

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	No.3 Stonecrop
Centre ID:	OSV-0002265
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Southern Services
Lead inspector:	Caitriona Twomey
Support inspector(s):	Margaret O'Regan
Type of inspection	Announced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 November 2017 09:35	28 November 2017 18:35
29 November 2017 09:25	29 November 2017 16:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
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 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the second inspection of this centre carried out by the Health Information and Quality Authority (HIQA). This announced, two day inspection took place to inform a registration decision. The centre was inspected against all 18 Outcomes.

Description of the service:

The centre was a semi-detached, two storey house located in a suburb of Cork city. Five residents lived in the centre. The centre provided a service for adults with an intellectual disability, including those with autism.

How we gather our evidence:

As part of the inspection, inspectors met with the five residents living in the centre, the person in charge, the social care leader, and two other members of the staff team. Inspectors reviewed documentation including personal plans, healthcare plans, training records, fire safety information, meeting minutes, risk assessments, reports completed by the provider following an unannounced visit to the centre, and questionnaires completed by the people living in the centre and their relatives.

Overall judgment of our findings:

The residents reported that they were happy living in the centre. All five residents were happy to meet with inspectors and appeared comfortable with staff and in their surroundings. Residents were very active members of their local community and engaged in a broad range of meaningful activities while in the centre and in the community. All five residents living in the centre had very strong relationships with family members. Staff told inspectors that they enjoyed working in the centre and felt supported by colleagues and the management team.

Major non-compliances were identified in Outcome 5: Social Care Needs, Outcome 12: Medication Management, and Outcome 14: Governance and Management. During the inspection it was identified that two staff, who at times worked alone in the centre, did not have training in the administration of an emergency medication required by one of the residents. The ongoing absence of multidisciplinary assessments of residents' needs and multidisciplinary input into the review of personal plans was also identified. Given the overall findings in the inspection, it was identified that the overall governance and oversight in the centre required improvement.

Outcomes found to be at the level of moderate non-compliance related to:

- lack of implementation of communication approaches as outlined in a resident's personal plan (Outcome 2)
- lack of clarity regarding the fees to be charged to residents (Outcome 4)
- fire safety precautions in the centre (Outcome 7)
- staff awareness of what constitutes abuse and a restrictive practice (Outcome 8)
- the notification of incidents, specified in the regulations, to HIQA (Outcome 9).

The reasons for these findings are explained under each outcome in the report.

A representative of the provider, the person in charge, the social care leader working in the centre, the sector manager (who also acted as a person participating in the management of the centre) and the organisation's quality coordinator attended a feedback meeting in the provider's head office at the close of the second day of the inspection.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

There was evidence to support that residents were active participants in the running of the centre and of the support they received there. A complaints process and a nominated person to deal with complaints were in place.

Residents were consulted with, and participated in, decisions about the supports they received and about the organisation of the centre. The social care leader reported that house meetings took place in the centre. An agenda was in place for each meeting. Residents were provided with opportunities to contribute to the topics discussed. Minutes of these meetings were reviewed by inspectors. Six meetings, covering a variety of topics, occurred in the previous 12 months.

The centre was managed in a way that maximised residents' capacity to exercise personal choice and to maximise each resident's independence. There were many observed instances of residents being supported to make day-to-day choices. Due to the preferences of the people living in the centre and their families, most often there were two or three people in the centre during any given weekend. Weekend activities were planned on Fridays with the participation of the residents involved. Residents spoke with inspectors about these plans. Information relating to residents' rights was displayed in the centre. One of the residents living in the house made reference to this poster when speaking with the inspector. All members of staff team were observed to be respectful in their interactions with the residents. Practices observed also indicated that each resident's privacy and dignity was respected.

Many of the residents chose to show inspectors their bedrooms. Bedrooms were

personalised and decorated to each resident's taste. Two of the residents chose to have televisions in their bedrooms. Residents and staff advised that storage in each of the bedrooms was adequate. Each resident living in the centre had designated household duties of their choosing. In addition, each resident had an allocated day to manage their laundry.

