

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | No.3 Seaholly |
| Centre ID: | OSV-0005135 |
| Centre county: | Cork |
| Type of centre: | Health Act 2004 Section 38 Arrangement |
| Registered provider: | Brothers of Charity Services Ireland |
| Provider Nominee: | Una Nagle |
| Lead inspector: | Carol Maricle |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 2 |
| 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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 16 March 2017 09:35 To: 16 March 2017 17:00

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

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| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 17: Workforce |

Summary of findings from this inspection

Background to the inspection:

This was an inspection carried out to inform an application to vary registration conditions. This centre was registered as a designated centre for children with disabilities and applied to be registered as a designated centre for adults with disabilities.

The statement of purpose confirmed that the centre provided residential supports for a maximum of two people aged over 18 years. It would provide support to persons with intellectual disabilities including those with autism. The statement confirmed that persons may have multiple and or complex support needs and may require support with behaviours that challenge.

At the time of this inspection there were two residents living at the centre. These residents had lived at the centre for a number of years from when they were younger than 18 years of age.

The centre was part of a larger single-story premises, the other section was a

designated centre for adults with disabilities. The centre was one of several centres in a congregated setting in the suburbs of a city.

The centre was divided into two separate areas (apartments) and each resident lived alone in their apartment. They each had their own secure garden, although for one resident their garden was not yet fully completed with a grass lawn.

How we gathered our evidence:

As part of this inspection, the inspector met with the person in charge, the team leader and two staff members directly supporting the residents. The inspector interacted with both residents. The inspector also met with the sector manager and the person nominated by the provider (director of service) at the feedback meeting. The inspector observed practices and read documentation such as a sample of care files, personnel files and records of incidents and accidents.

Overall findings:

In general, the inspector found that the residents received an individualised service. The service was led by a committed person in charge and a team leader who were both experienced in working for the organisation and very knowledgeable about the standards and regulations. The inspector was satisfied that there were systems in place to ensure that the residents received a quality service. However, the provider did not demonstrate how the appointment of the person in charge as a person in charge of six centres ensured the effective governance, operational management and administration of the designated centres concerned.

Good practice was identified in areas such as:

- personal planning (outcome 5).
- the healthcare needs of the residents were met (outcome 11).

Improvements were required in areas such as:

- not all arrangements regarding finance were in writing (outcome 4)
- a garden had not been completed and this was outstanding from the previous inspection (outcome 6)
- some improvements were required in fire safety (outcome 7)
- governance and management arrangements; the performance management arrangements of external agency staff were not clear (outcome 14)
- the requirements of Schedule 2 in relation to external agency staff were not fully in place (outcome 17).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end.

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

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

Not all components of this outcome were reviewed as the inspector focused on the action arising from the previous inspection. At the previous inspection, the criteria for admission of residents was not transparent.

At this inspection, the inspector reviewed the criteria of admission as set out in the statement of purpose and found that the criteria was transparent.

The inspector viewed the contracts in place for each resident. These were signed by all parties. However, there was a financial arrangement in place between a parent and the provider that was not sufficiently set out in writing.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The wellbeing and welfare of the residents was maintained by a good standard of care and support and the residents had opportunities to take part in appropriate activities.

Each resident had an assessment of need completed. The keyworker completed an assessment of need document. This was then complemented by a health check completed by a staff member within the organisation and finally the results of the individual's annual medical check up was also considered part of the overall assessment of need. These three documents formed the basis of the annual assessment of need. The assessment of need was also evidenced by multidisciplinary assessments and the subsequent reports arising from these assessments such as speech and language reports and behavioural therapist reports. There was relevant cross reference between all the documentation, for example, one of the residents had been seen by their speech and language therapist in 2016 and the recommendations of this assessment were incorporated into the resident's assessment of need and personal planning system. There were some sections of a health check that were not fully completed and this was brought to the attention of the person in charge who committed to reviewing this documentation issue.

