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:	No.5 Stonecrop
Centre ID:	OSV-0002278
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Southern Services
Provider Nominee:	Una Nagle
Lead inspector:	Julie Hennessy
Support inspector(s):	None
Type of inspection	Announced
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 inform a registration decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 August 2017 08:30	08 August 2017 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the second inspection of this centre carried out by the Health Information and Quality Authority (HIQA). The first inspection took place on 12 May 2016. This inspection took place in response to an application by the provider to register this centre.

How we gather our evidence:
As part of the inspection, the inspector met with three residents who were in the centre on the day of the inspection, with the fourth resident being on holiday at the time. The inspector also met with the person in charge of the centre, the social care leader and members of the staff team. The inspector reviewed documentation such as personal plans, healthcare plans, training records, fire safety information and risk assessments. The inspector also reviewed questionnaires received from family members. Relatives spoke well of the staff in the centre. The findings of the previous inspection also informed this inspection.

Description of the service:

The centre comprised a two-storey semi-detached house. The centre was located close to a town on the outskirts of Cork city. Residents availed of facilities and amenities in the locality or nearer the city, including local parks, walks, coffee shops, bowling or trips to locations of residents' choice. Community links had been developed and residents accessed services in their local community, attending the local general practitioner, dentist, bank, post office and shops.

Summary of our findings:
Where residents were non-verbal, staff were observed to support residents to communicate in making choices through the use of visual aids and manual sign language (Lámh). Interactions between staff and residents were observed to be appropriate and relaxed. Arrangements were in place in relation to setting personal outcomes with residents and providing an individualised service based on ability and any individual support requirements.

Local management systems were proving effective with the person in charge supported by a social care leader to deliver safe, quality care and support to residents. However, a major non-compliance was identified under outcome 14 due to a repeat failing from the previous inspection and across the service to ensure that the review of residents' personal plans was multidisciplinary. This failing has resulted in inadequate reassurances around the oversight of residents' communication and behaviour support plans in this centre. Also, while the arrangements in place relating to the person in charge were under review by senior management, the outcome of this review was not yet evident.

Findings are detailed in the body of the report and should be read in conjunction with the actions outlined in the action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Overall, arrangements were in place to protect residents' dignity, to consult with residents and to manage complaints. Improvement was required to ensure that privacy was respected in relation to professional consultations and personal information.

There were arrangements in place for consulting with residents and regular meetings took place. The inspector reviewed those minutes, which reflected conversations about relevant issues, such as outings, family visits and any matters of interest to residents. However, the meeting minutes included detailed discussions about personal issues, including health appointments, health concerns and the outcome of health assessments; this was not an appropriate forum for recording confidential information.

A complaints log was maintained in the centre and the complaints recorded in that log were reviewed with the person in charge. Documentation to support how decisions were reached was available for review. The outcome of the complaint and how it was resolved was recorded in a clear and transparent manner.

The annual review had considered the effectiveness of arrangements in place as they related to the management of complaints, consultation with residents and feedback from residents. Recommendations were identified arising from that review, including the need to better support residents to explain changes and how to evidence recognition of any such changes by residents.

Residents had their own bedrooms with space and storage for their personal possessions. Interactions between staff and residents were observed to be respectful.

Judgment:
Substantially Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Overall, staff supported residents to communicate their choices, wishes and preferences.

Residents' files contained comprehensive information to ensure that staff understood how to support residents to communicate in a predictable and consistent environment. Where personal communication passports were required, these had been developed by a speech and language therapist and the staff team.

Visual schedules, daily and weekly planners, object cues, pictures and Lámh (an Irish language manual sign-system) were observed to be used by residents and staff. All staff, except the social care leader had completed training in Lámh, who was scheduled to complete training the following month. Staff were observed to implement such interventions in practice.

However, where residents were non-verbal, there was no oversight of their communication programme by an appropriate health professional. This will be addressed under Outcome 5.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Overall, an assessment of the health, personal and social care and support needs of each resident had been carried out. However, a multidisciplinary review of the effectiveness of each resident's plan was not being completed. This is a repeat finding from the previous inspection.

