plan. The review of personal plans will include a comprehensive health assessment and any identified concerns will be addressed by appropriately qualified professional and recommended actions implemented. The Registered Provider will ensure that these assessments and related support plans will be reviewed by carrying out regular audits

Proposed Timescale: 28/02/2017

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:
Appropriate and suitable practices were not in place so that residents could receive any and all prescribed medicines in the most therapeutically effective format for their assessed needs.

21. 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:
Under Regulation 29 (4) (b) the Person in Charge will ensure that appropriate practices are in place to ensure that all residents receive all of their prescribed medications. The Person in Charge will identify any shortfall in staff training required to administer prescribed medications to residents to the Human Resource Department with a request for the identified training.
In the absence of immediate training the Person in Charge will arrange for the resident to receive their prescribed medications from a suitably qualified professional outside the immediate staff team.

Proposed Timescale: 28/02/2017

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:
These inspection findings did not support governance and management systems that monitored, supported, ensured and promoted the quality and safety of the supports and services provided to residents in this centre.

22. 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:
Under Regulation 23 (1) (c) the Registered Provider has reviewed the management and governance structures pertaining to the residence and has submitted a proposal to HIQA outlining how these changes in structure will monitor, support, ensure and

promote the quality and safety of the supports and services provided to residents in this centre.

Proposed Timescale: 21/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for reviewing the quality and safety of the care and services provided were not robustly applied to this centre and did not promote improvement as evidenced throughout the findings of this inspection. Where reviews had been undertaken including an unannounced visit in July 2016 there was no evidence of the progress to completion of actions required.

23. 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:
Under Regulation 23 (2) (a) the Registered Provider will ensure that the residence is subject to unannounced inspections as per the legal requirements and prepare a written report on the safety and quality of care and support provided in the centre. Following these visits the Registered Provider will meet with the Person in Charge to highlight any concerns regarding the standard of care and support provided to the residents and put in place a plan of action to address any concerns or deficits.
Unannounced audits will be carried out to monitor and ensure the implementation of the action plan.

Proposed Timescale: 31/01/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a formal staff supervision process but due to time constraints these had not been completed at the prescribed frequency for 2016.

24. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Under Regulation 23 (3) (a) the Registered Provider will ensure that sufficient time is made available to the Person in Charge to enable them to complete staff supervisions at the prescribed interval.
The Registered Provider will allocate additional hours to the Person in Charge to enable them to carry out management duties.

Proposed Timescale: 31/01/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records pertinent to the Outcomes inspected were not maintained in a manner that ensured completeness, accuracy and ease of retrieval

25. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
Under Regulation 21 (1) (b) the Registered Provider will ensure that the records specified in Schedule 3 will be reviewed and updated to ensure completeness, accuracy and ease of retrieval as part of the overall review of the residents personal plans.

Proposed Timescale: 28/02/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records pertinent to the Outcomes inspected were not maintained in a manner that ensured completeness, accuracy and ease of retrieval.

26. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Under Regulation 21 (1) (c) the Registered Provider will ensure that all records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

will be maintained in a manner that will ensure completeness, accuracy and ease of retrieval . All Schedule 4 documentation will be reviewed and updated to ensure compliance.
Proposed Timescale: 28/02/2017