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:	Caradas
Centre ID:	OSV-0003374
Centre county:	Meath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barry Dunne
Lead inspector:	Maureen Burns Rees
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	2
Number of vacancies on the date of inspection:	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:	To:
05 September 2017 10:00	05 September 2017 17:30

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

This was a seven outcome inspection carried out to monitor compliance with the regulations and standards. The previous 18 outcome inspection was undertaken on the 15 and 16 of March 2016 and as part of the current inspection the inspector reviewed the actions the provider had undertaken since the previous inspection. The centre was registered in October 2016.

How we gathered our evidence:

The inspector interviewed the person in charge, a staff nurse and two care assistants. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff supervision files.

As part of the inspection, the inspector met with the two residents living in the centre. Although these residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits.

Description of the service:

The service provided was described in the providers' statement of purpose. The centre provided residential care for up to three service users. At the time of inspection, two residents with complex support requirements were living in the centre and there was one vacancy.

The centre was located on the outskirts of a small town in county Meath. There was a health centre located adjacent to the centre. The centre comprised of a detached, three bedroomed one story house. It had a small back and front garden. There was a staff nurse on duty at all times to meet residents care needs.

Overall Judgment of our findings:

Overall, the inspector found that arrangements were in place for residents to be well cared for and that the provider had arrangements in place to promote their rights and safety. The inspector was satisfied that the provider had adequate systems in place to ensure that the majority of regulations were being met. The person in charge demonstrated adequate knowledge and competence during the inspection and the inspector was satisfied that she remained a fit person to participate in the management of the centre. Of the seven outcomes inspected on this inspection, three outcomes were compliant, three outcomes were in substantial compliance and one outcome had moderate non compliances as outlined below.

Good practice was identified in areas such as:

- Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. (Outcome 5)
- Resident's healthcare needs were met in line with their personal plans and assessments. (Outcome 11)
- There were systems in place to ensure the safe management and administration of medications. (Outcome 12)

Areas for improvement were identified in areas such as:

- Some improvements were required in relation to maintenance management and infection control arrangements. (Outcome 7)
- Improvements were required in relation to behaviour support arrangements for one of the residents and staff training requirements. (Outcome 8)
- Improvements were required in relation to the staff files and staff supervision arrangements. (Outcome 17)

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):
No actions were required from the previous inspection.

Findings:
Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support.

Each resident's health, personal and social care needs were assessed. A personal plan was in place for each resident which detailed their assessed needs, capacities and interests. There was a detailed activities of living plan of care. Personal goals were detailed in 'important goals for me and my action plan'. There was evidence that a review meeting was undertaken on a monthly basis by key worker with service user to review goals set and progress in achieving same. Residents were involved in a suitable range of activities appropriate to their capacities.

There were processes in place to formally review resident's personal support plans with the involvement of the providers multidisciplinary team on at least an annual basis. There was documentary evidence to show that resident's family representative were invited to review meetings although on occasions choose not to attend. The inspector found that the personal plan for each of the residents and found that they had been implemented to meet the support needs of the residents.

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):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, visitors and staff were promoted and protected. However, some improvements were required in relation to maintenance management and infection control arrangements.

There was a risk and incident management policy, dated June 2016 which met with the regulatory requirements. There was a formal risk escalation pathway in place. The centre had an up to date risk register in place. The inspector reviewed individual risk assessments for both of the residents which contained a good level of detail, were specific to the resident and had appropriate measures in place to control and manage the risks identified.

There was a safety statement dated May 2017, with written risk assessments pertaining to the environment and work practices. Health and safety audits were undertaken on a monthly basis with appropriate actions taken to address any issues identified. Hazards and repairs were reported to the provider's maintenance department. However, records showed that requests were not always attended to promptly. For example, there were a number of requests outstanding for longer than two months.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The inspector reviewed a sample of all incidents and accidents reported which also recorded actions taken. All incidents were risk reviewed and signed off by the person in charge and also reviewed by the director of nursing. There was evidence that incidents were reviewed and discussed at staff team meetings with learning agreed in the centre. In addition, specific trends of incidents were discussed at senior management team meetings on a monthly basis. This promoted learning across the wider service.
Overall, there were a low number of incidents reported.

There were procedures in place for the prevention and control of infection. A national infection control policy had been adapted in the centre. The inspector observed that all areas were clean and in a reasonable state of repair. Colour coded cleaning equipment was used and appropriately stored. The inspector observed that there were sufficient facilities for hand hygiene available with paper hand towels in use and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. A new cleaning schedule had been put in place a month previous to the inspection. However, at the time of inspection, this schedule was not being appropriately signed off by staff for tasks undertaken. The inspector observed some chipped paint on walls and woodwork in a number of places in the centre. This impacted on the ability of

staff to effectively clean these areas from an infection control perspective.