There were policies and procedures in place for the management of complaints. The complaints process was displayed in the kitchen and was also available in each bedroom. Inspectors reviewed the complaints log in the centre. The most recent complaint was recorded in December 2015. This was consistent with the 'satisfaction with the service' surveys maintained in the centre and residents' conversations with inspectors. Complaints were discussed at various staff meetings and there was also evidence that they had also been discussed and encouraged at a house meeting earlier in the year. Questionnaires completed by relatives of the residents also indicated that family members were aware of the complaints processes in the centre.

Judgment:

Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Staff were aware of the different communication needs of residents. However, for one of the five residents, staff did not implement the communication approaches outlined in her individual plan. Staff had not received training in these approaches.

The staff working in the centre appeared to know each of the residents and their communication requirements very well. Residents and staff were observed interacting with each other in a positive and relaxed manner.

One of the residents presented with higher communication support needs than her peers. There was evidence of repeated referrals to the organisation's speech and language therapy service in the resident's individual file. On the day of inspection, this support was still outstanding. The social care leader informed inspectors that while there had been some contact with a speech and language therapist, no communication assessment had been completed. A communication passport had been developed for this resident by her keyworker. Another document in the resident's file outlined the need for those providing support to be familiar with alternative and augmentative

communication methods including Lámh (a manual sign system used by children and adults with intellectual disability and communication needs in Ireland), a picture exchange communication system, and visual schedules to meet her needs in this area. There was no observed use of these approaches while inspectors were in the centre. The social care leader reported that the staff had not received training in these or other communication methods. The person in charge advised that these training requirements had been logged on the organisation's training needs analysis.

All residents had access to wireless internet, radio and television while in the centre.

Judgment:

Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

There was strong evidence to indicate that all of the residents were supported to maintain positive relationships with their families and links with their local community.

All of the residents regularly visited and spent time with relatives. Contact was also maintained through regular telephone calls and, for some, through use of social media. The social care leader reported that there were no restrictions in place regarding visitors and spoke about a friend of one resident visiting her in the centre over the summer. All relatives were invited to participate in the annual review of each resident's personal plan. This was referenced in many of relatives' questionnaires submitted to HIQA. The questionnaires also contained repeated complimentary references to staff, with many emphasising the positive relationships that existed between the residents, their relatives and the staff team.

All five residents attended a day service program from Monday to Friday. In addition, many of the residents participated in other group activities, including the Special Olympics, discos, short breaks away, and holidays. There was evidence to suggest that all residents were present and participating in their local community. All were known in the local area and regularly accessed local amenities such as the doctor, dentist, shops, the hairdresser, takeaway restaurants, pubs and the cinema.

Judgment:

Compliant

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:

Each resident had an agreed written contract, however further clarification was required regarding the nature of the fees to be charged.

Information in the relatives' questionnaires referred to families and prospective residents visiting the centre prior to moving in. The person in charge informed inspectors that all admissions were completed in line with the organisation's admissions, discharge and transfer policy and procedures.

A sample of residents' contracts were reviewed by inspectors. All had been reviewed in 2016 and included relatives' signatures. There was reference in the contracts to a voluntary contribution. During discussion with the social care leader, it was identified that this contribution was no longer voluntary. The representative of the provider informed inspectors that more information regarding this change was to be circulated by the end of December 2017. Inspectors also identified some inconsistencies between costs charged to residents as outlined in their contract and their individual financial plans. The person in charge advised that he planned to review the contracts and financial plans for all five residents.

Judgment:

Non Compliant - Moderate

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:

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

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

Findings:

There was evidence of residents' and family members' participation in an annual review of personal plans. However, lack of access to multidisciplinary professionals had been identified as a risk in the centre and this was evident when inspectors reviewed a sample of personal plans.

Residents were consulted in the development and review of their personal plans. There was evidence of an annual review and additional, more frequent reviews, where required. There was evidence that each resident had personal goals they were supported to achieve while living in the centre. Many documents included residents' signatures and at times those of their relatives. The annual review process involved input from day services' staff. However, there was no evidence to indicate input from multidisciplinary professionals in these reviews, as is required by the regulations. The provider representative described a pilot project that was underway in the organisation regarding multidisciplinary input into the review of personal plans. It was not yet clear when, or if, this would be adopted across the organisation.

