

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cherry Orchard Hospital
Centre ID:	OSV-0003730
Centre county:	Dublin 10
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Marie Byrne
Support inspector(s):	Karina O Sullivan
Type of inspection	Unannounced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	4

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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
22 March 2018 08:50	22 March 2018 19:40
22 March 2018 08:50	22 March 2018 19:40

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

Outcome 01: Residents Rights, Dignity and Consultation
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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was the fifth inspection of this centre following the submission by the provider of an application to register the centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. As a result of the concerns found at times of previous inspections of this centre, notices of proposal to cancel the registration and refuse the renewal of registration of the designated centre were issued. A representation document was submitted to the Health Information and Quality Authority (HIQA) by the registered provider following the issuing of the notices of proposal. A further inspection was completed to ascertain if the provider had implemented the measures outlined in the representation and the action plan from the previous inspection and to establish if progress was impacting positively on residents' lives. It remained there were significant ongoing non compliances.

Subsequent to this the provider was required to submit a further revised governance plan outlining how they would come into compliance. As part of this plan the representative of the registered provider was required to submit monthly assurance reports to HIQA for the duration of six months. This inspection followed up on not only the actions from the recent inspection but it also verified where relevant the progress outlined in the providers monthly assurance reports.

How we gathered our evidence:

This inspection was carried out by two inspectors over one day. The registered provider representative and Clinical Nurse Manager (CNM) facilitated the inspection. During the inspection, inspectors met and spoke with 13 residents, the registered provider representative, the person in charge, and 10 staff members including two agency staff. Inspectors viewed documentation such as personal support plans, policies and procedures, risk assessments and incident reports. Inspectors also discussed the governance plan and latest monthly assurance report with the registered provider representative during the inspection.

Description of the service:

The designated centre is based in Dublin and operated by the Health Service Executive (HSE). The centre consists of two buildings in close proximity to each other, within a hospital campus. Care is provided in the centre for 27 residents over the age of 18, both male and female with a disability. Six beds in the centre are used for respite care. Support is provided to residents over a 24 hour period by registered nurses and healthcare assistants. The registered provider representative was in the process of reviewing this document. Inspectors found that the service provided in the centre was not in line with the centers' current statement of purpose.

Overall judgments of our findings:

There was evidence of progress since the last inspection; however, progress was not significant enough to bring about compliance with the regulations or to improve residents' lived experience. Fourteen outcomes were inspected against during the inspection. Nine outcomes were found to be major non compliant and five were moderate non compliant. 24% of the actions from the previous inspection had been completed. Inspectors again found that residents' privacy, dignity and respect was not upheld at all times in the centre due to the layout, design and practices in the centre. Residents' had limited links with and involvement in their local community. A new care planning system was in its infancy but improvements were still required to ensure there was a comprehensive assessment of residents' health, personal and social care needs was in place for each resident. Non compliances remained in relation to fire containment and risk management in the centre. Plans were in place to ensure the skill mix in the centre was enhanced by employing social care workers, this was at an early stage. Areas of progress and findings of this inspection are discussed within the body of this report and the regulations which are not being met in the action plan at the end of the report.

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

Outcome 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):

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

Findings:

Overall, the inspectors found that residents' privacy, dignity and respect were not upheld at all times within the centre. The inspectors found improvements in relation to consultation with resident, however institutional type practices remained, and in line with the findings of previous inspections routines in the centre continued to be task orientated. The provider had put measures in place to complete one of the eight required actions following the last inspection, seven actions remained outstanding.

The inspectors found that enhancements had been made to the format of residents' meetings to ensure residents were more actively involved in and consulted with regarding the day-to-day operation of the centre. Residents' meetings were held monthly and minutes were made available in an accessible format. Residents were being supported to chair the meetings and there was evidence that residents' family members were invited and in attendance at some of these meetings.

To garner further feedback from residents about their lived experience of residing at the centre a residents' survey had been completed. This was developed by a newly formed project group who were tasked with the development of said survey, three residents were also part of this. At the time of inspection the survey had been completed and a draft report was presented to inspectors. Recommendations had been made as a result of the survey which were outlined in the report. The provider had identified a subgroup to review these findings and a timeframe to address the findings of the report.

Improvements had also occurred with regards to the provision of information about

advocacy and rights, this was now outlined on a notice board in reception. It contained details about residents' meetings, activities in the local area, and details on how to give feedback on service provision in the centre. The inspectors found that some of this information was not available in a format which was accessible for some residents. Further enhancements were planned for the promotion of advocacy as a part time social worker was due to commence employment in the centre. The provider had plans in place for this staff member to establish a residents' advocacy forum.

Inspectors found that the privacy and dignity of residents continued to be negatively impacted on. Residents continued to reside in multiple occupancy bedrooms and inspectors found that arrangements in place for respite admissions in the centre were not protecting the privacy and dignity of long term residents in the centre. Also inspectors found that there was inadequate storage facilities for personal use by residents. Inspectors observed residents in bed with their bedroom door open on numerous occasions during the inspection when there were high levels of foot traffic in the centre. In line with findings of the last report inspectors observed a number of people entering one of the premises in the centre without ringing the doorbell or signing the visitors' book. In addition a number of people were observed to ring the doorbell and then continue to walk straight into the centre without waiting for a reply.

Improvements were noted in relation to some residents' finances. An area specific procedure was now in place to provide guidance to staff and a safe was now in place in the centre and some money was held here securely for some residents. However, restricted access remained as some residents' funds were still held and managed through the campus manager's office which was only open at specific times. The provider had commissioned a retrospective financial audit into residents' accounts from 2013 and this was due to commence in the centre in April 2018.

There was a complaints policy in place but it did not contain area specific information including the name of the local complaints officer. Inspectors viewed the complaints log in the centre. Improvements were noted in relation to how complaints were recorded, however; further improvements were required such as the need to record details of the investigation of the complaint, and whether or not the complainant was satisfied with the outcome. The inspectors spoke with one complainant who voiced their dissatisfaction with the outcome of a complaint, yet it was recorded as resolved to the complainants' satisfaction in the complaints log.

