

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Parkview
<b>Centre ID:</b>	OSV-0002622
<b>Centre county:</b>	Sligo
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Ann Gilmartin
<b>Lead inspector:</b>	Catherine Glynn
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	2
<b>Number of vacancies on the date of inspection:</b>	1

## **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: 02 February 2017 10:15 To: 02 February 2017 18:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

Background to the inspection:

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

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

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

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

Standards).

How we gathered our evidence:

The inspector met with one resident and the person in charge on the day of inspection. The inspector observed practice and reviewed documentation such as personal care plans, healthcare plans, medical and clinical information, risk assessments, staff files and training records. The inspector found that one resident, who spoke with the inspector, was well informed and aware of the services available and chose how she lived her life. Interactions between staff and the resident was observed to be respectful at all times.

Description of the service:

The centre was a two storey dwelling located in close proximity to Sligo town. The residents were independent and received minimal staffing support. Both the residents had employment identified and were actively participating in their local community. Both residents had active family support and involvement as seen in their personal plans. A notification of the intended closure of this designated centre, had been submitted to the Health Information and Quality Authority . The staff and residents outlined the new premises and their future plans.

Overall judgment of our findings:

Overall the inspector reviewed five outcomes and found that there was a poor level of compliance in the designated centre. Improvements were required in all of the outcomes inspected. The inspector found that the governance and management arrangements in the centre were ineffective.

The findings and their actions are further outlined in the body of the report with 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 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:**

On the day of inspection, the inspector found that actions identified from the previous inspection had not been addressed.

Personal plans were reviewed as part of the inspection. The inspector found on review of one plan, the following:

- the plan was last completed in 2015
- no evidence of relevant people participating in the review
- no transition plans were available for review ahead of planned discharges
- no evidence of monitoring or updated reviews

The inspector found that the personal plan was last updated completely in 2014, there was no evidence of daily notes being completed since May 2015. There was evidence that documentation was updated following regular reviews which reflected the care and support needs for the residents. Residents' personal goals were not being identified and therefore no actions or timeframes set out as a result.

The inspector found that the residents' were very independent and chose how they were living their lives, however there was no documentation to support what was in place as required by the regulations.

**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):**

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

**Findings:**

On the day of inspection the inspector found that the person in charge had not maintained and implemented systems to ensure the health and safety of residents, visitors and staff was promoted in the designated centre.

The inspector found that actions identified from the last inspection had not been completed. The provider was required to ensure the health and safety statement was reviewed by October 2015. On the day of this inspection, there was no up-to-date health and safety document in the designated centre.

In addition, risk assessments were to be reviewed and completed by October 2015. This was not completed, the inspector found a risk assessment for a resident who smoked, which had not been updated since 2014. Therefore it did not reflect the measures and actions that were introduced to support the resident, and to ensure their safety, whilst respecting their choice.

There was no evidence of the maintenance and completion of all fire management documents in the centre. There was no record of fire drills completed since July 2015. None of the fire records were complete for the centre such as emergency lighting checks, obstruction of fire doors checks and fire panel checks. There were fire extinguishers in place and they had been serviced as required by the relevant engineer. Personal emergency evacuation plans were not kept up to date.

Residents spoken with talked about fire safety and outlined the steps they would take if required. They were familiar with the procedures for drills and outlined where they evacuated to. The residents also spoke of who they would contact for help or support in the event of an emergency.

**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):**

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

**Findings:**

The inspector found that there were policies and procedures in place on safeguarding and protection of vulnerable adults with disabilities.

On review of the training records, the inspector found that all staff working within the designated centre had completed training in safeguarding. However staff had not completed training in positive behaviour support, as required by the regulations.

The inspector found that staffing arrangements were appropriate to the residents. The inspector met with the person in charge who was also the designated officer for this centre. She had not completed training for her role as designated officer but had completed the safeguarding training as required.

There were no restrictive practices in place in the designated centre at the time of inspection.

**Judgment:**

Compliant

**Outcome 14: Governance and Management**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

The inspector found that the provider and person in charge had failed to ensure that effective governance arrangements were in place at the time of inspection. The inspector found that there was significant gaps in practice, reflected in changes in staffing and management structures within the centre.

The inspector found that the person in charge, had not ensured the maintenance of all governance systems in the centre. There was no annual review of quality and safety of care and support in the designated centre, completed at the time of inspection. Furthermore the six monthly unannounced visit had not been completed by the provider, which was failing identified during the last inspection. The management structure had responded to an action plan in the previous monitoring report, stating actions had been completed. On inspection, the inspector found that the majority of these actions were incomplete. There was no evidence of an internal auditing process to monitor and oversee the completion of tasks or actions.

The inspector found that the systems in place to monitor the service, were reliant on a former staff member that had moved to a new role in May 2015. In addition, documentation systems within the centre, had not been maintained. There was an overall lack of oversight and monitoring in the centre by the person in charge and the provider.