One of the residents was participating in a school leavers assessment at their educational setting and staff at this centre were involved in this assessment. The person in charge told the inspector that the results of this assessment would form the basis of the individualised day service programme that the resident would go on to participate in.

The inspector examined the personal planning systems in place at the centre. The inspector found that the personal plans were implemented and subject to multidisciplinary and regular review. Staff interviewed were very familiar with the needs of both residents, their strengths and abilities. Family members confirmed in writing that they were involved with the development of plans and that they participated in reviews.

The personal plan for each resident was an individualised plan that reflected their preferences and choices and included all aspects of their lives such as health, dietary requirements, personal care, communication and activities. Individual personal outcomes were described as goals and staff then planned activities to help residents achieve these goals. The inspector discussed with the team leader a goal whose commencement appeared to have been delayed without due explanation. The team leader discussed the circumstances regarding this goal which the inspector found to be appropriate.

There was evidence that the residents were supported in their key transitions. As both residents would continue to live at this centre from childhood through to adulthood the most significant transition for them was regarding their education. Both residents had turned 18 years of age in the previous 12 months and as such, had already, or were about to transition to adult day services following their secondary school education. The staff, in their discussions with the inspector, showed empathy and understanding regarding the significance of these transitions for each resident and spoke of how the

residents had already experienced and may experience this significant transition in their life. Reference to the transition for each of the residents was found in their files as part of their personal planning arrangements.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Not all components of this outcome were reviewed as the inspector focused upon actions arising from the previous inspection.

At this inspection, some of the actions arising from the previous inspection had been put in place however one of the actions regarding a garden was still outstanding and the completion of this action was significantly past the timeline set out in the action plan of the previous inspection. Some of the preparatory work regarding this action had been completed. The terrain of the area had been levelled and fencing installed. Some preparatory work for an artificial lawn had been completed. Recreational equipment had been ordered. The laying down of an artificial surface however had not been finalised and was only at a costing stage. There was no formal completion date in place although the person in charge stated that he was confident of the project completing prior to the summer of 2017.

At the previous inspection each resident had access to their own bathroom; one bathroom had a shower and the other bathroom had a bath. This meant that the residents did not have a choice in how their personal care was delivered. Since then, a connecting door had been erected in the bathrooms meaning that a resident could now walk into the other bathroom with the support of staff to use the facilities of the other bathroom. The person in charge told the inspector that the residents, to date, had not chosen to use the new facilities available to them but that the choice was now open to them.

The inspector viewed the premises during this inspection. One of the rooms used by one of residents was described as a soft room. This room had a padded door and walls (floor

to ceiling). There was little natural light in this room and the appearance of the room was not in keeping with the homely atmosphere that was in place at the centre. There were no other items in this room. The inspector queried with the team leader and person in charge the necessity of this room to have padded walls from floor to ceiling. The person in charge confirmed that they were seeking to reduce, over time, the amount of padding in the room. The inspector saw documentation throughout the file of the resident that showed how this room had previously been used and for seclusion purposes. There was documentary evidence to show that this practice was no longer in place and this was confirmed by staff during the inspection. Staff told the inspector that the resident chose to enter and leave this room of their own free will and appeared to enjoy the sensory feel of the padding. During the inspection, the person in charge confirmed in writing to a number of persons within the organisation, the intent of the staff team to reduce, over time, the amount of padding in this room.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

Overall, the health and safety of residents, staff and visitors was promoted and protected. There was an issue with a fire door during the inspection which was partially resolved during the day of inspection.

There was an organisational risk management policy in place and this referred to the specific hazards, as set out in the regulations. There was a centre-specific health and safety statement in place.

There was a centre-specific risk register in place and this set out hazards within the centre and the measures in place to control these hazards. However, there was no scoring of the overall risk. The inspector could not see which hazards were presenting at high, medium or low risk. The person in charge told the inspector that training in risk assessment was to be rolled out in the organisation in 2017 following which scoring would then be completed. The person in charge identified to the inspector the hazards at the centre that were high, medium and low. However, this information was not readily available to staff who would view this document.