Suitable precautions were in place against the risk of fire. There was a fire safety policy, dated August 2016. There was documentary evidence that the fire equipment, fire alarms and emergency lighting were serviced and checked at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures. All staff had received appropriate training. Fire drills involving residents had been undertaken at regular intervals. Records of residents meetings held on a two weekly basis showed that fire safety was discussed as a standing agenda item.

There was a moving and handling policy and a guideline document in place, but they were both overdue for review. All staff had received appropriate training. A manual handling risk assessment and plan of care was in place for one of the residents who required same. A manual handling hoist was being used in the centre and records showed that this had been appropriately serviced.

There was a major emergency plan in place, dated February 2016 to guide staff in the event of such emergencies as power outages or flooding.

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:
There were appropriate measures in place to keep residents safe and to protect them from abuse. However, there were some improvements were required in relation to behaviour support arrangements for one of the residents and staff training requirements.

The provider had a safeguarding vulnerable persons at risk of abuse policy, dated March 2016. The picture and contact details for the designated officer was observed to be on display in the centre. Staff who met with the inspector were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. There had been one incident or suspicion of abuse in the previous 12 month period, which had been appropriately dealt with. All staff had attended appropriate safeguarding training.

There was an intimate and personal care policy in place, dated March 2017. The inspector reviewed individual intimate care plans on each of the residents files. These contained a good level of detail to guide staff in meeting the intimate care needs of the residents. Staff interviewed were familiar with the policy and intimate care plans for residents.

Overall residents were provided with emotional and behavioural support. There was a policy re managing behaviour that challenges, dated November 2016. However, a supporting plan in place was in need of review. In addition, it was identified that three staff required training in the management of challenging behaviour.

There was a policy on the use of restrictive procedures, dated July 2017. A very small number of restraints were being used in the centre. All usage was monitored and recorded. Staff interviewed told the inspector that all alternative measures were considered before a restrictive procedure would be put in place. There were records on file to show that the provider's 'positive approaches support group' had approved that an application for the use of a chemical restraints on occasions for a resident requiring specific procedures.

Judgment:
Substantially Compliant

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:
Resident's healthcare needs were met in line with their personal plans and assessments.

There was a staff nurse rostered on duty at all times. This ensured that residents, who had medical conditions that required monitoring, had access to nursing care. Each of the

residents had their own general practitioner (GP) located in the healthcare adjacent to the centre. An out of hours GP service was also available. Residents also accessed a number of allied health professionals, including physiotherapists, occupational therapy, speech and language therapy and dieticians.

The inspector reviewed each of the resident's files and found that their health needs were appropriately assessed and were being met by the care provided in the centre. Up-to-date hospital passports were on file with all pertinent information should a resident require transfer to hospital. An end of life care policy was in place, dated July 2017.

The centre had a fully equipped kitchen come dining area. This was observed to be an adequate space to make meal times a social occasion. The service had 'guidelines on monitoring nutritional intake', dated July 2017. In addition, there was a protocol for supporting residents when dining, dated January 2017.

There was a weekly menu planner in place which was agreed at residents meetings with staff. Residents diet and fluid intake was recorded which showed that a range of nutritious, appetising and varied foods were provided for residents. Instructions from the speech and language therapist regarding thickening of fluids and consistency of diet were being adhered to. A nutrition and hydration plan of care was on file for both service users. These were found to contain a good level of detail to guide staff in meeting residents needs and included recommendations from dieticians and speech and language therapists as required.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
There were systems in place to ensure the safe management and administration of medications.

The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A registered staff nurse was on duty at all times and it was the policy of the centre that only nursing staff administered medications. A medication management policy was in place, dated July 2017. There was a secure cupboard for the storage of all medicines. The inspector reviewed a sample of

prescription and administration sheets and found that they had been appropriately completed. Staff interviewed had a good knowledge of appropriate medication management practices and medications were administered as prescribed. Medication care plans were in place for each of the residents.

PRN or as required medication protocols were in place for both of the residents. A PRN administration record was maintained of all administrations and included information on the reasons for administration and staff nurse review of effect.

Staff had assessed the ability of individual residents to self manage medication and found it was not appropriate for either of the residents to be responsible for their own medications. Easy to read information on individual medications were kept in each of the residents bedrooms.

There were systems in place to review and monitor safe medication management practices. Medication management audits were undertaken on a regular basis and where issues were identified appropriate actions had been taken. A count of all medication was recorded on a daily basis. The inspector observed that all medications in use could be accounted for at all times.

There were procedures for the handling and disposal of unused and out of date drugs. A record was maintained of all unused and out of date drugs medication returned to pharmacy. There was a separate secure area for the storage of out of date medications.

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):
No actions were required from the previous inspection.

Findings:
There were management systems in place to ensure that the service provided was safe, consistent and appropriate to resident's needs.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had taken up her post in January 2017. She is a registered nurse in intellectual disabilities and held a diploma in management and a degree in nursing. She had been working in a management position for more than 15 years. Staff interviewed told the inspector that the person in charge was a good leader, approachable and supported them in their role. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards. She also had a clear insight into the health needs and support requirements for both the residents.