Inspectors found that overall residents did not have opportunities similar to their peers and had limited access to their local community.

Judgment:
Non Compliant - Major

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):

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

Findings:

Inspectors found that the action required following the last inspection had not been completed. However, inspectors acknowledge that the proposed timeframe had not passed.

Staff employed at the centre were in the early stages of exploring opportunities for residents to engage in meaningful activities in the local community. The provider had also developed a plan to support this which looked at how residents' links with the community could be enhanced. However this was at its infancy at the time of inspection and had not yet had a significant impact on residents.

Inspectors viewed activity records in the centre which demonstrated that activity levels outside of the centre remained low. In one residents activity records a three month period was reviewed by inspectors. During this period the resident had not engaged in any activities outside of the centre. There had been an average of eight to ten activities recorded per week and all of these were home based.

Residents were observed to receive visitors during the inspection without any restrictions. Families were invited to monthly residents' meetings and plans were in place to hold family forum meetings once a new social worker commences employment in the centre.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

There was an admissions policy in place however it did not include transfers, discharges or the temporary absence of residents.

Contracts of care required further review and the provider had plans to address this, the timeframe for completion of this had not yet passed.

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:

Effective Services

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

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

Findings:

Inspectors found that the three actions required following the previous inspection had not been completed. However, inspectors acknowledged the timeframe for completion of some actions had not yet passed.

The provider was in the process of adapting a social care model in the centre and had introduced new personal plans based on this. However, inspectors found that the review of personal plans were in the infancy stage and improvements were still required in relation to ensuring they included a comprehensive assessment of residents' health, personal and social care needs. At the time of inspection arrangements were not in place to assess or review the effectiveness of personal plans.

Inspectors found that residents' assessments did not all times correspond with their plans of care. For example one residents' assessment completed by occupational therapist stated they required the assistance of two staff for transfers; however, their manual handling assessment stated they required the assistance of three staff for transfers.

Work had commenced on goal and activity planning, this was at its' infancy and yet to have a significant impact on residents' lives. Some goals reviewed for accessing the local community had timeframes which were months away and there was no evidence of

planning or steps involved in reaching these goals. Some residents' personal plans were not available in a format which was accessible to them.

Since the last inspection staff in the centre had attended training on person centred plans and practical support was now being offered. Work had commenced to involve residents and their representatives in line with their wishes, to review personal plans at multidisciplinary team meetings; however this had not been completed for all residents. A number of residents in the centre had a recent occupational therapy assessment and plans were in place for all residents to have one.

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):

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

Findings:

Inspectors found that one of the three actions required from the previous inspection had been completed. Inspectors acknowledged that the timeframe for completion of some actions had not yet passed.

Inspectors found that the centre remained compromised in relation to the layout and design of the centre to meet residents' needs. Multiple occupancy bedrooms remained and rooms were not of a suitable size and layout to meet residents' needs.

Some improvements had been made in the centre in relation to the state of repair and storage for residents' personal items, however, inspectors found that due to the layout of bedrooms there remained a lack of suitable storage for personal items. In line with the findings of the last inspection, inspectors found that some of the requirements of Schedule 6 were not provided in relation to residents' privacy and dignity.

For the most part inspectors found that there was suitable equipment, aids and appliances in place to support and promote their full capabilities. One resident required a wheelchair to access the community and this was in the process of being made available to them after an extended period of time being without one.

The centre was found to be clean throughout. There were a number of maintenance issues identified during the inspection such as hot water supply, ants in the dining room, a leak in one bathroom, and damage to boxing in one of the bathrooms. The provider put measures in place to have some of these fixed by the end of the inspection.

The provider previously identified a new build would be completed by 2021 for older persons services, and that this in turn would facilitate the relocation of one of the units in this centre to the premises previously used by older services.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Inspectors found that four of the eight actions identified by the provider following the last inspection had not been implemented. The inspectors found that some improvements had been made in relation to the health and safety of residents, visitors and staff.

Since the last inspection the risk management policy in the centre had been reviewed and updated however, the updated policy was not available to guide staff practice in the centre during the inspection. Also inspectors found that although a number of general and individual risk assessments had been developed they were not consistently identifying the individuals responsible for implementing the actions, the risk rating on the risk assessments was not proportionate, and the risk assessments were not reflective of the actual risks.

A risk register was not in place but the registered provider representative informed inspectors that this was in development. Inspectors found that improvement was required in relation to suitable arrangements for identifying and learning from incidents in the centre. For example, there was no evidence of follow up after the unexplained absence of a resident from the centre. The resident's risk assessment or the centers' general risk assessment had not been reviewed and updated.

Inspectors observed practices which did not ensure residents were protected from healthcare associated infections. On the day of inspection an unforeseen problem arose with the supply of hot water in a number of areas in the centre. A number of staff were

observed on several occasions to engage in ineffective hand hygiene by washing their hands in cold water. The provider put measures in place during the inspection to ensure hot water was restored in the centre.

While some improvements had occurred in relation to fire containment, the overall fire containment arrangements remained ineffective. Fire drills had improved but it remained that fire doors were not in place. Inspectors were informed an external company was due to attend the centre to review what works were required to assure the provider in relation to regulation 28. There was a new system in place to identify staff from other areas to assist with the evacuation of the centre in the event of an emergency.

There was a health and safety statement in place but inspectors found inaccuracies in relation to smoking in the centre. The risk assessment on smoking in the centre contained the same information as the health and safety statement. The inspectors discussed this with the CNM in the centre who confirmed that both documents were inaccurate.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

Overall, inspectors found that appropriate measures were not in place to safeguard residents and protect them from abuse. The arrangements to support residents with behaviours that were challenged were not sufficient. Inspectors found that the provider had put measures in place to complete one of the four actions required following the last inspection.