The continued absence of multidisciplinary assessment was also identified during the inspection. As described in Outcome 2, one resident with significant communication needs had not been assessed in this area. From review of personal plans, inspectors saw a referral made for behaviour support services for one resident in March 2017. In response to the referral, members of the staff team attended two consultation meetings in July and August 2017 and were advised to follow a plan developed in January 2014 until an assessment of the current behaviour challenges could be completed. On the day of inspection this assessment had not been completed. The January 2014 behaviour support report included a number of recommendations. While some had been completed, others including staff training in communication, referrals to speech and language therapy, occupational therapy, and the organisation's Marte Meo programme remained outstanding almost four years later.

As outlined in Outcome 3, each resident was involved in a variety of community based activities. Residents also had opportunities to participate in meaningful activities, appropriate to their interests and preferences while in the centre. There was also a noted emphasis on supporting the residents to develop their independence skills.

Judgment:

Non Compliant - Major

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets

residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The centre was warm, comfortable and homely throughout. The layout and location of the house promoted accessibility and residents' independence. The centre was clean, decorated in a homely manner and well maintained. There was a communal living room in the house. Inspectors also observed use of the kitchen for table top activities and listening to the radio. Some residents spoke about liking to spend time alone in their bedrooms. They used this time to relax, engage in preferred activities, and speak with family members on the phone. There was an outside area to the rear of the house that the residents could access. The social care leader reported that this was more likely to be used in the summer months. The residents had access to a vehicle assigned to the centre.

Each resident had their own bedroom, decorated to their own tastes. Storage was provided in each bedroom for personal belongings. The kitchen had suitable equipment and facilities to meet the residents' needs. At the request of two of the residents, a second shower was installed in the house in 2017. Residents expressed their satisfaction with this when speaking with inspectors.

The size of the house was highlighted in one of the questionnaires completed by a relative of one resident. This person described the house as too small to accommodate the five residents living in the centre and staff. The person in charge and social care leader were both aware of this concern. They expressed the opinion that, given the amount of time the residents spent engaged in community based activities and with family members, the size of the house did not negatively impact on any of the residents. The person in charge advised that he was keeping this situation under review as a change in circumstances for any of the residents or their families could affect this. Over the two days of the inspection, residents reported that they liked the house and were observed to be relaxed and engaged in preferred and meaningful activities in different parts of the centre.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The health and safety of residents, visitors and staff were promoted in the centre. However, some gaps were identified in documentation. The results of fire drills also required improvement.

The centre had policies and procedures in place for risk management. Inspectors reviewed the risk register in the centre. There was evidence of the use of risk assessment to further develop the independence of the residents. On the day of the inspection the centre had two open risks. One of these, lack of access to multidisciplinary professionals, had been escalated to the director of services. This was discussed in Outcome 5. Inspectors reviewed the records of any incidents in the centre. The frequency of incidents had markedly increased in July, August and September 2017. This was consistent with the other identified, open risk in the centre. The social care leader outlined procedures that had been put in place following a referral made in March 2017 and subsequent consultations with the behaviour support service in July and August 2017. The reduced frequency of incidents in October and November 2017 indicated that this approach had proved effective. In addition to the risks in the centre, there was also an individual risk profile for each resident in the centre. These profiles were not dated so it was not possible to tell when they were last reviewed. Of the sample reviewed by inspectors, one required an update based on other information reviewed during the inspection.

Due to the installation of a second shower in the centre, the laundry facilities were located in the kitchen. There was a risk assessment and suitable controls in place regarding the potential for cross contamination in the kitchen area. Staff had attended training in the prevention and control of infection.

A fire risk assessment had been completed in the centre by the organisation's health and safety officer. This was most recently reviewed in March 2017. The procedure to follow in the event of a fire was readily available in the centre. Suitable fire equipment was provided; records reviewed indicated that this was inspected annually. The centre had a fire detection and alarm system in place which included emergency lighting. This was inspected at quarterly intervals. According to records reviewed, all eight staff members had participated in a drill or fire evacuation training in 2017.

Each resident had a personal emergency evacuation procedure. These indicated that four out of the five residents required staff assistance to evacuate the centre. Not all of these residents' bedrooms were on the same floor in the centre. Staff and residents participated in fire drills. Six had been completed in the previous 12 months, two in night time conditions. The results of these drills required review, especially those that occurred in night time conditions when one staff member was on duty. There were records of weekly visual checklists completed in the centre. Fire exits were part of the

weekly visual checklist, however each exit was not listed separately. No issues were documented in 2017. On the day of inspection one fire exit was obstructed by two wheelie bins. This was brought to the attention of the social care leader who advised that she would move them immediately.

