Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Adults Services Palmerstown Designated Centre 2
Centre ID:	OSV-0003899
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Lead inspector:	Thomas Hogan
Support inspector(s):	Helen Thompson
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal 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 February 2018 08:20	22 February 2018 18:30
22 February 2018 08:20	22 February 2018 18:30

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

Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was an unannounced inspection to assess the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the provider's application to renew the registration of this designated centre. It was the Health Information and Quality Authority's (HIQA) fifth inspection of this designated centre and it was completed over one day by two inspectors. 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 HIQA by the registered provider following the issuing of the notices of proposal and the assurances outlined in this document formed a core element of this inspection process. As a result of assurances provided in the representation document, a decision was taken by HIQA to initiate a six month regulatory programme for this designated centre during which intensive monitoring would take place. In response to the six month regulatory plan the provider submitted a detailed governance plan outlining their intention to address the areas where failings had been found in addition to building in their own internal mechanisms to enhance auditing and monitoring. This report reflects the findings of the first sampling inspection which took place in the context of the aforementioned six month regulatory programme.

Description of the service:
The registered provider had produced a statement of purpose which outlined the services provided within this designated centre. The centre was based in a large campus based setting in Dublin and comprised of five individual buildings which provided residential services to 30 persons with disabilities at the time of inspection.

How we gathered our evidence:
Inspectors met with 22 of the residents availing of the services of the centre and spoke with 11 staff members, persons in charge, programme managers, the director of care, and the chief executive officer. Various sources of documentation, which included a statement of purpose, residents' files, centre self-monitoring records, policies and procedures, risk assessments etc., were reviewed as part of this inspection. Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement and interactions with residents. Also a full walkthrough of the centre was completed by the inspectors.

Overall judgment of our findings:
Seven outcomes were inspected against as part of this inspection. Improvements were identified and the provider has developed a robust governance plan to enable them to come into compliance however a high level of regulatory non-compliance remained present. The inspectors found that 20 of the 31 actions issued to the registered provider at the time of the previous inspection had been satisfactorily implemented and 11 remained outstanding. Of the seven outcomes inspected against as part of this inspection, three outcomes were found to be in major non-compliance and four outcomes were found to be in moderate non-compliance with the regulations. This was an improvement since the last inspection where eight of nine outcomes inspected against were found to be major non complaint.

The improvements observed by the inspectors remained at a very early stage of implementation and at the time of the inspection it had not had any notable positive impact on the quality life of residents who were availing of the services. The inspectors found that significant numbers of incidents and accidents which had occurred in the designated centre did not have appropriate follow up to mitigate risks to residents. In addition, fire assessments had not been completed with regards to night time evacuation and further improvement was required in relation to emergency lighting as it was absent in a five places. With regards to the safeguarding of residents, inspectors found that residents were not protected from experiencing abuse in the centre and 53 allegedly abusive incidents occurred in a time period sampled. There remained a lack of recognition of incidents as abuse and as a result 27 of the 53 incidents were found not to have been followed up on or responded to in line with national policy requirements.

These findings, along with further details, can be found in the body of the report and accompanying action plan.

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 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:
The inspectors found that while some improvements were made to the premises of the designated centre in the time period since the last inspection, there remained areas of non-compliance with the regulations.

The provider, at the time of this inspection, had future plans to provide individual bedrooms to each resident in the future. There remained a lack of private accommodation for residents who were availing of the services of the designated centre. Four residents were found to be sharing two separate bedrooms at the time of inspection and these rooms did not provide adequate space and storage facilities for the personal use of these residents. Since this inspection and as of 09 March 2018 all residents now have their own individual bedroom.

While bedrooms were observed to be personalised to the individual tastes of residents across the designated centre repairs, upkeep and maintenance was required to a number of areas including the need for painting and decorating. For example In one unit, a number of bedrooms, dining areas, and hallways required painting and decorating. Curtains required attention and outdoor furniture was observed to be broken in the garden area.and some items of furniture in the living areas of this unit was observed to be worn and damaged.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:
Effective Services

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

Findings:
Inspectors found that while there were some minimal improvements in this area in the time since the last inspection the health and safety of residents, visitors and staff was not satisfactorily promoted and protected in the designated centre.