Safeguarding concerns were identified by inspectors during the inspection which had not been identified by the provider such as a lack of control regarding access to the residents' home via the front door. The inspectors met with the designated officer for the centre who confirmed that there were no safeguarding risk assessments or plans in

place in the centre. Inspectors reviewed training records and found that 50% of staff in the centre had not completed safeguarding training. In addition to this plans to train designated officers in the centre had not been completed. The inspectors acknowledge that 23% of staff had received safeguarding training since the last inspection and some staff who spoke with the inspectors demonstrated an understanding of their responsibilities in relation to responding to and reporting allegations of abuse.

Inspectors reviewed risk assessments and care plans in place in relation to residents' behaviour support needs and found that they did not guide staff practice effectively. The language used in some care plans reviewed did not respect residents' dignity. In one resident's care plan it referred to them being vulnerable and at risk of being affected by other residents' behavioural expression however, there was no safeguarding risk assessments or plans in place. Another resident's personal plan identified that they could become verbally and physically aggressive towards other residents and staff. However, this resident did have a risk assessment in relation to this and they did not have a positive behaviour support plan in place.

Inspectors also found that staff did not demonstrate sufficient knowledge to respond to behaviour that is challenging, or how to support residents to positively manage their behaviour. The inspectors acknowledge that the provider had identified a new system that would be put in place, in the near future, to support residents with behavioural support needs. The inspectors met with the clinical nurse specialist in behaviour therapy and they outlined the new system for the assessment and management of responsive behaviour in the centre.

Inspectors requested an update in relation to staff members without Garda vetting in the centre from the registered provider representative. This was provided and confirmed that 32% of staff had Garda clearance completed, 58% had sent Garda vetting applications and had not yet received a Garda clearance report, and 10% of staffs' Garda vetting reports could not be located.

Judgment:

Non Compliant - Major

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):

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

Findings:

Inspectors found that a record of incidents occurring in the designated centre was

maintained. However, on review of a number of incident reports in the centre, inspectors identified an incident involving an unexplained absence of a resident from the designated centre which had not been notified to the Chief Inspector in line with the regulations.

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):

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

Findings:

Inspectors found that the action required following the last inspection had not been implemented.

In line with the findings of the last four inspections, inspectors found that there was limited evidence of developments in relation to opportunities for residents to engage in new experiences or social participation, education, training and employment in line with residents' wishes.

A project group had been established following recent inspections, and they were in the process of reviewing resources available in the centre from a social care perspective. They were in the process of recruiting social care workers and linking with other services for guidance. Staff were also in the process of exploring the local community for meaningful activities for residents.

Judgment:

Non Compliant - Major

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):

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

Findings:

Overall, inspectors found that there had been some improvements in relation to the plans of care for residents' healthcare needs. Inspectors found that the provider had put measures in place to complete three of the five actions required following the last inspection.

Residents had access to allied health professionals in line with their assessed needs. The inspectors acknowledge that work had commenced on reviewing healthcare plans in the centre. However, inspectors found that residents' healthcare needs were not appropriately assessed. Inspectors also found that some healthcare plans were not guiding staff practice to support residents with the management of their healthcare needs. Some documents were not fully complete and interventions were not found to be person-centred. In addition some care plans were not being fully implemented. For example, a resident had a risk assessment and management plan in place for the treatment of an identified healthcare need which was not being fully implemented, despite the fact the resident was still presenting with the identified need on a regular basis.

Inspectors viewed a number of residents' care plans which identified that they were not for resuscitation. In line with the findings of the last inspection there was no documentary evidence of discussions held with the residents or their representative. They did not outline the decision making process and some care plans which were in place had not been reviewed or updated in a number of years.

Inspectors observed mealtime experiences for a number of residents during the inspection. This experience was not found to be person-centred and residents were not adequately supervised or appropriately supported during mealtimes. One resident was observed to make seven cups of tea within a 45 minute period, this was not observed by staff and a few minutes later they were asked if they wished to go to a local shopping centre for a cup of tea. The lack of staff engagement with residents regarding their mealtime choices was further reinforced as inspectors observed another resident having two breakfasts, each given by different staff. The second staff member was not aware that the resident had already had breakfast nor did they wait for a response from the resident as to whether they were hungry or wanted breakfast. Inspectors reviewed a number of residents' speech and language therapy (SALT) assessments and feeding guidelines and found that two of them had not been reviewed or updated in a number of years.

Snacks and drinks were now more freely available at times in the centre. However, residents did not have access to drinks and snacks at all times during the day. The inspectors acknowledge that catering staff were observed to offer residents drinks between meals.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Inspectors found that the action following the last inspection had not been completed.

The registered provider representative informed inspectors that the statement of purpose was under review. The statement of purpose in place in the centre did not fully meet the requirements of schedule 1 of the regulations.

Judgment:

Non Compliant - Moderate

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:

At the time of this inspection, the inspectors found a significant number of actions that had previously been identified had not yet been completed and multiple failings

remained. Although there was evidence of increased monitoring in the centre it had yet to positively impact on multiple aspects of service provision. Improvements were still required in relation to the oversight of the centre to ensure it was safe, consistent and effectively delivering care in line with residents' needs. Clarity regarding who was the person in charge was also required.

Following on from the most recent inspection there was evidence that the provider had put some additional measures in place to build their capacity and capability to provide a good quality of care and support for residents in the centre. These measures were in their infancy and yet to have a positive impact on the quality of life for residents.

Additional measures, implemented since the most recent inspection, included audits and meetings leading to increased monitoring by the registered provider. Although a suite of audits had been implemented, failings had been identified and action plans developed these had not been implemented to drive improvement. There was an increased presence of the registered provider representative at the centre. Inspectors also found announced and unannounced visits, including annual and six monthly visits, were being completed. As highlighted previously the action plans as a result of these were not being fully implemented.

Inspectors found that effective arrangements were not in place to support, develop and performance manage all members of staff in the centre. Staff supervision was not in place for staff in the centre. Inspectors found this did not facilitate staff to exercise their personal and professional responsibility for the quality and safety of care and services they provided in the centre.