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):

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

Findings:

While the appropriate policies, procedures and staff training were in place, staff awareness of what constitutes abuse and a restrictive practice required improvement.

Records indicated that staff had received training in relation to the safeguarding of vulnerable adults. There was a designated officer in place, based in the organisation's local head office. Although all staff had attended training in safeguarding and were aware of the procedures to follow, inspectors found that staff were not clear on what constituted abuse. Inspectors reviewed the record of incidents in the centre and identified four incidents between peers that may constitute abuse, with a pattern emerging in three of the incidents. Some of these incidents had been discussed with the designated officer. The person in charge advised that following discussion, it was decided that these incidents did not meet the threshold for abuse. Therefore, no follow up investigations were completed. There did appear to be learning from these incidents with additional supervision provided and multidisciplinary supports requested as a result.

A relative of one of the residents expressed concern regarding the compatibility of all of the residents living in the centre. The person in charge advised that this situation was under review, had been discussed at a higher level within the organisation, and would be incorporated into future multidisciplinary reviews. A review of this placement was also included as an area for improvement in the April 2017 report following an unannounced visit. Monitoring of the frequency of incidents formed part of this review. When speaking with inspectors, residents identified that there can be challenges with their housemates but clearly communicated they liked where they lived and who they

lived with. The staff team also reported that the residents all appeared to enjoy living together.

The social care leader advised inspectors that residents who had their own mobile phones had received guidance from staff about staying safe online. Two of the residents had also attended raising understanding and awareness (RUA) training regarding relationships. Residents who spoke with inspectors reported that they felt safe in the centre. Based on the questionnaires completed by relatives, family members also shared this view.

Staff had received training on how to respond to behaviour that is challenging, including de-escalation and intervention techniques. There was a policy in place on the use of restrictive practices dated September 2017.

At the outset of the inspection, inspectors were informed that there were no restrictive practices in the centre. This was consistent with the information contained in the reports that resulted from unannounced six-monthly visits to the centre. The residents appeared to have free access to the majority of the centre and accessibility was promoted by staff. However, inspectors identified some environmental restraints including a locked cupboard in the kitchen. There was a risk assessment in place regarding the cupboard in the kitchen and this measure appeared reasonable. However, the procedures in the organisation regarding restrictive practice, including referral to the organisation's rights committee and notification to HIQA, had not been followed. Inspectors saw evidence regarding the use of PRN medication (medication only taken as the need arises) as part of a resident's healthcare management plan. This plan referenced and was implemented in tandem with the resident's behaviour support plan. The use of this medication was outlined in a PRN protocol signed by the resident's psychiatrist. A referral had been submitted to the behaviour support service in an effort to identify and alleviate the cause of the resident's challenging behaviour.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre was maintained, however, not all were reported to HIQA as required by the regulations.

As outlined under Outcome 8, inspectors identified restrictive practices and incidents of suspected abuse that were not reported to HIQA.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents' opportunities for new experiences, social participation and skills development were facilitated and supported. There was evidence to indicate that skills development was supported for each of the residents while they were attending their respective day centres, and also while they were being supported by staff working in the designated centre. One of the residents spoke with inspectors about her job and her roles and responsibilities while there. As outlined under Outcome 3, residents were engaged in a wide variety of social activities in the centre and in the wider community.

Judgment:

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):

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

Findings:

Each resident was supported to achieve and enjoy the best possible health.

Inspectors reviewed a sample of residents' files and found that each contained a recently completed OK health check and hospital passport. Both documents were completed by each resident's keyworker. Individual files also contained a list of identified medical issues. For each identified issue, there was a corresponding healthcare management plan. Information was also on file regarding relevant medical conditions. All residents were supported to access their choice of general practitioner and dentist. Residents who required specialist medical input were supported to attend scheduled appointments and more frequent appointments if there were indications that this was required.

Staff had a good awareness of the health needs of the residents living in the centre. Some residents had medical conditions that required regular monitoring and review. There was evidence to indicate that these needs were addressed. Where residents chose to be supported with their healthcare needs by relatives, there was evidence of good communication systems in place to ensure all appropriate information was shared.

