Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Gainevale House
Centre ID:	OSV-0005051
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services Unlimited Company
Provider Nominee:	Ann Morahan
Lead inspector:	Maureen Burns Rees
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
29 August 2017 09:30	29 August 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 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 an inspection carried out to monitor compliance with the regulations and standards. The previous inspection was undertaken on the 28 of April 2015 and the centre was registered in June 2015.

How we gathered our evidence:
As part of the inspection, the inspectors met with the person in charge, regional manager, team leader and a social care workers. The inspectors spoke with five of the six service users living in the centre. A number of whom outlined that they enjoyed living in the centre. All of the service users were in good spirits and were observed to have warm interactions with the person in charge and staff caring for them. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff supervision files.

Description of the service:
The service provided was as described in the providers statement of purpose. The centre provided residential care for six adults with a diagnosis of an intellectual disability.

The centre consisted of a large two storey house located on a spacious site within walking distance of a small village in Westmeath. There were two separate stair

cases providing access to bedrooms and bathrooms on the upper level. Six bedrooms were set aside for residents and five of these had ensuite facilities. There were four additional bathrooms and adequate separate communal spaces for the residents. There was a well maintained landscaped garden area surrounding the centre.

Overall Judgment of our findings:
Overall, the inspector found that service users were well cared for and that the provider had arrangements in place to promote their rights and safety. The inspector were satisfied that the provider had put 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 were satisfied that he remained a fit person to participate in the management of the centre.

Good practice was identified in areas such as:

- Service user's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified (Outcome 5).
- Arrangements were in place to support service users on an individual basis to achieve and enjoy the best possible health. (Outcome 11)
- There were systems in place to support staff in protecting service users in relation to medication management. (Outcome 12)
- There were arrangements in place to monitor the quality and safety of care and support in the centre. (Outcome 14)

Areas for improvement were identified in areas such as:

- Some improvements were required in relation to the reporting of incidents and provision of fire safety training for staff. (Outcome 7)
- A small number of staff were overdue to attend training in safeguarding. (Outcome 8)
- Some improvements were required in relation to staff supervision and staff training 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:
Service user's individual needs and choices were appropriately assessed and personal plans had been put in place to meet the needs identified.

A full assessment of service users needs was completed as part of the admission process and reviewed at regular intervals. These assessments informed personal plans put in place. There was evidence that service users and their families were involved in these assessments.

There were person centred plans for each of the service users which detailed their individual needs and choices. Personal goals, actions required to achieve same and timelines were also recorded for each of the service users. Task analysis sheets had been completed for some goals. There was evidence that outcomes were reviewed by key workers with service users on a monthly basis. Person centred plans had a multidisciplinary input and service users and their family representatives were involved in the development of plans put in place. They were found to be in an accessible format.

The inspector reviewed daily activity lists on file for service users which showed that service users were engaged in a good range of activities in the local community and inside the centre. Visual timetables had been put in place for service users regarding their daily planners. A number of service users who spoke with the inspector referred to their activity timetable and it was evident it assisted them in organising their day.

Personal plans were formally reviewed on a minimum of a yearly basis. There was evidence that service users and their families were invited to review meetings, although

on some occasions they chose not to attend.

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:
There were arrangements in place to promote and protect the health and safety of service users and staff. However, some improvements were required in relation to the reporting of incidents and provision of fire safety training for staff.

There was a health and safety policy and procedure, dated June 2016, which was specific to the centre. There was a safety statement, dated Ma7 2017. Site specific risk assessments had been undertaken and appropriately recorded. Health and safety checks were completed at regular intervals. There was an emergency plan in place to guide staff in responding to an emergency. The provider had a quality team which was accessible as a resource for the centre. There was a risk management policy, dated June 2016 which met the requirements of Regulation 26. Individual risk assessments for service users had been undertaken with plans put in place to address risk identified.

Arrangements in place for investigating and learning from serious incidents and adverse events involving service users required some improvements. There was a computer based system for incident and near miss reporting which included a section to record action taken and further actions required. A procedure for completing incident forms was in place to guide staff. There was evidence that individual incidents were reviewed and discussed at staff team meetings.The person in charge provided the regional manager with a weekly written report on the numbers of incidents in the centre. There was some evidence that incident trends were considered. In pre consultation and daily notes, the inspector noted reference to an incident which had occurred in the centre. However, there was no evidence that the incident referred to, had been appropriately recorded or reported on an incident report form. This was contrary to the providers incident reporting policy. This meant that some incidents may not have been recorded. Hence opportunities for learning to improve services and prevent incidents were not being promoted.