As with recent inspections it remained that the person in charge had a remit over two designated centres, one of which was for older persons. This impacted upon their available time to oversee and be responsible for the running of this designated centre. As part of the providers' representation and governance plan they too acknowledge the lack of capacity the person in charge had while two large centres were within their remit. In response to this the provider had identified a new person in charge and the inspectors were told the relevant documentation would be forwarded to HIQA in due course. However, on the day of inspection it was unclear as to was the actual person in charge.

An additional nursing resource was being employed in the centre through an agency to support staff in the centre two days a week.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and

recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

Overall, inspectors found that staffing in the centre was not organised to meet residents' needs. Inspectors found that two of the three actions required following the last inspection had not been completed.

The inspectors acknowledged that the provider had recognised the need to review the skill mix of staff in the centre to ensure that there were staff with the right skills, qualifications and experience to meet the assessed needs of residents. A project team was now in place and in the process of reviewing resources available to meet residents' needs. Plans were in place to employ a number of social care staff in the centre.

During the inspections, inspectors found that staffing resources in the centre were not organised to ensure effective delivery of care and support. Residents were not in receipt of adequate support and assistance during mealtimes, and at times during the inspection staff were not found to support residents to engage in meaningful activities.

Inspectors reviewed rosters over an eight week period and there were four occasions in one unit, and seven occasions in the other unit where there were not sufficient staff to meet residents' needs.

Some staff in the centre had not completed training in line with residents' assessed needs. 7% of staff in one unit and 25% in the other had not completed CPR training. 10% of staff in one unit had not completed MAPA training and 5% of staff had not completed fire training.

Inspectors spoke with an agency staff who was not clear in relation to their roles and responsibilities in the centre, and was not in receipt of formal supervision or support in the centre.

Judgment:

Non Compliant - Major

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):

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

Findings:

Inspectors found that the actions following the last inspection had not been completed.

Inspectors reviewed Schedule 5 policies in the centre and found that some policies had not been reviewed within the timeline identified in the regulations. These policies included:

- The prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies
- Provision of behavioural support
- Recruitment, selection and Garda vetting of staff
- The creation of, access to, retention of, maintenance of and destruction of records.

The directory of residents in place did include residents who were on respite admissions. The residents' guide was in the process of being reviewed as it was not reflective of services and facilities in the centre.

A number of staff files reviewed did not contain all documents required by schedule 2 of the regulations. This included evidence of the persons' identity including a recent photograph, evidence of a Garda vetting disclosure, the date they commenced or ceased employment in the centre, a full employment history together with a satisfactory history of any gaps in employment, or two written references.

In line with findings of the last inspection, inspectors identified that improvements were required in relation to some Schedule 3 documents. A new system of care planning was in the process of being implemented in the centre which included an assessment of need and corresponding care plans. However these plans were in the early stages of development and inspectors found that some residents' care plans did not contain a date of completion or review, and that some documents were not fully completed. Also conflicting information was found in a number of residents' assessments and plans of care.

Judgment:

Non Compliant - Major

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:

Marie Byrne
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 Health Service Executive
Centre ID:	OSV-0003730
Date of Inspection:	22 March 2018
Date of response:	27 June 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Routines in the centre did not demonstrate consultation with residents.

1. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability,

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

participates in and consents, with supports where necessary, to decisions about his or her care and support

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

Multidisciplinary team meetings have now taken place for all but one resident which has been rescheduled for 05/06/18. A schedule of review meetings is now being developed for the remainder of the year by the Person in charge. An accessible information leaflet is being developed by occupational therapy to assist residents with this process.

Resident meetings continue to be held on a monthly basis chaired by one of the residents. Minutes are available in the centre and an agenda is circulated in advance.

The additional social worker commenced on 17/04/18 which was several weeks longer than originally planned. A model of advocacy support is being developed and will be available by 31/05/18.

The project group with resident representation continues to meet fortnightly and is actively addressing some outstanding issues. This includes a review of accessible information required for residents.

The action plan following the resident survey has been completed and was submitted to the regulator on 11/05/18. These actions are being worked through currently.

Access to one of the units is currently being changed and this work has commenced. Staff will be alerted to the ringing of the doorbell via a pager call bell system which will not be heard throughout the centre. Residents and permanent staff will have access via a swipe system. Residents will be supported to use this system by staff. All other visitors to the centre will have to wait for access by staff via the silent pager system.

The retrospective financial audit has been completed, with a follow up audit planned by finance department in October 2018.

A complaints audit has taken place and recommendations are being actioned. All staff are required to complete the HSEland online module by 01/06/18. A local complaints training session is planned. The complaints recording form is being amended to ensure complaints are recorded in detail with record of the investigation. Complaints will be reviewed monthly by the PIC and nursing management representative.

A Quality of interactions Schedule is being done weekly as part of the schedule of provider visits and will be audited on completion of 6 of them.

Proposed Timescale: 30/06/2018

Theme: Individualised Supports and Care

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

Routines in the centre were found to be task orientated and impacting on residents

choice and control over their daily life.

2. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

The centre continues to move towards a social care model. Consultation with residents takes place on a daily basis and also through the monthly resident meetings.

A comprehensive action plan has been developed following the resident survey and a team is acting on these recommendations.

All residents participate in individualised activities of their choosing. Some residents participate in activities in local community centres. A booklet of activities in the local community is available in the centre for residents to access independently or with support from their key worker.

Obtaining specific vehicle for use of residents from the designated centre is almost finalised. This will provide further opportunities for residents to have more choice in their daily activities.

Proposed Timescale: 30/06/2018

Theme: Individualised Supports and Care

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

Residents privacy and dignity were not upheld at all times due to the layout of the premises and institutionalised practices in the centre.

3. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

HSE Estates are exploring options around the design and layout of bed rooms, to include possibly partitioning bedrooms to create single occupancy rooms.