Each of the residents had a set of individualised risk assessments. The risk assessments in place for the residents focused on activities they enjoyed and which were appropriate.

Arrangements were in place for the recording of incidents, accidents and behaviours that challenge. The inspector viewed the records of incidents and accidents which were signed off by the person in charge. There was evidence of analysis of incidents and accidents by the team leader and the person in charge. These records were then entered onto a computerised system in order that reports could be printed. Where necessary, details of incidents and accidents were forwarded to behavioural therapist for their review. The inspector saw that learning from incidents and accidents was discussed at staff team meetings. The annual review of the service for 2016 also commented on accidents and incidents that took place within the previous 12 month period. Overall, the person in charge and team leader told the inspector that the level of behaviours of concerns had reduced significantly from when the residents first came to live at the centre and both residents were enjoying a better quality of life than before.

Suitable procedures were in place for the prevention and control of infection and staff had received training in hand hygiene which formed part of a wider training in infection control. The majority of the core team had completed this training or were booked to attend in 2017. There were sufficient facilities and materials available for hand washing.

Fire safety management systems were in place, however, some improvements were required. The fire alarm system and emergency lighting were serviced on a quarterly basis in 2016. Suitable fire equipment was available and had been routinely serviced. Fire exits were unobstructed. A fire evacuation notice was displayed in a prominent place. Records of daily checks on the fire equipment, fire precautions and on the means of escape were completed by staff. With the exception of one staff member, all staff member had received training in fire fighting. One staff member was due to complete this training in 2017. All staff had received training in 2015 and 2016 on fire evacuation.

Planned fire drills were carried out regularly and personal emergency evacuation plans were in place for the residents. The behaviour of the residents during fire drills was not always cross referenced in their personal emergency egress plan. This meant that important information about residents' behaviour during a drill was not always set out and planned for in their plan. Furthermore, staff told the inspector that they may need to use a wheelchair in the event of a resident refusing to leave the centre. The wheelchairs were stored in an outdoor shed that would require a staff member to open, retrieve and then carry or push the wheelchair into the centre. The fire drills had not fully incorporated the use of these wheelchairs and their retrieval from the outdoor shed in the event of an emergency.

On the day of the inspection one of the fire exits was locked. The keys to this door were in the lock but a staff member could not open fully the fire exit (a set of double doors). Prior to the conclusion of the inspection the team leader placed instructions on the doors on how to open them. Both the team leader and the person in charge informed the inspector that a thumb lock system would be installed for ease of egress. The inspector observed that one of the fire doors was not fully operational. This was resolved during the inspection; however, an excessive under-door threshold gap remained. The person in charge was observed attending to this issue immediately and provided written assurances to HIQA immediately following the inspection that the issue was being attended to in an appropriate time frame.

The centre had a vehicle for transporting the residents and if required, residents could access a second vehicle. There was evidence of appropriate tax and insurance in place. There was an fire extinguisher in one of the vehicles but the service details of this could not be read. One of the vehicles had the necessary breakdown equipment but the other did not.

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 measures in place to safeguard residents and protect them from abuse. However, the majority of the staff team had not yet completed the relevant training in adult safeguarding.

There was a policy on adult safeguarding in place. There were various safeguards in place to protect the residents, however, not all staff had yet completed training in adult safeguarding. This was significant given that the residents had turned 18 years of age in the previous 12 months. Staff were booked to attend this training in March and May of 2017. Staff members interviewed by the inspector were clear about how to report any concerns they may have. There had been no child protection or adult protection concerns since the previous inspection. The person in charge and team leader were aware of their responsibilities in relation to safeguarding concerns and the person in charge outlined the steps he would take in the event of an allegation of abuse or neglect by a staff member.