The inspector reviewed personal plans for residents residing in this centre. Templates were in place that facilitated an assessment of the health, personal and social care and support needs of each resident. This included assessments of residents' current communication skills, independent living skills, leisure activities, participation in the community, home activities, money skills and healthcare needs.

Each resident had a written personal plan. Information was individualised and specific. Personal plans included information pertaining to individuals' likes and dislikes, people important in their lives, personal goals and the supports required to achieve the best possible health and other areas of their lives. Information was in an accessible format. There was evidence that residents and their representatives were involved in identifying goals that were important to them. Goals were reviewed each quarter and any barriers to achieving goals were documented. Where the local team could not address those barriers, there was a process in place to allow for barriers to be escalated to the person in charge and the sector manager. At the previous inspection it was identified that improvements were required to demonstrate how any barriers to achieving goals would be assessed and addressed. This had been satisfactorily addressed since the previous inspection with a system for reviewing any such barriers introduced.

Other specific plans had been developed based on assessment of residents' support requirements. These included healthcare plans, risk management plans, intimate care plans and behaviour support plans.

However, some support plans were based on assessments that had been completed by an appropriate health professional a number of years prior to this inspection. While the person in charge and social care leader said that no resident was currently having difficulty in relation to any identified area of need, the programmes in place were not overseen by an appropriate health professional in that field. For example, where a resident was non-verbal, the speech and language report that underpinned the support plan dated from 2013. For another resident, where protocols were in place to support behaviour support needs, it was not recorded who had developed the protocol and what any reviews entailed.

At the previous inspection, it was not demonstrated that the compatibility of residents in this centre had been adequately assessed. The person in charge and social care leader

demonstrated how this had been explored in detail and that individual resident's wishes were captured in their personal plan and supported.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
Overall, the design and layout of the premises was suitable for its stated purpose.

The centre was a domestic two-storey house located close to Cork city and accessible to a number of services and facilities. The premises had been renovated since the previous inspection to meet fire safety standards. There was a small garden to the front and a larger space to the rear of the house; both used by residents.

Changes to the design and layout of the centre since the previous inspection meant that it was not in line with the centre's statement of purpose or the floor plans submitted to HIQA. The person in charge was progressing this action at the time of the inspection. This will be addressed under Outcome 13.

There was adequate private and communal space for residents. The premises comprised five bedrooms; four bedrooms for residents and a fifth bedroom for staff. Bedrooms were individualised and reflected residents' preferences (for example, interests in music, technology or reading). Built-in storage space was provided for residents' personal use. Rooms were of ample size and suitable layout. Where residents required ground-floor accommodation, this was provided. The premises was homely, comfortable and pleasantly decorated with pictures, art work and personal photographs.

There were adequate sanitary facilities provided with one en-suite bedroom and a shared bathroom upstairs with an accessible shower. The centre had a kitchen, a separate dining space and living space. The kitchen was fitted with appropriate cooking facilities and equipment. Adequate laundry facilities were provided for residents to launder their own clothes if they so wished.

The centre was clean and well-maintained. There was suitable heating, lighting and

ventilation and the centre was free from obvious hazards. There were suitable and sufficient furnishings, fixtures and fittings.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Overall, there were systems in place to ensure that residents were protected from injury and harm. However, improvements were required to the investigation of medication errors.

At the previous inspection, the system for recording and reporting of incidents required review as an incident form had not been completed for all incidents. At this inspection, a review of the incident book indicated that incidents were being recorded and reported, including injuries, near-miss incidents, medication errors and incidents of behaviours that may challenge. However, the inspector found that there had recently been two identical medication errors in a two-month period and it was not demonstrated that adequate steps had been taken to prevent a reoccurrence.

At the previous inspection not all risks had an associated risk assessment or were included in the risk register. At this inspection, a review of the risk register indicated that risks had been assessed with a corresponding risk assessment completed and the risk register was being maintained by the person in charge.

At the previous inspection, the fundamental design and layout of the premises required review as a downstairs inner room was used as a bedroom. Since the previous inspection, alternations to the premises had been completed and the downstairs bedroom was no longer an inner room. In addition, a review by an occupational therapist had been completed, so as to ensure that the new layout would not present any difficulties for residents.