There was evidence that the residents who wished to do so, were supported to buy, prepare and cook their own meals. Inspectors observed choices being offered at mealtimes and planning for future meals. The food available appeared wholesome and nutritious. There was also access to refreshments and snacks. The social care leader reported that one resident received support from a dietician and these recommendations were incorporated into mealtimes 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):

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

Findings:

There was evidence of appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines in the centre. However, two staff members required training in the use of an emergency medication.

The actions outlined in the previous HIQA report were completed. All staff had received training in the administration of medication. Separate training had been completed regarding the administration of emergency medication. Two staff required this training on the day of inspection. This was of significant concern as both staff were occasionally the only staff member on duty in the centre.

Two residents administered their own medication. Both of these women chose to show inspectors the secure areas where this medication was stored. Self-medication agreement forms were in place for both of these residents. The forms were signed by the person, their keyworker in the centre, a family member and general practitioner. Self medication assessments and risk management plans had also been completed.

Judgment:

Non Compliant - Major

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose accurately described the services provided in the centre. However, it did not contain all of the information required by the regulations.

Inspectors were provided with a statement of purpose for the centre that was updated on 21 November 2017. This set out a statement of the aims, objectives and ethos of the centre. The services and facilities outlined in the statement of purpose reflected the identified needs of the residents. The statement of purpose also included a list of the key policies that inform practice in the centre.

The admission criteria as outlined in the statement of purpose did not correspond with the profile of all of the current residents. The person in charge advised that this was a typing error and would be corrected. Not all of the information required, as per Regulation 3, was included in the statement of purpose. This information is further specified in the action plan at the end of this report.

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):

No actions were required from the previous inspection.

Findings:

The quality of care and experience of the residents was monitored on an ongoing basis. However, some issues were not identified and a clear, time bound plan was not in place outlining how identified issues would be addressed and the personnel responsible. Given the number of non-compliant findings identified during the inspection and their significance, inspectors were not confident that the provider could ensure the effective governance, operational management and administration of the designated centre. As outlined throughout the report, areas for improvement included communication supports for residents, staff training in communication and the administration of emergency medication, residents' contracts, multidisciplinary input into assessments and personal plan reviews, fire precautions, staff awareness and reporting of abuse and restrictive procedures, and notifications to HIQA as required by the regulations.

The person in charge worked fulltime for the organisation. He met the requirements as outlined in Regulation 14 regarding management experience and qualifications. The person in charge informed inspectors that he fulfilled this role for seven houses, comprising six designated centres. He explained to inspectors that each of the centres, including No. 3 Stonecrop, was staffed with a fulltime social care leader. The person in charge met with social care leaders approximately once a month. Inspectors reviewed records of these meetings and found that nine had taken place in the previous 12 months. A comprehensive range of topics were addressed including residents' finances, staff training and appraisals, complaints, referrals to multidisciplinary professionals, notifications to HIQA, incident reports, risk management, staff's awareness of the organisation's restrictive practice process, confidentiality, and six-monthly unannounced visits. The person in charge informed inspectors that in the previous year he had completed training in coaching and risk management.

An annual review had been completed for the centre. The person in charge advised that the annual review report for 2017 would be completed in December. During the inspection two reports were available relating to unannounced six-monthly visits of the centre in April and October 2017. Inspectors reviewed the annual and six monthly reports. The six-monthly visit reports were comprehensive and identified some of the issues identified by inspectors during the two day inspection. However, as outlined under Outcome 8, the restrictive practices in the centre were not identified during either of the six-monthly visits. Other areas identified by inspectors such as staff training and fire safety precautions were also not identified. Although areas for improvement were identified in each report, there was no clear, measurable, time bound action plan outlining who was responsible for following up on the issues identified in each area.

Progress made in addressing the issues identified was not documented in the centre.

The person in charge outlined other audits completed in the centre. These included financial audits completed by both internal and external personnel, a medication audit, a healthcare plan audit, and an environmental risk assessment completed by the organisation's health and safety officer.