Efforts were made to identify, understand and alleviate the underlying causes of behaviour that was challenging for each resident. Behavioural support plans were compiled by the relevant professionals and then discussed at staff team meetings as part of the reviewing process. The plans were then reviewed on a more formal basis by the behavioural therapist. All staff had completed training in a recognised brand of training in 2015, 2016 and 2017. The majority of the staff team were due to complete

separate training on positive behavioural support in 2017, whereas the remaining staff had already completed this training.

Some restrictive practices were used at the centre and were governed by an organisation policy and a multidisciplinary behaviour standards committee. Restrictive practices were also discussed at staff team meetings. Minutes of meetings were viewed by the inspector. Restrictive practices included a key pad on the front door, a harness used during transport, a bodysuit and an 'as required' (PRN) medicine for anxiety type behaviours and or behaviours of concern. The use of a seclusion room for one resident had been discontinued and this was confirmed in writing.

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:

Residents had access to healthcare services and their healthcare needs, as set out in their personal plans, were assessed and met.

The residents' files contained comprehensive assessments of their healthcare needs (as set out in their assessment of need) and the actions to meet those needs were set out in the personal plans. There were records of general practitioner (GP) visits, specialist appointments, referrals to various professionals and records covering allergies, medical card numbers, management plans for physical or mental health concerns, consultant and dental information. An out-of-hours GP service was available if required.

There had been a hospital admission to accident and emergency the day prior to this inspection. The resident had returned to the centre and was recovering well from the treatment administered in hospital. Staff were observed caring for him in an empathetic way and of being mindful of the resident's need for rest and observation. During the inspection, staff told the inspector that some issues had arisen during the resident's visit to the accident and emergency services. These concerned the resident's interaction with the service, which would now require further study, and the learning used for future planning. This was confirmed by the person in charge.

There were appropriate arrangements in place regarding residents' diet and nutrition. Meals were freshly prepared and cooked in one of the apartments by staff. Staff

monitored the consumption of food by the residents and one of the residents had achieved a significant weight loss in the previous 12 months which had resulted in better overall health. This was confirmed in records viewed by the inspector. However, the same resident was awaiting a dietician appointment for just over six months. The person in charge told the inspector that he had now received clarity on service level agreements between a health service and the provider but due to the inability of the resident to attend a traditional type clinic appointment the resident could not utilise this service. The person in charge informed the inspector that staff would seek a private appointment which would be arranged in such a way to suit the assessed needs of the resident.

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):

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

Findings:

Overall, residents were protected by safe medicines management policies and practices. An improvement was required in the area of administering medicines in a covert manner.

There was a comprehensive policy and procedure in place on medicines management, however, this was dated 2012. While the policy was generic to the entire service it guided staff practice in the centre. At the feedback meeting, the person representing the provider informed the inspector that the medicines management policy had been reviewed in 2016 and was due to be rolled out across the organisation.

The inspector found that staff followed appropriate medication management practices. Medicines were stored in a locked area in the staff office and were clearly labelled for each resident. All medicines were individually prescribed and overall prescription and administration charts were completed in line with relevant professional guidelines and legislation. The maximum dosage of 'as required' (PRN) medicines were recorded.

There was a procedure in place for the disposal of medications that were out of date or no longer used. No such medicines were found at the centre.

None of the residents had been assessed for their ability to self-administer medicine. Given that both residents were now adults, the team leader told the inspector that this assessment would be completed in 2017.

Medicines were administered by staff who had undertaken a course in the safe administration of medication and the inspector saw evidence of this training in the staff training matrix. Staff also completed separate training in management and support of residents with epilepsy.

The inspector reviewed the medicines management folders for each resident and there was adequate information on each type of medicine prescribed. This meant that staff could see clearly the purpose of each medicine and its side effects. Medicine was administered in blister pack format and the team leader told the inspector that this arrangement ensured greater safety in the administering of medicines.

There were no residents prescribed controlled medicines and no medicines requiring refrigeration at the time of this inspection.

A medicine was given in a covert manner to a resident which was prescribed by the GP. While there was a clear procedure set out in the organisational policy on the administration of covert medicines, this was not being followed stringently by staff at the centre.