At the previous inspection the arrangements in place for containing fires were not adequate as fire doors were wedged open with door wedges. This matter had been addressed with door closures fitted, connected to the fire alarm system and capable of being held open safely.

At the previous inspection the suitability of the evacuation procedure and the assembly

point required further review to ensure that residents would be brought to a safe location following the evacuation of the centre. The emergency evacuation plan had been revised to include the new evacuation route and the assembly point had been identified.

At the previous inspection there was no system in place to monitor the effectiveness of infection prevention and control practices or procedures, such as staff hand hygiene practices or the standard of environmental hygiene in the centre. Since the previous inspection, staff had received training in relation to the prevention and control of infection and a policy had been introduced at organisational level to guide practices and procedures in the centre. An infection control audit had taken place and any required actions had been completed.

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):
No actions were required from the previous inspection.

Findings:
Overall, there were measures in place to support residents from abuse or harm. However, it was not clear how protocols and behaviour support plans in place for residents had been developed, how plans were being reviewed or that the oversight arrangements were adequate.

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

The organisation had a committee in place that reviewed requests relating to the use of restrictive practices. Where chemical restraint was in use, it had been sanctioned by that committee. Documentation pertaining to the use of chemical restraint outlined the rationale for its use and what alternatives had been considered if available. Its use was reviewed by the committee on a quarterly basis. The inspector noted that where

adverse side-effects had been reported, these had been reported to the person in charge and the prescriber.

Since the previous inspection, staff had received the required training in relation to safeguarding vulnerable adults and positive behaviour support. Also, a small number of staff had completed a more intensive behaviour support course. The inspector spoke with members of the staff team, who were aware of what to do in the event of an allegation, suspicion or allegation of abuse. There was a designated person within the service to whom any concerns were reported. However it was not clear how protocols and behaviour support plans in place for residents had been developed, how they were being reviewed or that the oversight arrangements were adequate. The person in charge told the inspector that they were working to address this gap and stated that they had sought advice from the behaviour support team in this regard.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Overall, residents were supported by staff to meet their healthcare needs. Improvements were required to healthcare plans to ensure that they reflected residents' actual and current needs and directed the care to be given at any one time.

Residents had access to their own general practitioner (GP) and medical consultants where required. At the previous inspection, it was not demonstrated where a resident required services provided by allied health professionals, that access to such services was provided or arranged. Since the previous inspection, assessments that had been outstanding had been arranged and reports were available in residents' files; recommendations were being implemented.

Where residents had difficulties with swallowing, an assessment had been completed by a speech and language therapist. Where residents had dietary requirements or nutritional needs, assessments had been carried out by a dietician and other health

professionals as indicated. Menu plans and exercise programmes for residents were in place, where required, and being followed.

However, while healthcare plans were in place for a number of identifiable resident healthcare needs, they did not always reflect actual changing needs. It was evident through conversations with staff and review of meeting minutes and the communication book that changing needs were being supported in practice. However, the gaps in healthcare plans (residents with epilepsy and possible swallowing difficulties) meant that it was not clear what residents' current needs and supports were and this would not be clear to any staff who were unfamiliar with individual residents.

Residents who were non-verbal were supported to make choices in relation to meal planning and meal selection when eating out by using pictures. Residents were supported to participate in meal preparation on an individual basis.

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

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
There were written policies and procedures in place relating to the ordering, administration, storage and return of medication.
Medicines were ordered from the pharmacy on a monthly basis. Medicines were checked on arrival in the centre and a visual check was also completed prior to administration of any medications.

Medicines were stored safely in the centre. The key to the medicines cupboards was kept in a pad secured via key code. Psychotropic medication was counted daily. The inspector completed a random count of a sample of psychotropic medication and found the count to be correct.