The inspectors found that although some improvements in relation to the fire precaution arrangements had taken place additional action was required. Emergency lighting was not in place in five separate areas of the designated centre all of which contained emergency fire exits. One exit was found to have been locked at the time of inspection and did not have an emergency break glass unit in place with keys for the exit door. In addition, in one unit of the centre an emergency fire exit was found not to have appropriate signage in place. An internal fire door in one unit of the centre was observed by inspectors not to have been in full working order.

Fire drills were being completed at the centre and inspectors review a sample of these records. Overall, the records demonstrated that residents could be evacuated safely from the buildings in the event of a fire or emergency, it was not evident however from a review of records if the recommendations are per residents' personal emergency evacuation plans were being adhered to, this specifically related to the number of staff residents required in the event of an evacuation. Inspectors also found that while these personal emergency evacuation plans were now in place for each resident they did not clearly state the supports required from staff members to evacuate safely. Furthermore in the case of recommendations made following completion of fire drills, the inspectors found that in one case equipment to be used in aiding a resident while being hoisted in and out of bed was not in place as recommended in a fire drill record.

In one unit of the designated centre the inspectors viewed emergency fire evacuation procedures for both day and night times and found that the day time procedures had not been reviewed or updated since August 2014. The inspectors found that no risk assessments had been completed for risks associated with fire at night time in the designated centre.

A review of incident and accident records which had occurred in the designated centre were sampled by inspectors. Incidents and accidents reports relating to the period 04 October 2017 to 12 December 2017 (inclusive) were reviewed and it was found that 99 incidents or accidents had occurred in this time period. The inspectors found that while some minor improvements had been made in the area of incident management, the occurrence of incidents in the centre remained high and the follow up to incident remained a concern. Of the 99 incidents reviewed by inspectors, 57 were found to have

been adequately followed up on however 42 incidents were found not to have had appropriate follow up actions in place to minimise the likelihood of reoccurrence.

Improvements had been made in the area of infection control in the time since the last inspection. Inspectors found that additional hand towel dispensers had been installed at hand washing stations in the centre and hand soaps were in place for staff, residents and visitors to wash their hands. In addition, antibacterial hand sanitizer was available at locations throughout the centre. Information and reminders to sanitize and wash hands were on display on notice boards and in other locations also.

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:
Inspectors found that some improvements were made in this area in the period since the last inspection such as an increased knowledge base amongst staff spoken with and an in increase in the recognition of incidents which were potentially safeguarding issues, however Inspectors found that satisfactory measures were not in place to protect residents from experiencing harm and abuse at all times in the designated centre.

A review of all incident and accident records which occurred in the designated centre between the dates of 04 October 2017 and 14 December 2017 (inclusive) found that 53 incidents occurred which met the definitions of abuse as outlined in the 'Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures' document (HSE, 2014). 23 of these incidents involved alleged peer to peer abusive incidents and a further 30 incidents related to unexplained injuries or bruising sustained by residents. While 28 of these incidents were recognized as potential safeguarding matters 27 of the 53 incidents identified by inspectors were found not to have been recognised as so by the registered provider or managed in accordance with the 'Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures' document (HSE, 2014). Improvements were also required regarding the reporting of these as 32 of the 53

incidents were found not to have been reported by the registered provider to HIQA as required. While the inspectors found that systems in place to prevent and appropriately respond to allegations, suspicions and incidents of abuse had been strengthened in the period since the last inspection, there remained significant concerns about the high levels of alleged peer to peer abuse in the centre and the lack of recognition of incidents as such, and, as a result the absence of appropriate investigation and follow up by the registered provider.

Staff knowledge of safeguarding and protection was found to have improved in the period since the last inspection. Four staff members were spoken with and overall, inspectors found that those spoken with held a good level of knowledge on the different types of abuse and the actions to take in the event of witnessing or suspecting the abuse of a resident.