Frosted privacy sheets are being erected on bedroom windows looking onto central courtyard to create greater privacy in bedrooms.

Respite service users do not share bedrooms with long term residents.

Work on changing access to one of the units via the main door has commenced which will facilitate greater privacy for residents. This includes installation of a pager system

which is connected to the doorbell to minimise the noise disruption to residents when the doorbell is rung.

Proposed Timescale: 31/12/2018

Theme: Individualised Supports and Care

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

Some residents could only access some of their money in the centre, and remaining residents could only access their money when the general office was opened Monday to Thursday 10:00 to 12:30 and 14:15 to 16:00.

4. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Access to finances is being facilitated at the centre for 5 residents which they can access whenever they wish. A Standard Operating Procedure to support staff regarding finances has been implemented. All other residents manage their finances independently or receive support from family members in doing so.

Proposed Timescale: 30/04/2018

Theme: Individualised Supports and Care

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

Some complaints reviewed lacked detail in relation to actions taken to resolve the complaint, and details on how complaints were resolved.

5. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

All staff have been asked to complete the HSE Effective Complaints Handling Module on HSELand. To date 19% of Lisbri and 57% of Elm have completed with an action completion date of 01/06/2018.

The complaints log locally has been amended to ensure that complaints are recorded properly, staff are aware to communicate the appeals process to complainants and that outcomes are clearly documented.

Local training is planned for staff to review the new log and to emphasise the process

with them on 31/05/18 and 07/06/18.

All complaints are now being closed off by the Person in Charge to ensure oversight and resolution.

Proposed Timescale: 07/06/2018

Theme: Individualised Supports and Care

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

Some complaints did not detail measures for improvements in response to complaints.

6. Action Required:

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

The complaints log locally has been amended to ensure that complaints are recorded properly and that staff are aware of the process and can identify learning from complaints.

Local training is planned for staff to review the process with them on 31/05/18 and 07/06/18 which will focus on improvement measures and learning outcomes to respond to a complaint.

All complaints are now being closed off by the Person in Charge to ensure oversight and resolution.

Proposed Timescale: 07/06/2018

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

Theme: Individualised Supports and Care

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

Residents had limited opportunities to develop and maintain links with the wider community.

7. Action Required:

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

A new daily activity board have being designed and is updated on weekly basis. An

activity sheet measures involvement in activities in each person centred plan.

Residents are engaging more in the local community and links are continuing to develop with the community. A booklet of available activities is available in the centre for residents to access with support. Some residents are spending more time with family members in their homes or in their own homes. Some residents are engaging more in the local community e.g. computer classes. These activities were all identified through the person centred planning process individually with each resident. Residents will continue to be supported by staff to engage in activities of their choosing. The social work departments and occupational therapy departments are working with Rehabcare and South Dublin City council to identify further opportunities for residents.

The outdoor wheelchair for the resident has been ordered and delivery is expected over the coming weeks.

Acquisition of a specific vehicle for designated centre is being finalised currently.

The additional social worker for the centre commenced on 17/04/18 and is working with individual residents to develop opportunities for greater links with them.

Proposed Timescale: 31/07/2018

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:

The agreement for the provision of services for residents required improvement in terms of the care and support, and services to be provided for residents while in the centre. It was unclear in the agreement what residents were being charged for.

8. 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:

This is currently being prepared for issue to residents which details the breakdown of fees.

Proposed Timescale: 31/05/2018

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, from a health, personal and social care perspective was not available for all residents to reflect changes in need and circumstances.

9. 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:

The Occupational therapy comprehensive assessments which reflect the residents need has been carried out and are completed for both units.

The newly commenced social worker has commenced her social work assessments with each resident. One has been completed to date.

All other resident needs will be assessed appropriately as their needs change.

A schedule of care plan reviews is currently being put in place which will see 4 care plans being reviewed monthly by the Person in charge with support from nursing management.

Proposed Timescale: 31/08/2018

Theme: Effective Services

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

Effective arrangements were not in place to meet the assessed needs of each resident from a social care perspective.

10. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

The person centred planning system is being bedded in. Assessed needs will be met by the relevant healthcare professional. Risk assessments are being reviewed to reflect changing needs of residents.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

Some residents' personal plans were not available in a format which was accessible to them.

11. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The O'Brien model of resident's personal plan are being used and are made available to residents and where appropriate to their significant others. An accessible format is being developed for residents who require this.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

The system in place did not consistently demonstrate how residents and their representatives, in line with residents' wishes were involved or consulted in relation to the development and review of their plans.

12. Action Required:

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

A schedule of person centred plan reviews is currently being developed following the initial multidisciplinary meetings with each resident which have been held to date. These will ensure the maximum participation of each resident, and their representative as appropriate. An accessible information leaflet is being developed by occupational therapy for issue to residents to explain the purpose of the reviews.

Proposed Timescale: 31/12/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The premises was not designed and laid out to meet the number and needs of

residents.

13. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates are exploring options around the design and layout of the bedrooms, with a view to reducing the multi occupancy bedrooms. It is envisioned that some of these rooms will be adapted by the 30th of September 2018.

Frosted covers on bedroom windows are being put in place to increase the privacy in bedroom windows. This should be completed by 15/07/18.

No new admissions are being taken to the centre currently. One resident has expressed interest in moving home to her own house and this will be explored with her.

Proposed Timescale: 31/12/2021

Theme: Effective Services

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

There were areas of the centre in need of maintenance and repair as outlined in the body of this report.

14. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The issues with the hot water supply were resolved at the end of the inspection.

Pest control precautions have been reviewed in the centre.

One of the units in the designated centre will be painted, following exploration of reducing multi occupancy bedrooms as described above. Funding has been approved for this. This will address the areas mentioned in the body of the report.

Weekly maintenance of the external courtyards is being carried out.

Proposed Timescale: 31/12/2018

Theme: Effective Services

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

The requirements of Schedule 6 were not met within the centre.