There were arrangements in place for the safe administration of medicines. Staff had received training in relation to medication management. A 'biodose' system was in use in the centre. At the previous inspection, it was not demonstrated that residents would always receive medication as prescribed as satisfactory arrangements were not in place to ensure that staff were trained and competent to respond to an instruction from the prescriber to withhold or adjust the dose of a medicine. At this inspection, this had been addressed and staff demonstrated competence to follow instructions form the prescriber if such a situation arose.

There was a system in place for the administration and oversight of medicines taken as prescribed (PRN medicines). The administration of psychotropic medication was reviewed on a three-monthly basis by each resident's psychiatrist, or more frequently as required. The inspector observed that residents had an individual medication management plan in place and a PRN protocol, where PRN was prescribed.

Staff outlined the procedure in place for the segregation and return of any medicines that are used or out-of-date. Used or out-of-date medicines were segregated from other medicines and a log of returns to pharmacy was maintained.

The inspector reviewed a medication audits that had been completed by the person in charge in February 2017. As identified on the previous inspection, the system in place for carrying out medicines management audits required development as the audit template did not consider all parts of the medicines management cycle. This had been addressed with the introduction of a new template across the service. The person in charge said that the new template would be used for any future medicines management audits.

Medication errors were recorded and reported. Staff supported family members and residents to self administer medicines when in the family home. Improvements required to ensure learning from medication errors were previously addressed under Outcome 7.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:

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

The statement of purpose submitted to HIQA was dated 2015. A review of the statement of purpose was required to reflect changes to who was identified as a person participating in the management of the centre, changes in the design and layout of the centre and to ensure that the statement of purpose adequately reflected the service being provided in the centre. In addition, the section on multidisciplinary supports did not meet the requirements of the Regulations.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall, while the local management arrangements in place were satisfactory, repeat failings in some key areas resulted in a finding of major non-compliance in this outcome.

There was a clearly defined management structure in place in the centre. A social care leader oversaw the day-to-day running of the house and reported to the person in charge. The person in charge reported to the sector manager who in turn reported to the provider representative who was a member of the executive management team.

The person in charge was suitably qualified and experienced to fulfil the role of person in charge. He had 10 years experience as a social care leader and two years in the role of person in charge. There were suitable deputising arrangements in place with the sector manager deputising in such an event.

The person in charge was responsible for six centres, comprising eight houses across Cork city and surrounding suburbs and into East Cork. At the previous inspection, the

person in charge visited the centre approximately once a month. This was identified as a failing at the previous inspection and the person in charge had increased his presence and visits to the centre since that inspection to twice a month with regular phone contact in between. However, these arrangements did not ensure that the person in charge was involved in the operational management of the designated centres concerned. At service level, the representative of the provider was reviewing the arrangements in place for persons in charge across the service and a plan had been developed to ensure that persons in charge were supported to meet the requirements of the regulations.

A social care leader was identified as a person participating in the management of the service. The social care leader worked full-time in this centre, held an appropriate social care qualification and had significant experience in supporting residents with an intellectual disability. The staff team, led by the social care leader and person in charge, demonstrated that they knew residents and their support requirements well. Feedback from residents and their families and follow-through of actions demonstrated that the centre was being run in a safe, individualised and efficient manner at local level.

At the previous inspection, systems for monitoring the safety and quality of care on an on-going basis required improvement. Examples were provided of where audits required development under Outcomes 7 and 12 in the context of infection control, health and safety and medicines management. Since the previous inspection, infection control and health and safety audits had been completed. A new template for completing medicines management audits had been introduced across the service. However, the medicines management audit available for this centre at the time of this inspection remained inadequate, as identified on the pervious inspection.

Unannounced visits had been completed on behalf of the provider, with two visits completed to date in 2017. The visits considered eight outcomes. However, while the visits identified some actions that were required in a number of key areas, they stated what was in place rather than the effectiveness of adequacy of those arrangements. For example, the visits recorded that two residents had behaviour support plans and that one resident received regular review of their support plan, rather than assessing the adequacy of behaviour support services in the centre. Also, the visit took a sample of one file and recorded which allied health services the resident had accessed without assessing whether supports were being provided based on residents' assessed needs. Visits did not address the lack of multidisciplinary review for the majority of residents in this centre; this has also been discussed under Outcomes 5 and 8.