Restrictions and restrictive practices were reviewed in three units of the designated centre and the inspectors found that there were physical, environmental, and chemical restraints in place in at least three of the units at the time of inspection. While some processes had taken place to identify restrictions and restrictive practices which were in place in the centre by the person in charge, evidence was not made available to the inspectors to demonstrate that all restrictions and restrictive practices had been appropriately recognised as such. The person in charge outlined recent undertakings to reduce the restrictive practices in place and gave examples of how restrictive clothing had been discontinued for one resident in the two weeks prior to the inspection. To ensure that the rights of residents were protected in the application of restrictions and restrictive practices in the designated centre the inspectors were informed that a new committee was in the process of being established by the registered provider to specifically oversee the use of restrictions and restrictive practice. However, at the time of inspection, inspectors remained concerned regarding the restrictive environment in which residents availed of services provided by the centre.

The inspectors found that overall, the provision of behavioural support to residents had improved in the period since the last inspection. This improvement was at its infancy and had not yet at the time of inspection resulted in improved quality of life for all residents. The inspectors observed one resident engage in behaviours which significantly compromised their dignity for a 20 minute period in which no staff member responded. When the staff member present at this time was spoken with by inspectors was asked about this resident's behavioural support plan, they responded by stating that they had not read the plan in full. When inspectors viewed the behavioural support plan for the resident it was found to provide no guidance on managing the behaviour in question.

The inspectors observed all interactions between staff and residents to be respectful and warm throughout the time of inspection.

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, the inspectors found that some improvements had been made in the provision of healthcare support to residents in the time since the last inspection. Despite this, the inspectors identified several areas of non-compliance.

A range of multidisciplinary services were available to residents which included speech and language therapy, psychology, general practice, dietetics, psychiatry, occupational therapy, social work, physiotherapy. These were accessed through a referral system and the person in charge informed inspectors that a prioritisation process was in place with individual allied health professionals. The inspectors found, however, that in some cases residents were not facilitated with required reviews by allied health professionals in accordance with their needs. The provider was aware there were weaknesses in this regard and was in the process of reconfiguring clinical supports to ensure more efficient access which was organised in terms of priority.

Staff members spoken with by inspectors demonstrated satisfactory levels of knowledge of the healthcare needs of residents. Inspectors found that staff members spoken were aware of the actions to take to respond to urgent healthcare conditions such as seizure activity. Individual health needs were found to have been assessed through an 'Annual Medical Review' processes in the centre. The inspectors reviewed a sample of seven resident files and found that all seven residents had an annual medical review completed in the previous 12 month period. Healthcare needs which were identified through the annual medical review and through discussions with staff members were compared against healthcare support plans in place for each resident. The inspectors found that a range of healthcare needs identified such as anemia, constipation, hypothyroidism, coeliac disease, hepatitis B, and obsessive compulsive disorder did not have healthcare support plans in place for residents.

A review of healthcare support plans, completed by inspectors, which were in place for residents found that overall the plans did not provide sufficient for staff on how to support individual residents achieve best possible health outcomes. The support plans in place acted as a source of information on what each health condition meant in a generic manner and was accompanied by a log of medical interventions such as attending specialist consultants etc. There was an absence of individualised supports required by each resident to ensure best possible health was achieved and how this support looked in practical day-to-day terms. In addition, the inspectors found that there was an absence of a review of healthcare support plans with regards to their effectiveness. There was no evidence of allied health professional input in a review process.

Inspectors found that while recent changes in practices in preparing meals in the designated centre led to meals being prepared in individual units on one to two occasions per week, overall, meals remained being prepared in a centralised catering unit on campus and delivered to the designated centre before being later reheated and served to residents. A review of dietary intake records of residents by inspectors found that one individual had the same main meal each day for six day period sampled. In general, the total daily intake for this resident remained largely unchanged from day to day. The resident's file was examined by inspectors and it was found that they were identified to be underweight and had been seen by a dietician last in May 2014. A referral had been sent by staff members in January 2017 and a 'priority rating' desktop review was completed by a dietician in February 2018.