15. 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:

A new build plan is in place for 2021 on the site. It is anticipated that disability services will then transfer to one of the vacated units on site which will meet the requirements of Schedule 6. HSE Estates are exploring options around the design and layout of the bedrooms, with a view to reducing the multi occupancy bedrooms.

Frosted covers on bedroom windows are being put in place to increase the privacy in bedroom windows.

No new admissions are being taken to the centre currently. One resident has expressed interest in moving home to her own house and this will be explored with her.

Communal space continues to be explored to see if usage can be increased for residents.

Proposed Timescale: 31/12/2021

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:

Suitable arrangements were not in place for identifying and learning from incidents in the centre.

16. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

Risk Management policy is in place on both units. Training has taken place on the 02/05/2018 with a further session scheduled for 29th May. Further sessions will be scheduled to capture all staff members. Training in Incident reporting and Management took place on May 10th for disability staff also.

Incident reviews are taking place on a weekly basis with the Person in Charge with support from nursing resource in nursing administration.

Proposed Timescale: 31/05/2018

Theme: Effective Services

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

Suitable arrangements were not in place to ensure control measures in place on general and individual risk assessments were proportional to the risks identified.

17. Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

Individual risk assessments are reviewed within care plans as required for individual residents.

General risk assessments pertaining to the premises are reviewed.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

The system in place in the centre for assessment, management and ongoing review of risk, including a system for responding to emergencies in the centre required improvement.

18. 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:

Individual risk assessments are reviewed within care plans as required.

General risk assessments are reviewed on a regular basis by the person in charge.

The emergency plan for the centre is completed and is awaiting sign off by senior management.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

Infection prevention and control measures were not appropriately implemented in relation to staff hand washing.

19. Action Required:

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

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

All staff have been informed they must complete Standard precautions training which is inclusive of Hand Hygiene. Additional training sessions are being run for staff.

Proposed Timescale: 31/07/2018

Theme: Effective Services

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

An effective fire safety management system was not in place in the centre.

20. Action Required:

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

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

All works pertaining to the fire doors to bring them into compliance with fire regulations have been completed by Masterfire and signed off by the HSE fire prevention officer. Fire training - Fire Training Lisbri -90% - 2 members of staff just reached their review date. Fire Training Elm- 93%- 1 member of staff has just reached their review date

Simulated fire drills continue to take place on a monthly basis with staff. Residents can participate if they wish.

More accurate floor plans are being re done in the centre currently to correspond with numbering of doors in the centre.

A schedule of fire checks, including weekly tests and regular servicing of equipment, including emergency lighting is done by Mastefire. Records are held in the centre.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

Adequate precautions were not taken against the risk of fire.

21. Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

All works pertaining to the fire doors to bring them into compliance with fire regulations have been completed by Masterfire and signed off by the HSE fire prevention officer.

Fire training - Fire Training Lisbri -90% - 2 members of staff just reached their review date. Fire Training Elm- 93%- 1 member of staff has just reached their review date

Simulated fire drills continue to take place on a monthly basis with staff. Residents can participate if they wish.

More accurate floor plans are being re done in the centre currently

A schedule of fire checks, including weekly tests and regular servicing of equipment, including emergency lighting is done by Mastefire. Records are held in the centre.

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

Adequate arrangements were not in place for fire containment in the centre.

22. 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:

All works pertaining to the fire doors to bring them into compliance with fire regulations have been completed by Masterfire and signed off by the HSE fire prevention officer.

Proposed Timescale: 30/04/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff did not demonstrate sufficient knowledge in relation to responding to behaviour

that is challenging, or on how to support residents to manage their behaviour.

23. Action Required:

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

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

A new responsive behaviour care pack has been developed and is with an external for final proofing, HSE print have advised completion of job will take 4-6wks and same will then be rolled out. The RB care pack will assist and guide staff in all areas of RB from assessment through to management

A responsive behaviour suite of education is under development and will be rolled out in collaboration with the care pack. The CNS will provide this education and oversee the roll out of the project

The responsive behaviour guideline has been completed and has been submitted for sign off 21/05/18. Education will be provided by the CNS on launch of the guideline.

Proposed Timescale: 31/07/2018

Theme: Safe Services

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

Care plans in place relating to residents' behavior support needs were not guiding staff practice in a person-centred manner. Every effort to identify and alleviate the cause of residents' behaviour was not evident.

24. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

On the day of inspection the CNS Behaviour met with the inspector and advised that there was no behaviour support plans in place rather care plans. The CNS acknowledged that these needed to be changed over to support plans and advised re the RB pack development, the plan for roll out of same which includes responsive behaviour support plans and assessment tools

Two residents highlighted by the inspectors in relation to RB were further identified by the CNS and elements of the pack were implemented. The CNS has worked 1:1 with the keyworkers and identified residents re the development of these plans which are presently on-going. All staff on the unit have been advised of plans now in place for both these residents

- To date

- o The CNS has completed a functional assessment of behaviour with both residents and

an RB risk profile and the following is now implemented in the residents care folder. The functional assessment carried out by the CNS incorporates considerations to the RB Occurrence, known and potential precipitating factors, risk, likes and dislikes of the resident.