An annual review had been completed that considered feedback from residents and their representatives. It also considered progress against unannounced visits completed on behalf of the provider and reviewed restrictions, errors and environmental improvements. Goals were outlined for the coming year for this centre and progress against those goals was evidenced. However, the annual review required further improvement. For example, the failing identified at previous inspections and at other inspections in this service, for the review of the personal plan to be multidisciplinary was not addressed in the annual review.

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

Findings:
Overall, staff were supported through training and supervision to deliver safe effective care.

At the previous inspection, a formal supervision system was not in place for all staff to improve practice and accountability. Since the previous inspection, staff appraisal and supervision systems had been introduced and staff had participated in such meetings.

At the previous inspection not all staff had received the training that they required to support residents. Since that inspection, staff had received training to support residents with communication needs. Where a staff member required this training, they had been scheduled to attend same. A small number of staff had also completed an intensive behaviour support training course. However, findings under Outcome 11 indicate that training in relation to care planning was required for the staff team. Training records indicated that mandatory training for staff was up-to-date including in relation to the protection of vulnerable adults, medicines management, first aid, food safety, fire safety, infection control and nutrition.

There was a planned and actual staff roster in place which showed the staff on duty during the day and sleepover staff on duty at night. Based on observations, a review of the roster and these inspection findings, it was demonstrated that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs and abilities of residents at the time of this inspection.

A sample of staff files was reviewed against the requirements of Schedule 2 of the Regulations. There was a discrepancy between the time allowed for a Garda Síochána (police) vetting disclosure of staff by the organisation (which allowed for Garda vetting every 3 to 5 years) and the regulator (who required a vetting disclosure every three years). The sector manager and person in charge brought this to the attention of their human resources department immediately following the inspection.

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

Staff were observed to be supervised appropriate to their role on an informal basis. Regular staff meetings were held and items discussed included health and safety, medicines management, residents' needs, complaints and compliments, safeguarding and documentation. Staff told the inspector that they could add to the agenda if they wished to do so.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Brothers of Charity Southern Services
Centre ID:	OSV-0002278
Date of Inspection:	08 August 2017
Date of response:	12 September 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that privacy and dignity was respected in relation to professional consultations and personal information.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
The Person in Charge will ensure that

1.Staff are reminded that the issues personal to residents are not to be discussed at the residents group house meetings [09/09/2017]

2.Residents and staff will be advised that the current key-working arrangements are the appropriate forum for such discussions.

3.A footnote will be inserted into all House Meeting Agendas to clearly state the above process to ensure ongoing awareness of this issue.

Proposed Timescale: 14/09/2017

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:
The review of the personal plan was not multidisciplinary, as required by the Regulations.

2. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
The Person in Charge has arranged for the residents personal plan review process to include multidisciplinary inputs. The system of review is currently under review and a new system is being piloted to identify how multidisciplinary staff can best work with the staff team to review the resident's plans on an annual basis or more frequently if there is a change in needs or circumstances for the resident. This pilot will be complete by 31 October and the revised system will then be applied in this Centre.

Proposed Timescale: 17/11/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The effectiveness of residents' reviews was not demonstrated.

3. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The Person in Charge has arranged for the effectiveness of the residents personal plans to be reviewed and for the review to take into account changes in circumstances and new developments.
The current system of review of personal plans for residents is being re-evaluated in two pilot areas. The overall objective of the pilot is to inform how the Regulations can best be met. The pilot will include a meeting with the residents and for the following key documentation for each resident to be reviewed:-
• The residents Personal Profile
• The log of significant events for the person in the past year (changes in circumstances and developments)
• A review of the outcomes on the personal plan for previous year
• The updated 3 part Comprehensive Assessment of Health Social and Personal Goals (i.e. GP Annual Review, OK Health Check and the CAHSP Assessment Checklist) which in turn identifies Goals that form the basis of the persons plan.
• the Individual Risk Profile and relevant Risk Management Plans
• The individuals Health Care Management Plans
• The Individuals PSR (if applicable)
• The draft Personal Plan developed from the above

The pilot also aims to address concerns in relation to the scope of the review required of multidisciplinary clinicians and it is envisaged that the outcome of the pilot will include a 'Review Template' which will evidence the team and multidisciplinary review of the effectiveness of the plan.
The revised system as informed by the pilot will then be applied in this Centre.