When the matter was discussed with the person in charge, inspectors were informed that the resident experienced behavioural difficulties regarding dietary intake, however, when the resident's behavioural support plan was examined, it was found that no specific guidelines were provided with regards to this matter and it only listed the residents likes and dislikes. Assurance were provided to the inspectors by the director of nursing that the resident would receive dietetics input as a matter of priority.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
The inspectors found that while some improvement had occurred in the centre regarding medication management inspectors found that residents were not satisfactorily protected by the procedures in place for medication management.

Appropriate arrangements were found to be in place in the centre for the handling and disposal of unused and out of date medications.

A staff member spoken with by the inspectors demonstrated appropriate knowledge of actions to taken in response to a medication error. A newly introduced medication error flow chart was on display in the centre and provided guidance for staff on how to appropriately respond to an error.

In two units of the designated centre inspectors completed a visual check of storage arrangements for medications and all stocks contained within. All medications were found to be within the listed expiry dates and appropriately labeled with details of the resident for which the medication was prescribed. Cabinets were found to be locked and secure at the time of inspection.

A review of a sample of prescription and medication administration records for five residents found that two residents had not been administered medication which had been prescribed. In the case of one of these residents, a medication which had been prescribed for administration once daily was found not to have been administered on any of the 35 days leading up to the inspection. The person in charge later informed the inspectors that this medication had been discontinued for the resident locally, however, a review by the prescribing clinician was found not to have taken place as part of this decision. The inspectors found that in the case of another resident, a risk presented as a result of lack of clarity provided on a prescription. This risk was mitigated somewhat by the use of blister packs which had been prepared by a local pharmacy for use in the centre.

The inspectors found that capacity and risk assessments had not been completed for some residents with regards to the self-administration of medication.

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:
The inspectors found that some improvements had been made in strengthening the governance and management structures of the designated centre in the time since the previous inspection. These improvements remained at the early stages of implementation and as a result had minimal impact on the standard and quality of care and support being provided to residents.

In the time since the last inspection, three additional managers had been recruited to and were employed in the designated centre. This recruitment initiative formed part of an overall restructuring of designated centres across the services provided by Stewarts Care and in summary planned for an increase in number of smaller designated centres with an increase in managers and persons in charge. While this plan had not been implemented by the time of this inspection, some of the managers employed in the centre and who were met with by inspectors had been identified as future persons in charge in the restructured service plan. At the time of inspection, the increase in managers was found by the inspectors to provide strengthened governance in the centre along with clearer lines of accountability. Staff members spoken with by inspectors welcomed the new developments and stated that it had made a positive impact on the quality of care and support being delivered.

Managers met with by the inspectors were found to work a variety of shifts across all areas of the designated centre and were based in individual units. Managers were present for between 14 and 20 days each month and in their absence appointed shift leaders to take charge of each unit. In addition, an on-call manager support service was available to staff for outside of office hours and provided supports such as rostering, medical assistance, behavioural support, general advice etc.

An annual review for 2017 was found not to have been available at the time of inspection. An annual review for 2016 was available, however, in the absence of a completion date it was not clear if this was prepared in the previous 12 months.

Reports from unannounced six monthly visits by persons on behalf of the representative of the registered provider were made available to the inspectors. Four of the five units of the designated centre were found to have had unannounced six monthly visits completed in the six months prior to the date of inspection. These were completed on 08 January 2018, 18 December 2017, 13 November 2017 and 06 November 2017. One unit was found not to have a unannounced six monthly visit completed as required.

The inspectors found that the reports of the unannounced six monthly visits were not completed to a high standard. In total, across four completed unannounced visits, only one family member or representative of residents was consulted with by the author. Similarly, only three residents were consulted with regards to their experience of availing of the services of the centre. Action plans had been formulated as a result of the unannounced visit findings and the inspectors observed that some actions listed had been successfully completed while other actions remained ongoing. The inspectors found that concerns identified at the time of inspection were not raised as part of the unannounced visit process and as a result were not satisfied that the restructured management arrangements had resulted in sufficient oversight of the designated centre. In addition, there remained an absence of management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment:
Non Compliant - Moderate

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:
The inspectors found that in the time since the last inspection some improvements had been made in the stabilisation of the workforce in the designated centre. Despite this, areas of non-compliance with the regulations remained at the time of inspection.