There were procedures in place for the prevention and control of infection. There was an infection control policy and procedure, dated June 2016. There were cleaning schedules in place and sign off sheets. Colour coded cleaning equipment were in place

and appropriately stored. The inspector observed that there were facilities for hand hygiene available. All areas were observed to be clean and in a good state of repair. However, there were a number of areas which required repainting. This had been identified and a date had been set for same to be completed.

Overall, there were adequate precautions in place against the risk of fire. However, a small number of staff were overdue to attend fire safety training. A procedure for the safe evacuation of service users and staff, in the event of fire, was prominently displayed. Each of the service users had a personal emergency evacuation plan completed and plan in place which considered the mobility and cognitive understanding of the service users. There were adequate means of escape. The fire assembly point was identified with appropriate signage in an area to the front of the building. Fire drills involving service users were undertaken at regular intervals with appropriate records maintained of those attending, time required for full evacuation and issues encountered. A fire risk assessment had been undertaken. Records showed that fire fighting equipment, fire alarms and emergency lighting were appropriately installed and serviced by an external company. Fire doors with self closing hinges had been installed in the centre and were in the process of being upgraded at the time of inspection. Formal safety checks of fire equipment and other safety precautions were undertaken at regular intervals.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There were measures in place to safeguard service users and appropriate actions had been taken in response to allegations or suspicions of abuse. However, a small number of staff were overdue to attend training in safeguarding.

There was a policy and procedure on protection of vulnerable persons, dated June 2016, which was in line with the national guidance. The inspector noted that the responsibilities and contact details for the designated officer and a deputy, were detailed

in the policy. The person in charge and staff interviewed were knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. There had been a small number of suspicions of abuse in the previous 12 month period and these were found to have been appropriately responded to. There was a policy and procedure on service users finances, dated January 2017. However, records showed that a small number of staff were overdue to attend refresher training in safeguarding.

The centre had an intimate care policy in place, dated June 2016. Intimate care assessments and plans were in place for service users identified to require same.

Arrangements were in place to provide service users with emotional and behavioural support that promoted a positive approach to the management of behaviour that challenges. The centre had a policy and procedure on behaviour support, dated June 2016. Incidents of challenging behaviour were reported for a small number of the service users. Risk assessments and safeguarding plans had been put in place. Reactive strategies and anxiety plans were on file for service users who were identified to require same. Training records should that staff had received appropriate training in a recognised behaviour management approach. Staff interviewed were familiar with the management of challenging behaviour and de-escalation techniques. The centre had access to the providers behaviour support team which included expertise in psychology, psychiatry and psychotherapist. The provider had a facility for a drop in clinic for behavioural support.

There was a policy and procedure on restrictive practices, dated June 2016. Restrictive practices in place were approved and regularly reviewed by the providers behaviour support team. There was a restrictive practice log maintained. Risk assessments had been completed for restrictive practices in place. There was evidence that restraints used were discussed at providers clinical meetings on a two weekly basis.

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:
Arrangements were in place to support service users on an individual basis to achieve and enjoy the best possible health.

Service users healthcare needs were met by the care provided. The person in charge was a registered staff nurse and there was one other staff nurse on the staff team. Overall service users had low healthcare needs. There was a policy on health and wellbeing, dated June 2016. Comprehensive health assessment and action plans had been completed for service users. Personal plans included a section on personal health. A hospital passport was in place which included pertinent information. Pre and post consultation notes were maintained of all contact with GP's (general practitioner) and other health professionals. Each of the service users had their own GP. The provider employed and or had access to a number of therapeutic supports which where available to service users. These included: speech and language therapy, dietician, occupational therapy, physiotherapy, behaviour specialist, psychology, psychiatry and counselling therapist.

There were arrangements in place for service users to be involved in choosing and assisting to prepare meals in the centre. There was a fully equipped kitchen come dining area with adequate seating to allow meal times to be a social occasion. A weekly menu planner was agreed at the weekly service user forum meeting which were generally attended by all of the service users. There was a policy on diet and nutrition, dated June 2016. The inspector observed that a healthy diet and lifestyle was promoted in the centre. There was evidence that service users, identified to require such support, had access to a dietician. Recommendations from dieticians for some service users were being implemented in the centre.

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 support staff in protecting service users in relation to medication management.

There was a policy and procedure on the safe administration of medication, dated June 2016. A secure storage press was in place for medications. All staff had completed appropriate training in the safe administration and management of medications. The inspectors reviewed a sample of medication prescription and administration records and found that they had been appropriately completed. Records showed that medications had been administered as prescribed. Individual medication management plans were in

place. Procedures were in place to check all medications ordered and delivered by pharmacy with medication stock control logs maintained. A seven day supply of all medications including PRN or as required medications was maintained in the centre.