Proposed Timescale: 17/11/2017

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:
It was not demonstrated that adequate steps had been taken to prevent a reoccurrence of medication errors.

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

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

1.Staff will be reminded to complete the actions taken to remedy the error in the incident reporting form. [9/08/2017]

2.A full review of all medication errors recorded and the remedial actions taken has been conducted by the Person in Charge and the Team Leader. This will be written up and will form part of the local Medication Management Policy to be kept updated by the staff team.

Proposed Timescale: 29/09/2017

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 had not ensured that where required, therapeutic interventions were reviewed as part of a multidisciplinary personal planning process.

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

Please state the actions you have taken or are planning to take:
The Person in Charge has arranged for an annual review of the residents therapeutic intervention plans with multi-disciplinary inputs.

Proposed Timescale: 17/11/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans did not always reflect residents' actual and current needs so as to direct the care to be given to individual residents at any one time.

6. 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:
All health care issues pertaining to a resident that exist currently or indications of a changing need or a risk thereof will be clearly documented in residents' health care management plans.

The plans will be reviewed quarterly with nursing oversight and updated when there is a change. Staff will receive training on the health care planning system as part of refresher training on the overall care planning system.

Proposed Timescale: 30/09/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of the statement of purpose was required to reflect changes to who was identified as a person participating in the management of the centre, changes in the design and layout of the centre and to ensure that the statement of purpose adequately reflected the service being provided in the centre. In addition, the section on multidisciplinary supports did not meet the requirements of the Regulations.

7. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The 2017 Statement of Purpose will be submitted to the Authority together with updated floor plans for the Centre.

Proposed Timescale: 08/09/2017

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:
It was not demonstrated how the person in charge was facilitated to ensure the effective governance, operational management and administration of the designated centres concerned.

8. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
1.The Person in Charge will ensure that the designated weekly time in the Centre is evidenced going forward

2.The Provider Nominee and Sector Manager has reviewed the scope of the role of the Person in Charge . Changes are in the progress which will reduce the number of Centres under the remit of the Person in Charge of the Centre.

Proposed Timescale: 17/11/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medicines management audit available for this centre remained inadequate, as identified on the pervious inspection.

9. 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:
There has been a review of the Person Centred Medication Management Policy. A new template for the audit has been introduced effective from September 2017 in this Centre. In addition arrangements have been made for a local pharmacy to conduct an annual audit.

Proposed Timescale: 29/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings, the unannounced visit was limited in scope and findings in the unannounced visit indicated that improvement was required to ensure that the safety and quality of care and support being provided in the centre was fully reviewed.

10. 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:
The Service Provider and Quality Department are currently reviewing six monthly reporting and annual reviews to ensure that the safety, quality and care and support provided in the centre will be addressed.

Proposed Timescale: 29/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, improvement was required to the annual review.

11. 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:
The Provider Nominee will meet with the Person in Charge and PPIMs to revise the format of the Annual review to ensure that it captures the relevant care and support issues in the centre together with the governance thereof and any related actions for improvement.

Proposed Timescale: 29/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a discrepancy between the time allowed for a vetting disclosure of staff by the organisation (which allowed for vetting every 3 to 5 years) and the regulator (who required a vetting disclosure every three years).

12. 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 Service Provider has advised the Human Resources Department who are currently working on vetting to ensure each staff member receives their vetting within a 3 year timescale in accordance with National Policy.

Proposed Timescale: 15/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, Lámh training had yet to be completed for all staff with respect in order to support residents' communication needs. Also, inspection findings indicated that training in relation to care planning was required for the staff team.

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

Please state the actions you have taken or are planning to take:
Staff have been scheduled in for Lámh training on 28th September 2017.

Staff will receive training on all elements of the care planning, monitoring and review systems in place as amended under Outcome 5 above.

Proposed Timescale: 17/11/2017