The lines of accountability in the centre were clear. All staff that inspectors spoke with reported that they felt well supported in their roles by colleagues and their direct line managers. Staff meeting records were also reviewed by inspectors. 12 meetings had taken place in the previous 12 months. The social care leader attended all of these meetings, the person in charge attended one. Topics discussed included confidentiality, appointments to be arranged for the residents living in the house, upcoming outings and events such as birthdays and Christmas, care management and personal outcome plans, challenges regarding referrals to multidisciplinary professionals, complaints, maintenance issues, professional development, training and supervision, the need to be familiar with restrictive practices and notifiable events, the centre's risk register, and audits planned for the centre.

Judgment:

Non Compliant - Major

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:

There were arrangements in place for the management of the centre during any absence of the person in charge. There were no documented absences of the person in charge from the centre for 28 days or more.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

The centre was resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose. The facilities and resources in the centre supported residents to achieve their individual personal goals.

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):

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

Findings:

There were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services.

The residents living in the centre received continuity of care and support. There was a consistent staff team in the centre. The social care leader and person in charge reported that when relief staff were required, they were sourced from within the organisation and in the majority of cases were familiar to, and with, the residents. Inspectors reviewed a sample of staff personnel files. All reviewed contained the information as required by Regulation 15.

Staff had up-to-date mandatory training. However as outlined under Outcome 12, two staff required training in the administration of an emergency medication. Outstanding staff training needs relating to communication were discussed under Outcome 2. The person in charge reported that a performance management system was in place in the centre. Each staff member had completed one cycle of this process. The planned introduction of supervision sessions was also outlined to inspectors.

The person in charge informed inspectors that there were no volunteers working in the centre.

Judgment:

Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

This outcome was not inspected in full. Inspectors found that systems were in place to maintain complete and accurate records in the centre.

The majority of records reviewed were comprehensive, accurate and up-to-date. These were stored securely in the staff office in the centre. The social care leader told inspectors that the people living in the centre could access their own records if they wished. A residents' guide was available in the centre.

There were operational policies and procedures in place. Inspectors looked at a sample of policies, all had been reviewed recently.

The designated centre was adequately insured. Inspectors reviewed a document outlining the insurance in place, dated January 2017.

Judgment:

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:

Caitriona Twomey
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 Southern Services
Centre ID:	OSV-0002265
Date of Inspection:	28 & 29 November 2017
Date of response:	05 March 2018

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 02: Communication

Theme: Individualised Supports and Care

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

During inspection staff were not observed implementing the communication supports outlined in one resident's personal plan.

1. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

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

The Person In Charge will ensure that a Total Communication Environment including the use of LAMH and PECs is in place to support residents in the Centre in line with their personal plans.

Proposed Timescale: 28/02/2018

Theme: Individualised Supports and Care

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

Staff had not received training in the communication supports identified in one resident's personal plan.

2. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

Staff training in LAMH will be provided on 28 February 2018. Staff Refresher training on other augmentative communication techniques will be provided to the Team.

Proposed Timescale: 28/02/2018

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Fees to be charged, as outlined in residents' contract, were not consistent with other documentation regarding residents' finances. It was also identified that a payment described as voluntary in the contract was now mandatory.

3. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the 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. All residents' contracts will be cross referenced to letters issued to residents' representatives on 1 December 2016 outlining the changes to residential contributions effective from 1 January 2017.

2. The Provider will ensure that the residential charge is reflected in each resident's documentation in line with the HSE Charges and Contributions Information Booklet i.e. invoiced to each resident based on occupancy.

Proposed Timescale: 31/01/2018

Outcome 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment by appropriate health care professionals of each resident's identified needs had not been completed.

4. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

1. The Person in Charge will seek a consultation with the relevant Head of Discipline on all outstanding referrals to establish if they are still appropriate and to identify their priority rating [14/02/2018]
2. Following this, the Person in Charge will ensure that the outcome of these consultations will form part of the annual review of the personal plans, which will include multidisciplinary inputs. [31/03/2018]
3. All outstanding referrals following this review will be addressed as priority.

Proposed Timescale: 31/05/2018

Theme: Effective Services

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

The personal plan reviews did not involve the appropriate multidisciplinary professionals.

5. Action Required:

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

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

The residents' individual plans will be reviewed with multidisciplinary inputs to ensure the effectiveness of the plans and that these take into account changing circumstances and new developments for the individuals.

Proposed Timescale: 31/03/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The individual risk profiles completed for each resident were not dated. One individual risk profile read by inspectors required review.

6. 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 Person in Charge has ensured that all individual risk profiles have been dated and updated where necessary.