PRN or as required medication protocols were in place for service users who were identified to require same, which had been signed off by the service users physician. A PRN administration record was maintained of all administrations and included information on the reasons for administration, synopsis of all other techniques used prior to resorting to the PRN administration and the outcome as a result of the medication being given.

There were a small number of controlled drugs used in the centre. These drugs were found to be appropriately stored with appropriate checks recorded in the controlled drugs register.

There were arrangements in place to review and monitor safe medication management practices in the centre. Medication audits were undertaken by the providers quality assurance department on a regular basis. There was evidence that the output from these audits, with any learning identified was discussed at staff team meetings.

There were procedures for the handling and disposal of unused and out of date drugs including controlled 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 arrangements in place to monitor the quality and safety of care and support in the centre.

There was a management structure in place. The person in charge reported to the regional manager who in turn reported to the director of operation who reported to the chief operating officer. Staff interviewed had a clear understanding of their role and responsibility, and of the reporting structure.

The person in charge held a full time position and was not responsible for any other centre. For a period, the person in charge had been responsible for another centre. However, the provider had reversed this decision some months previous. The person in charge had been working in the centre for the past 14 months. He was a registered nurse in intellectual disability and held a bachelor degree in social care. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards and had a good understanding of the individual care needs of each of the service users. He was supported by a team leader.

The providers quality department had undertaken a range of audits in the centre. These included audits of personal plans, medication management and cleaning schedules. The regulatory requirements for the provider to undertake six monthly unannounced visits to the centre and produce a report of the quality and safety of care had only been undertaken for the first time in April 2017. An annual review of the quality and safety of care in the centre had been undertaken. There was evidence that issues identified were reported to the regional manager along with an action plan and timelines to address issues identified. The person in charge submitted a weekly report to the regional manager which included information such as incidents, restrictive practices, maintenance concerns and any clinical concerns.

The provider was in the process of implementing a new governance plan across the service which had been submitted to HIQA. There was evidence that the person in charge had attended two governance meetings regarding said plan with the senior management team. The person in charge was knowledgeable about the governance plan and requirements in the centre to adhere to the plan.

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 were recruitment procedures in place, which were managed centrally by the provider. However, some improvements were required in relation to staff supervision and staff training arrangements.

There was a recruitment and selection policy and procedure in place, dated June 2016. The inspector reviewed a sample of four staff files and found that the information as required in Schedule 2 of the regulations was available in the files reviewed.

There was an actual and planned staff roster in place which showed that there were adequate numbers and skill mix of staff on each shift to meet the needs of the service users. The full whole time equivalent staff complement identified for the centre was in place. The inspector noted that copies of the standards and regulations were available in the centre. Staff interviewed were knowledgeable about their role and the regulatory requirements.

There was a training and development procedure in place, dated June 2016. There was a training programme in place which was coordinated centrally by the provider. Records for staff training were held off site but a summary record was provided by the training department on the day of inspection. This document showed that a number of staff were overdue to attend mandatory training. This included training in fire safety and safeguarding training for vulnerable adults.

There were formal supervision arrangements for staff in place. The inspectors reviewed a sample of supervision records and found that they were of a good quality. However, a small number showed that supervision had not been undertaken in line with the frequency proposed in the providers policy.

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

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:

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 Nua Healthcare Services Unlimited Company
Centre ID:	OSV-0005051
Date of Inspection:	29 August 2017
Date of response:	22 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 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector identified an incident which had occurred in the centre but which had not been appropriately recorded or reported through the providers incident reporting system.

[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 (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:
PIC to ensure all incident are recorded and reported in line with providers incident reporting system.

Proposed Timescale: 12/09/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A small number of staff were overdue to attend fire safety training.

2. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Identified staff in the Centre to undergo Fire Safety Training

Proposed Timescale: 31/10/2017

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:
A small number of staff were overdue to attend training in safeguarding.

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

Please state the actions you have taken or are planning to take:
Identified staff in the Centre to undergo training in Safeguarding

Proposed Timescale: 31/10/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A small number of records showed that supervision had not always been undertaken in line with the frequency proposed in the providers policy.

4. 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 PIC to conduct a full review of the Supervision taking place in the Centre
PIC will continue to support staff through supervision on a regular basis as per the Centre's Supervision Policy

Proposed Timescale: 07/10/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff were overdue to attend mandatory training. This included training in fire safety and safeguarding training for vulnerable adults.

5. 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:
Identified staff in the Centre to undergo Fire Safety Training.
Identified staff in the Centre to undergo training in Safeguarding

Proposed Timescale: 31/10/2017