The prescription record chart did not accurately state the address of the residents. However, this was corrected by the team leader during the inspection.

Medicine was prescribed for use as a chemical restraint for one resident who engaged in behaviours of concern. This was prescribed PRN. The inspector reviewed a protocol for the administration of this PRN. This had been developed by the medical professionals as part of the therapeutic response to challenging behaviour and was linked to a positive behaviour management programme.

There were processes in place to monitor medicines management practices. The six monthly unannounced inspections reviewed medicines management. There were in-house audits completed by nursing staff employed by the provider. The most recent audit was in January 2017 and the inspector could see how the actions had been closed off by the team leader. A process was in place for the recording and review of medicine errors which were managed in line with incidents and accidents.

Judgment:

Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

There was a statement of purpose which was available to residents and their families and this mostly contained the information required by the regulations.

The statement of purpose, dated February 2017, described the aims and objectives of the centre and the facilities and services which were to be provided for the residents.

The whole-time equivalent of the person in charge role was not set out clearly in the statement of purpose. This was significant given his responsibilities to other designated centres.

The conditions of the registration were not set out in the statement of purpose but the person representing the provider told the inspector that these would be in place following the changeover of the centre from a designated centre for children with disabilities to a designated centre for adults with disabilities.

Judgment:

Substantially 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:

There was a defined management structure in place. There was a programme of six monthly unannounced inspections and an annual review of the service had been conducted for 2016. An action from the previous inspection was not yet fully in place at the centre and this related to the timelines for the roll out of performance management arrangements.

The management structure identified the lines of authority and accountability in the

centre and these arrangements were set out in the statement of purpose. Staff reported to a social care leader (team leader) who in turn reported to the person in charge. Staff rostered to do awake nights reported to a night supervisor. The staff, with whom this inspector met with, were clear about the relevant reporting mechanisms and told the inspector that the team leader and the person in charge were available to them as required. On-call arrangements were in place so that staff could contact a manager within the organisation for advice or support at any time of the day.

There were arrangements in place for the performance management of staff, and formal supervision and appraisal of all staff was being rolled out in 2017. The team leader had already had their first formal supervision with the person in charge. The roll out of these arrangements was not however in line with the timeline set out in the previous action plan response. Notwithstanding this, the team leader had attended specific training in supervision in 2016 and had already devised a supervision schedule for all staff in 2017. This was displayed in the staff office for all staff to see. The person in charge told the inspector that in 2017 that there would be one appraisal and two supervision sessions conducted with staff annually.

The arrangements for the performance management of awake night staff were not as clear. This shift was covered by agency staff at the time of this inspection. These staff were supervised by night-time supervisors based within the campus who visited them in person during their shift. These staff were not included in the supervision schedule. It was not clear who would provide formal supervision to them and how this would be conducted. These staff were not included in the training matrix.

There were arrangements in place regarding staff team meetings. The inspector viewed the records of team meetings and found that the meetings discussed a range of issues relevant to the practice of staff. There were some gaps in the regularity of team meetings held in 2016 that the team leader told the inspector she would be addressing and rectifying this in 2017.

There was evidence that audits took place to monitor the quality and safety of the service in the centre; for example; medicines management, health and safety and finances. Restrictive practices were monitored by the behavioural standards committee. The person in charge signed off on HIQA notifications.

There were systems in place within the organisation for six monthly unannounced visits to the centre by sector managers. The inspector viewed a completed report and the action plan generated. The status of all actions was not always clear as some did not have any comments whereas other actions had. However, the team leader and the person in charge gave the up-to-date situation on actions arising from the unannounced visit.

The annual review of the safety and quality of the service was made available to the inspector. The inspector saw reference in the annual review to feedback received from families and there was also reference to residents' feedback. One of the residents had engaged in anxiety type behaviours in the summer of 2016 and information received by HIQA set out that one of the factors contributing to this behaviour was staffing arrangements at night-time. At the time of this inspection, the person in charge told the

inspector that this situation had stabilised but that this particular shift could be problematic from a rostering point of view at certain times of the year. The person in charge and team leader were cognisant of the difficulties this had posed in 2016 but this issue was not sufficiently referred to in the six month unannounced inspection nor the annual review.