The rota did not reflect attendance of the person in charge to the centre. The inspector was informed that they had been attending more frequently in the last few weeks, prior to the inspection. However there was no records to reflect this attendance.

At the time of inspection, the person in charge had responsibility of five designated centres, in addition to a day service. She also had the responsibility for designated liaison officer and had requested management qualifications in her role. She identified there was a new senior management structure in place, and felt that this was an improvement. She outlined that there was clear direction received and support systems in place with the new structure. However it was apparent that the systems in place for this designated centre did not meet the requirements of the regulations, and had not been maintained since the last inspection.

The person in charge outlined the arrangements with regard to on-call support for the staff and residents. She had revised her working schedule and provided on-call support, in conjunction with another person in charge, on a rotational basis. For example they worked alternative weekends, providing support if required. She also outlined that there were additional nurses on call 24 hours a day for the community houses, if 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):**

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

**Findings:**

The inspector found that there was not consistent staffing provided to the centre. In addition, when a consistent member of staff moved within the organisation, the provider had failed to recruit someone to fill the position at the time of inspection. However the inspector found that the current staffing was inconsistent and agency staffing was provided at times on review of a four week roster.

The inspector requested the rota and found that for the month of January, the residents had not engaged with the staff provided. This had resulted in a meeting being called with the residents to discuss the staffing arrangements and their engagement prior to a new roster being set out.

On review of staffing files, inclusive of the person in charge, the inspector found they were not in line the requirement's of schedule two.

Education and training records were reviewed, which identified refresher dates for mandatory training.

**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:***

Catherine Glynn  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0002622
<b>Date of Inspection:</b>	02 February 2017
<b>Date of response:</b>	15 March 2017

### Requirements

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

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

#### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

Residents' personal plans had not been reviewed annually or more frequently as required in the designated centre.

**1. Action Required:**

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are

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

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:**

- PIC has ensured that all residents personal plans have been reviewed and this action is now complete.
- A transition plan has been completed by the PIC for each resident to assist in their planned discharge.
- PIC will ensure that a system will be put in place to review and monitor personal plans on a regular basis.

**Proposed Timescale:** 20/03/2017

**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:**

Risk assessments had not been reviewed in line with identified dates for review.

The health and safety statement had not been reviewed since the last inspection.

**2. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

Risk assessments have been reviewed by the PIC based on the current need.

The PIC will ensure that all risk assessments will be reviewed to reflect the transitioning of the residents to their new accommodation

The PIC has ensured that the health and safety statement has been reviewed and will be subject to ongoing update as required.

**Proposed Timescale:** 20/03/2017

**Theme:** Effective Services

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

The fire management systems had not been maintained in the designated centre;

- no daily checks of fire panel

- no checks of emergency lighting
- no checks of fire doors

### **3. Action Required:**

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

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

The PIC has ensured that the requirements as laid out in the new fire register are being fully implemented. These will include checking of the fire panel, emergency lighting and fire doors.

**Proposed Timescale:** 03/03/2017

**Theme:** Effective Services

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

Fire drills had not been completed as required in the designated centre.

### **4. Action Required:**

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

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

Fire drills have been carried out on February 5th and March 1st and have been documented in the fire register by the PIC.

The PIC will ensure that all fire drills are carried out in accordance to regulations and a log of these will be maintained in the fire register.

**Proposed Timescale:** 01/03/2017

## **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:**

Staff working in the centre had not completed training in the management of behaviour that is challenging including de-escalation and intervention techniques.

### **5. 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:**

The PIC has arranged that the staff working in the centre is scheduled to undergo relevant training in behaviours that challenge on 20.03.17.

**Proposed Timescale:** 20/03/2017

**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:**

There was no annual review had been completed at the time of inspection.

**6. Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The Provider will ensure that an annual review of the centre will be completed and forwarded to Inspector.

**Proposed Timescale:** 30/03/2017

**Theme:** Leadership, Governance and Management

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

The provider had failed to ensure that six monthly unannounced visits had been completed in the designated centre.

**7. 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 will ensure that a six monthly unannounced visit will be completed and forwarded to Inspector.

**Proposed Timescale:** 30/03/2017

**Theme:** Leadership, Governance and Management

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

The provider had failed to ensure that management systems were in place to ensure that the service was effectively monitored.

**8. Action Required:**

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

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

The Provider will ensure that the PIC visits the designated centre regularly and completes monitoring checks to provide assurance that the service provided is safe and is meeting the needs of residents.

**Proposed Timescale:** 03/03/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Staff files did not contain required information as set out in schedule two.

**9. 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 PIC has ensured that all staff files have been up dated and contain all relevant information as per schedule 2 of staff requirements.

**Proposed Timescale:** 10/03/2017

**Theme:** Responsive Workforce

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

The provider had failed to replace a staff, therefore consistent and familiar staff was not provided to the residents'.

**10. Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than

full-time basis.

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

The Provider will ensure consistent and familiar staff support residents on a regular basis based on the residents assessed needs.

**Proposed Timescale:** 03/03/2017