Lisbri House – subsections entered in residents file re Responsive behaviour for 2 residents

All relevant documents relating to RB are in this sub section & they contain the following

Resident 1 Resident 2

- Functional assessment of behaviour (completed 28/04/18) • Functional assessment of behaviour (completed 28/04/18)
- Risk profile completed 28/04/18 • Risk profile - completed 28/04/18
- Colour box continuum – guidance • Colour box continuum – guidance
- Support plans • Support plans
- Pain assessment and management • Pain assessment and management
- Sleep – wake cycle 24hr recording commenced • RB log recording commenced

Following collaboration with staff further residents have been identified as requiring behaviour support plans and implementation of the RB care pack. To date the CNS has linked in with the relevant staff and work has begun on RB care packs for these residents

Lisbri – 8 residents identified

Elm – 4 residents identified

Risk assessments are in place and are reviewed and updated monthly on the responsive behaviour risk register, a folder of this RB risk register is kept on each unit and a central folder is maintained in nursing admin

The RB pack incorporates risk and as the pack is rolled out all risk will be reassessed using the risk care triangle and risk – benefit ratio, support plan will be developed in accordance with this and in collaboration with the CNS, resident, keyworker and significant other if appropriate

o RB incorporating safeguarding champions have been recruited and to date two meetings have been facilitated. The overall aim of these champions is a communication network as they bring house concerns to the meeting and also convey information back to the house that is current and / or trending in the areas of responsive behaviour and safeguarding

o An RB talk time newsletter has been developed and the first launch occurred in April. This newsletter provides information for staff on what's new and what's trending, the progress on the RB guideline, RB care pack and developments in safeguarding

Proposed Timescale: 31/10/2018

Theme: Safe Services

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

Residents were not protected from all forms of abuse as detailed in the body of this report.

25. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

Additional places on safeguarding awareness training are being provided on 26/06/18 in Newbridge for staff who did not attend previously scheduled training. Following this we will have 100% compliance with safeguarding training in both units. Training places have been sought from the Safeguarding Team to train up 2 staff as 'Train the Trainers' to ensure all staff are re-trained every 2 years. Confirmation of a date for training is awaited from the Safeguarding Team.

A Resident register has been developed and initiated which includes resident name, MRN, HIQA UIN, capacity to recall & convey information - task specific, capacity to manage day to day monies, ability to consent, permission to contact significant other, RB/SG concern, schedule of reassessment

A safeguarding register has been developed and identifies residents with a SG concern identified, NFO6 and preliminary screening completed and submitted, this register will be reviewed and updated monthly.

All residents identified on the safeguarding register will have risk assessed and risk assessment developed and implemented week beginning 28/05/18 and support plans will be advised to staff following same

A resident group has been developed to explore and discuss safeguarding – 'What it means to me'. This group is resident led and facilitated by the CNS Behaviour (DSO). This group facilitates a safe environment for all residents to openly explore and discuss all areas within safeguarding in the comfort of their own home.

The group is named Couch corner chat and the first group was facilitated on Saturday 12/05/18 by the CNS in Behaviours / Designated Safeguarding Officer. As agreed with residents this group will meet approx. every 4-6wks, dates will be set with residents and a memo distributed. The DSO plans also to meet with significant others to discuss the area of safeguarding – it is envisaged that another group will be facilitated with the residents and then link in with significant others.

A folder will be kept on the unit titled Couch corner chat in relation to safeguarding. It will contain a copy of the memo distributed and attendance lists. The minutes of the group will be held with the DSO.

RB incorporating safeguarding champions have been recruited and to date two meetings have been facilitated. The overall aim of these champions is a communication network as they bring concerns to the meeting and also convey information back to units that is current and / or trending in the areas of responsive behaviour and

safeguarding

An RB talk time newsletter incorporating safeguarding has been developed and first launch occurred in April. This newsletter provides information for staff on what's new and what's trending, the progress on the RB guideline and care pack, safeguarding information; next issue June 2018

Changing access to the centre to assist in the greater management of access and exit from the centre will ensure that all visitors to the centre must wait to be granted access. This will minimise the risk of people not known to residents accessing the centre.

Greater financial controls are now in place in the designated centre which reduces the potential for financial abuse.

Proposed Timescale: 31/07/2018

Theme: Safe Services

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

50% of staff members required training in the area of safeguarding residents and the prevention, detection and response to abuse.

26. 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:

Safeguarding Training percentages are increasing with 83% of staff in the designated centre now having attended training. The remaining staff members are attending safeguarding training on the 26th June.

Proposed Timescale: 26/06/2018

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:

The unexplained absence of a resident from the designated centre was not notified in line with the requirement of the regulations.

27. Action Required:

Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector

within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

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

This notification was submitted retrospectively.

The CNS Behaviour has spoken with staff at report handovers and each time on the unit re the importance of completing the relevant documentation required when an incident occurs.

NIMs reporting is included in the RB guideline and will also be in the RB education suite to be delivered to staff.

A safeguarding information form has been developed and is being utilised for all residents who are reported to be a safeguarding concern and / or present with an unexplained injury. This form will be completed in full by staff and submitted to Nursing admin with the NIMs report

Resident identified re unexplained absence from unit has had a functional assessment completed and risk assessed, risk assessment will be implemented week 28/05/18 by the DSO, same completed

Proposed Timescale: 31/05/2018

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Residents had limited access to opportunities for education, training and employment.

28. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

2 residents have enrolled in computer class in the community and 1 of the residents have commenced and attending every Tuesday for the next four weeks.

Some residents attend day centres in the community.

One resident has expressed an interest in pursuing employment and this will be explored individually.

Residents who identified lifeskills they would like support with following the resident survey are being met individually and a programme of support put in place.

Proposed Timescale: 31/07/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The decision making framework for do not resuscitate orders for some residents, and collaboration with residents was not documented within their files in relation to the decisions made.

29. Action Required:

Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

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

The DNR was reviewed with each resident during April 2018. A copy of the discussion and outcome of this multidisciplinary discussion with residents is documented in each medical file.

Proposed Timescale: 04/05/2018

Theme: Health and Development

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

Residents were not supported with eating and drinking in an appropriate manner in accordance with their assessed needs.

30. Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

Residents are being supported with eating and drinking and there is sufficient number of trained staff present at meal times to assist the residents.

Proposed Timescale: 30/04/2018

Theme: Health and Development

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

Residents did not have access to drinks and snacks outside of certain times in the day.

31. Action Required:

Under Regulation 18 (4) you are required to: Ensure that residents have access to

meals, refreshments and snacks at all reasonable times as required.

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

There is a snack fridge situated at the dining area and easily accessible to residents if they wish. Snacks are available in the evenings and at night if residents request anything from the kitchen out of core operating hours.