The person in charge was suitably qualified and experienced to fulfil the role of person in charge. His post was full-time and he was supernumerary to the roster. He knew the residents well. He demonstrated to the inspector how he was involved in the day to day management of this centre. The team leader reported directly to him and he visited the centre frequently in both an announced and unannounced capacity. Staff told the inspector that they were well supported by the person in charge and the team leader.

However, the provider did not demonstrate how the appointment of the person in charge as a person in charge of six centres ensured the effective governance, operational management and administration of the designated centres concerned. At the feedback meeting the person nominated by the provider told the inspector that the person in charge arrangements was under constant review due to the number of centres that the person in charge was responsible for. This inspector noted that there was no significant negative impact on the residents identified at this inspection as a direct result of this arrangement however notwithstanding this, key documentation such as the statement of purpose did not set out clearly to the reader the responsibilities of the person in charge to this and other centres.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Formal arrangements were in place that identified a specific deputising arrangement for any notifiable absence of the person in charge.

For periods of time less than 28 days, the team leader would be in charge of the centre. For periods of 28 days or more, the sector manager would manage the centre.

There had not been any times in the previous 12 months when the person in charge had

been absent from the designated centre for 28 days or more. The person nominated by the provider was aware of the requirement to notify HIQA in such an event.

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):

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

Findings:

At the time of inspection, the numbers and skill mix of staff were appropriate to the assessed needs of the residents. However, the personnel files of the external agency staff did not meet the requirements of Schedule 2 of the regulations. The arrangements for external agency staff to receive on-going training in line with the core team were not clear.

There were arrangements in place regarding staffing. This comprised a core team, complemented by an internal relief panel and external agency staff. There were eight whole time equivalent staff members. When the residents were in the centre, four staff were on duty with two staff assigned to each resident. At night, there was one waking and one sleeping staff. The roster was planned one month in advance. The staff ratio arrangements, as set out in the statement of purpose, were reflected in the roster.

There was an organisational training programme in place and the team leader could book staff on relevant trainings as they arose within the training calendar. Records showed that staff received training in a range of areas including fire evacuation, fire safety, manual handling, medicines management, epilepsy and infection control. The on-going training arrangements for the awake night staff were not clear, although there was evidence that they had completed training prior to their commencement at the centre. There was an induction process in place for new staff.

The inspector viewed the staff files of four staff members; this included members of the core team, internal relief and agency staff. The files of staff employed by the provider were well-maintained and the documents required by Schedule 2 were easily accessible. However, the personnel files of external agency staff were not in line with the

regulations. These files did not contain the required information as per the regulations, for example vetting information was not sufficient.

There were no volunteers involved 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:

Carol Maricle
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 report¹

| | |
|----------------------------|---|
| Centre name: | A designated centre for people with disabilities operated by Brothers of Charity Services Ireland |
| Centre ID: | OSV-0005135 |
| Date of Inspection: | 16 March 2017 |
| Date of response: | 24 April 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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

A financial arrangement between a parent and the provider was not sufficiently set out in writing.

1. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the

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

provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

1. We will review the base expenditure level for residents to ensure that all residents have a good quality of life regardless of who manages their finances
2. We will ensure that our local finance agreement/ annual Personal Budget 'My Money Plan' is complete for all residents. 'My Money Plan' is part of our Local Procedure for the Management of service Users Monies.
3. Following this process, we will ask the family representative to sign off the My Money Plan as the formal agreement on the finances for the year.

Proposed Timescale: 26/05/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

A garden area was still not fully available for a resident to enjoy. A room described as a 'soft room' had a significant amount of padding that restricted natural light.

2. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

The Garden area is scheduled for completion [27/05/2017].