Proposed Timescale: 17/01/2018

Theme: Effective Services

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

One of the fire exits was obstructed by two wheelie bins. It was unclear if this exit was included in the weekly visual fire checklist.

7. Action Required:

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

The weekly fire checklist will be revised to list all of the fire exits to be visually checked

Proposed Timescale: 19/01/2018

Theme: Effective Services

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

The results of the fire drills completed in the centre, especially those in night time conditions when one staff member was on duty, required review.

8. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

The Person in Charge will ensure that the frequency of the fire drills is increased in an attempt to improve residents' response times. Monitoring of the drills will be done in conjunction with the Safety Officer and all necessary remedial actions will be taken to ensure fire drill results are in line with standard.

Proposed Timescale: 28/02/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The use of some environmental restraints had not been identified. Therefore, the appropriate procedures were not applied.

9. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

The Person in Charge will carry out an updated environmental audit to identify any environmental restraints and ensure that any such restrictions are processed in accordance with Services Policy.

Proposed Timescale: 31/03/2018

Theme: Safe Services

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

Staff required additional training and support regarding the detection of abuse.

10. 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:

The Person in Charge has arranged a training workshop for the staff team with the

Designated Person for Safeguarding Issues. The purpose of this workshop is to review all incidents in the Centre, how these were managed, reported and the learning therefrom.

Proposed Timescale: 28/02/2018

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Incidents of any allegation, suspected or confirmed, of abuse of any resident were not reported to HIQA.

11. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

Staff together with the Person in Charge and the Designated Person will review all incidents in the Centre to establish if these were managed and reported appropriately. All concerns not previously notified to the Authority will be made by the Person in Charge.

Proposed Timescale: 15/03/2018

Theme: Safe Services

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

Occasions where environmental restraints were used were not reported to HIQA.

12. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

The Person in Charge will ensure that the Authority is notified of environmental restraints from Quarter 4 2017.

Proposed Timescale: 31/01/2018

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:

Two staff members, who at times work alone in the centre, did not have training in the administration of an emergency medication required to meet the assessed needs of one resident.

13. Action Required:

Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

All staff requiring training in the administration of emergency medication will be trained on 8 February 2018. No staff awaiting this training will be assigned to work on their own in the interim.

Proposed Timescale: 08/02/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not include all of the information required as per Schedule 1 of the regulations. This included the arrangements made for the supervision of therapeutic techniques and the total management and staffing complement in full-time equivalents in the centre.

14. 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 statement of Purpose will be updated to include all information required under Schedule 1 including arrangement for the supervision of staff providing therapeutic interventions, the full time equivalent staffing and management inputs and the admission criteria for the Centre.

Proposed Timescale: 08/03/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Inspection of the centre identified two major non-compliances regarding staff training in the administration of emergency medication and the ongoing lack of multidisciplinary input into assessments and personal plan reviews. Moderate non-compliances were found regarding the implementation of communication approaches, lack of clarity regarding the fees to be charged to residents, fire safety precautions, staff awareness of what constitutes abuse and a restrictive practice, and the notification of incidents to HIQA. As a result of these findings inspectors were not satisfied that the provider could ensure the effective governance, operational management and administration of the designated centre.

15. Action Required:

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

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

1. To reduce the workload of the Person in Charge the Provider will finalise the recruitment of additional Persons in Charge across the Services. [16 March 2018]. This will ensure that the PIC appointed will have more time devoted to the operation of this Centre. The Person in Charge will undergo handover training and take up duties prior to 18 May 2018.
2. The provider has put in place a system to address the annual review of personal plans with multidisciplinary inputs [31/03/2018]
3. The Provider and the Person in Charge will streamline the risk escalation system to ensure that open risks are addressed on a timely basis this will include such risk as backlog of multidisciplinary referrals, incident management, notifiable events etc. [31/03/2018]
4. The Person in Charge will ensure that mandatory staff training in the centre is kept updated.

Proposed Timescale: 18/05/2018

Theme: Leadership, Governance and Management

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

There was no clear plan to address concerns identified during the unannounced six monthly inspections.

16. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the

designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

The Provider will ensure that the actions identified during inspections in the centre have a clear measurable time bound action plan, which identifies who is responsible for addressing each action.

Proposed Timescale: 31/03/2018