Proposed Timescale: 31/03/2018

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 in place in the centre did not meet all the requirements of schedule 1 of the regulations.

32. 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 has been completed and is available in the centre. An accessible version has also been completed for residents and is available.

Proposed Timescale: 15/05/2018

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:

The person in charge was also person in charge for another designated centre and effective governance, operational management and administration of the centre was not evident.

33. 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 CNM II in the centre is now the new Person in Charge in a supernumerary capacity for the designated centre only and not the entire campus. This notification was submitted to the regulator.

Proposed Timescale: 26/04/2018

Theme: Leadership, Governance and Management

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

The management structure in the designated centre did not clearly identify specific roles and responsibilities, and the lines of authority and accountability.

34. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

New Organisational supervision chart have been developed outlining lines of authority and responsibility for all staff in the designated centre. A meeting is required to inform staff and this can then be displayed in both units. This will be facilitated by the Education Officer and the Person in charge.

Development of Competency Assessment Framework for Nurses and Care Assistants/Social Care Workers- Draft HCA Competency tool has been developed, needs further work in order to improve validation. Work has commenced on nursing competency tool.

New documentation is being developed that provides continuum of monitoring of staff from induction, through probation and onto continuous monitoring of performance inclusive of PDP development.

Training has been provided to CNM's and PIC in person development plans.

The Person in Charge reports to the CNM in nursing administration.

Proposed Timescale: 15/07/2018

Theme: Leadership, Governance and Management

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

The management systems in place in the centre were not ensuring that the service provided was effectively monitored, safe, or in line with residents' needs.

35. Action Required:

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

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

Monthly provider management meetings are held.

Bi monthly quality and risk meetings specifically for disabilities have commenced.

Dedicated nursing support from nursing administration is now being provided weekly on site and to the person in Charge. This role includes review of audits carried out, monthly complaints review.

The schedule of visits on behalf of the provider is continuing. A review of recent findings took place on 10/05/18.

Actions from the Quality and Safety annual review were reviewed on 10/05/18 with the Person in Charge.

Proposed Timescale: 30/06/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

Staffing in the centre was not organised to meet residents' assessed needs. Also there were four occasions in one unit, and seven occasions in the other unit where there were insufficient staff numbers to meet the residents' assessed needs.

36. Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

A new Additional Training and Education Matrix has been developed and completed by the education officer. This highlights all Additional training completed by staff and highlights where possible deficits in training are occurring. It will highlight the appropriateness of the skill mix of staff moving forward and where either training is required to improve the skill mix or where alternatively staff may require sourcing training to address deficits highlighted or alternatively staff may be relocated to address the issue. In Areas where training appears to be lacking and in conjunction with the Education needs analysis tool, specific education will be sourced and made available for staff. Having scheduled training and where staff are non-compliant in their attendance this will be addressed in their individual support and supervision sessions (Commencing week of 25/06/2018) and a Smart action plan put in place. It will also be brought forward to the monthly nursing administration meeting for discussion and further actioning. We have one regular agency Social care worker (SCW) employed who is on the roster, another permanent HCA who is going into her second year of SCW training

and one HCA commencing the SCW training in September. Two other HCA's are going into their third year also of SCW training. We are releasing staff on a staggered basis to do SCW training to minimise the disruption to residents and promote continuity of staff as far as is possible.

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

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

The person in charge was not displayed on the roster in the centre on the day of inspection.

37. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The name of the person in Charge is now displayed on the off duty roster in the centre and also planned roster showing staff on duty for both day and night

Proposed Timescale: 30/04/2018

Theme: Responsive Workforce

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

Staff did not have access to some training and refreshers in line with residents assessed needs as outlined in the body of this report.

38. 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:

Education Matrix development highlights deficits in training and which staff in particular require it.

Staff all have access to mandatory training and with the implementation of regular meetings with supervisors and PDP development improved compliance will be addressed. New competency assessments will also be completed on all staff members.

CPR – ELM 100% Lisbri – 75%

MAPA – Elm 93% Lisbri – 93%

Manual Handling- Elm- 100%- Lisbri -90%

Proposed Timescale: 15/07/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

A number of Schedule 5 policies were not available in the centre including:

- Provision of behavioural support
- Recruitment, selection and Garda vetting of staff
- Education Policy for residents

39. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

Education and Training Policy for Service Users in Lisbri and Elm (2016) is in place.

Provision of behavioural support is completed and waiting sign off

Recruitment, selection and garda vetting of staff SOP in progress will be implemented by 11th June 2018.

Proposed Timescale: 11/06/2018

Theme: Use of Information

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

A number of Schedule 5 policies in the centre were not reviewed in line with the timeframe identified in the regulations as outlined in the body of this report.

40. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

Policies are being reviewed in line with time frames. Tracker almost completed to highlight review dates.

Proposed Timescale: 08/06/2018

Theme: Use of Information

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

The directory of residents in the centre did not include the names of residents in receipt of a respite break.

41. Action Required:

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

This has been amended to include respite service users.

Proposed Timescale: 30/04/2018

Theme: Use of Information

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

The residents guide was not reflective of the services and facilities available in the centre.

42. Action Required:

Under Regulation 20 (2) (a) you are required to: Ensure that the guide prepared in respect of the designated centre includes a summary of the services and facilities provided.

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

The residents guide is now in place in the centre and each resident has a copy.

Proposed Timescale: 30/04/2018

Theme: Use of Information

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

Inspectors reviewed a number of staff files and they did not contain all records of the information and documents in relation to staff specified in Schedule 2 as outlined in the body of the report.

43. Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:

An audit of staff files held in the centre was conducted and the findings are with the Human resources department for actioning.

Proposed Timescale: 31/07/2018

Theme: Use of Information

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

Improvements were required in the maintenance of records in relation to each resident as specified in Schedule 3.

44. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

Schedule 3 records are available in the centre.

Proposed Timescale: 15/05/2018