Soft Room: meeting scheduled with Adult Multi-Disciplinary Team to discuss the environmental changes of this room and the necessary changes will be complete as soon as possible.

Proposed Timescale: 07/06/2017

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:

The risk assessment of hazards identified at the centre did not include the scoring of the risk they posed to staff, residents and visitors.

3. 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:

Person in Charge will ensure that all the overall risks are scored for each risk/hazard in the Risk Register to ensure that all staff are aware of the high medium and low risks in the Centre and can prioritise the risk management processes accordingly.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

One of the vehicles did not have any breakdown equipment. It was not possible to read the service date on a fire extinguisher found in one of the vehicles.

4. Action Required:

Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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

The service date of the fire extinguisher has been re-checked and is now clearly visible on the container. The breakdown equipment has been installed on the leased vehicle and the Person in Charge has alerted staff to ensure this equipment is on all vehicles in the future.

Proposed Timescale: 21/04/2017

Theme: Effective Services

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

One of the fire doors was not fully functional on the day of the inspection. A fire exit could not be easily opened on the day of the inspection.

5. Action Required:

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

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

The fire door and the fire exit opening have been repaired to comply with the regulations.

Proposed Timescale: 21/04/2017

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:

The residents had progressed to adulthood in the previous 12 months. Not all staff had completed training in safeguarding of vulnerable adults although there were booked to attend same.

6. 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:

All staff will have completed Safeguarding of Vulnerable Adults Training on various dates.

Proposed Timescale: 26/05/2017

Outcome 12. Medication Management

Theme: Health and Development

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

Staff were not administering medicines in line with the organisational procedure on covert medicines.

7. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

The Person in Charge will ensure that the covert administration of medication is done in accordance with Organisation procedures on Person Centred Medication Management, and the consent of the resident or their representative will be received and documented in the person's Medication Management Plan.

Proposed Timescale: 24/04/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The whole time equivalent of the person in charge at this centre was not sufficiently set out.

8. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Provider will review the Statement of Purpose to provide more detail of the full role of the Person in Charge and the specific inputs of the Person in Charge into this Centre.

Proposed Timescale: 31/05/2017

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:

The provider did not satisfy the chief inspector that the person in charge arrangements ensured the effective governance, operational management and administration of the designated centres concerned. There was insufficient reference to the role of the person in charge and his responsibilities to other centres in written reports of the service, for example the statement of purpose, the six monthly inspections and the annual review.

9. Action Required:

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

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

The Provider is reviewing the scope of the current role and inputs of the Person in Charge into the Centre to determine if an alternative management structure may be necessary.

As part of this review the Provider will ensure that detailed references to the role of the Person and Charge in this and other Centres will be set out to demonstrate effective governance, operational management and administration of the designated centres concerned.

The Provider will ensure that the role of the Person in Charge is clearly referenced in

written reports in relation to the Centre.

Proposed Timescale: 31/05/2017

Theme: Leadership, Governance and Management

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

Supervision and performance appraisals had not yet commenced for all staff at the centre. The performance management arrangements for external agency staff were not clearly set out.

10. Action Required:

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

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

The Provider will ensure that there is clear system in place for the performance management including appraisal of external agency staff. [30/06/2017]

The team leader has scheduled supervision and performance appraisals for all staff, the first being completed 05/04/2017.

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:

The information contained within the personnel files of external agency staff did not meet the requirements of the regulations.

11. 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 Person in Charge has introduced a system to ensure that all Agency staff working in this designated area now meet with the requirements of the regulations as specified in Schedule 2.

Proposed Timescale: 03/04/2017

Theme: Responsive Workforce

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

The arrangements for external agency staff to participate in on-going training offered by the provider were not clear.

12. 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:

As part of the Services agreement with the Agency, Agency staff will have undertaken appropriate training before commencing work in the Centre. The Person in Charge will ensure that there are local procedures in place to check the Agency staff training records.

Proposed Timescale: 08/05/2017