The person in charge was in a full time post and held responsibility for an adult day service located some distance away. She worked core working hours Monday to Friday but was also available outside of these hours. On-call arrangements were in place and staff were aware of these and the contact details.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. Staff who spoke with the inspector had a clear understanding of their role and responsibility. The person in charge reported to the assistant director of nursing who in turn reported to director of nursing. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

An annual review of the quality and safety of care and support for 2016 had been undertaken and made available to families. An unannounced visit to review the safety and quality of care had been undertaken by the provider on a six monthly basis as required by the regulations. An improvement action plan to address issues identified had been put in place, with an appropriate assignment of responsibility and timelines.

There was an audit plan in place which was overseen by the person in charge. This included audits undertaken by staff at regular intervals pertaining to cleaning, health and safety, pillows and mattresses. The person in charge undertook a suite of audits on a two monthly basis. Matters audited included, residents finances, health and safety, medications, fire safety, residents care plans and 'my important to me' goals. There was evidence that appropriate actions were taken to address any issues identified. Quality and safety meetings were held on a monthly basis. These were attended by members of the senior management team and persons in charge of centres in the area. There was evidence that results of audits and trends of incidents were reviewed at these meetings with shared learning across the service agreed.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
There was a consistent team of staff working with service users who had received up-to-date mandatory training. However, improvements were required in relation to the staff files and staff supervision arrangements.

Overall, the staffing levels and experience were sufficient to meet the needs of the two residents in the centre. The majority of staff had worked in the centre for a number of years which meant that the residents had continuity in their care givers. It was a nurse led service with a registered staff nurse on duty at all times. There were emergency on call arrangements on display in the centre.

A training programme was in place for staff which was coordinated by the providers training department. Training records showed that staff were up-to-date with mandatory training requirements. Staff interviewed were knowledgeable about policies and procedures in place. The inspector observed that a copy of the standards and regulations were available in the centre.

There was a recruitment and selection procedure in place. The inspector reviewed a sample of four staff files. Overall, the information as required by schedule 2 of the regulations was in place. However, in one of the four files reviewed, the inspector found that evidence of the staff members identity including a recent photograph was not on file. This was rectified on the day of inspection for this staff member but the remaining staff files needed to be checked.

Staff supervision arrangements in place were not adequate for all staff. There was a standard operating procedure for staff support and performance, dated June 2017. This document stated that staff support meetings should be scheduled on at least an annual basis. The inspector considered that the frequency proposed might not provide appropriate supervision for staff. The person in charge had devised a schedule to supervise staff on two occasions in a 12 month period. However, on review of supervision records, the inspector identified that there were four or more staff who had not had formal supervision in more than 12 months.

There were no volunteers working in the centre at the time of inspection.

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:

Maureen Burns Rees
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 Health Service Executive
Centre ID:	OSV-0003374
Date of Inspection:	05 September 2017
Date of response:	06 October 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 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:
Maintenance requests were not always attended to promptly. For example, there were a number of requests outstanding, for longer than two months.

There was a moving and handling policy and a guideline document in place, but they were both overdue for review.

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

Please state the actions you have taken or are planning to take:
The Registered Provider and Office of the Director of Nursing have met with maintenance management and agreed a revised plan to provide assurances that maintenance requests will be responded to in a timely manner.

The moving and handling policy/guidance document is under current review and guideline updates are planned for completion by November 2017.

Proposed Timescale: 30/11/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The cleaning schedule was not being appropriately signed off by staff for tasks undertaken.

There was some chipped paint on walls and woodwork in a number of places in the centre. This impacted on the ability of staff to effectively clean these areas from an infection control perspective.

2. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
The cleaning scheduled has been reviewed and sign off on completed duties as set out on the schedule is active.

Painting of the internal walls, ceilings, doors and door frames & Skirting areas has been escalated to the Provider Nominee & maintenance department and is on a schedule for completion by end of March 2018.

Proposed Timescale: 30/04/2018

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:
A behaviour support plan was in need of review.

3. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
The Behaviour Support Plan referred to has now been reviewed and updated as of 17-09-2017.

Proposed Timescale: 17/09/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was identified that three staff required training in the management of challenging behaviour.

4. 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:
Two of the staff identified missed scheduled training in July 2017 due to long term sick leave.

Further training has been organised for the 11-10-2017 and 20-10-2017 with the relevant staff scheduled to attend.

Proposed Timescale: 30/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One, in a sample of four staff files reviewed did not include information as required by schedule 2 of the regulations, i.e. evidence of the staff members identity including a recent photograph.

5. 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:
All files were checked on the 06-09-2017 and all official ID's were in place.

Proposed Timescale: 06/09/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were four or more staff who had not had formal supervision in more than 12 months.

6. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The staff on duty assigned to the centre have received clinical supervision meetings since the inspection and the policy for clinical support/supervision is scheduled for review based on feedback by 30th Jan 2018

Proposed Timescale: 30/01/2018