Through discussions with staff members and with the person in charge, the inspectors found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services across the designated centre during day hours. In one unit of the centre concerns were identified with the numbers of staff deployed during night time hours. These concerns were brought to the attention of the person in charge and to the management team. Through a review of staff duty rosters and discussions held with the person in charge, the inspectors found that one unit of the designated centre regularly operated below their minimum staffing levels. This unit was found to operate below the stated minimum levels approximately one day per week.

Significant gaps were found in staff training in all mandatory training categories. 35 per cent of staff were found not to have completed training in safeguarding vulnerable persons, 16 per cent of staff had not completed training in children first, 14 per cent of staff had not completed training in fire safety, 55 per cent of staff had not completed a fire drill, 20 per cent of staff had not completed training in hand hygiene, 20 per cent of staff had not completed training in manual handling, and 22 per cent of staff had not completed training in break away techniques. The provider was aware of these deficits and had a plan of how these would be addressed.

The inspectors found that arrangements in place in the designated centre for the formal supervision of staff were not satisfactory. A review of supervision records for five staff members found that supervision meetings did not take place on a regular basis or on a quarterly basis as outlined as required in local organisational policy. Despite this, the inspectors found that informal supervision of staff had been significantly improved in the period since the last inspection. There were additional managers deployed to work in the centre and were based in individual units of where they worked with staff members on a regular basis. As part of their regulatory plan the provider informed HIQA they were

ensuring the competencies of their persons in charge were adequate and that they were receiving supervision prior to rolling out supervision to the staff which they line managed.

The inspector reviewed two staff files held in the designated centre and found that these were compliant with the requirements as set out 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.

The person in charge confirmed that no volunteers were employed in the designated centre in the time since the last inspection.

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:

Thomas Hogan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stewarts Care Limited
Centre ID:	OSV-0003899
Date of Inspection:	22 February 2018
Date of response:	04 May 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 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some areas of the designated centre required painting and decoration.

1. 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.

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

Please state the actions you have taken or are planning to take:
Regular maintenance audits shall be carried out to identify areas of work required. Where painting and decoration is required, requests shall be landesked for the attention of the Technical Services Department and shall be addressed. Regular visits by the Programme Manager will include a walk about the premises to identify any maintenance issues and ensure quality completion of issues.

Proposed Timescale: 31/12/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Furniture in one unit of the designated centre was observed by inspectors to have been worn and damaged.

2. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
Regular maintenance audits shall be carried out to identify areas of work required. Furniture that is worn and damaged shall be repaired or replaced. Regular visits by the Programme Manager will include a walk about the premises to identify any maintenance issues and ensure quality completion of issues.

Proposed Timescale: 01/05/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Four residents were found to be sharing two separate bedrooms at the time of inspection and these rooms did not provide adequate space and storage facilities for the personal use of these residents.

3. 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:
Residents shall be provided with rooms of their own with adequate space and storage for personal items.

Proposed Timescale: 01/05/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Incidents were found not to have been appropriately followed up on in a timely manner in order to mitigate risks to residents.

4. 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:
All follow up to incidents shall be recorded. Incidents shall be reported to the Programme Manager on a weekly basis to ensure appropriate follow up in a timely manner to prevent reoccurrence. Incidents shall be discussed at monthly team meetings to ensure shared learning. The risk management policy shall be reviewed to ensure that it guides practice.

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 inspectors found that no risk assessments had been completed for risks associated with fire at night time in the designated centre.

5. 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:
Environmental risk assessments shall be reviewed to ensure they adequately assess risk with fire at night time. A schedule of night time fire drills shall be established to ensure that all houses in the designated centre carry out deep sleep fire drills. All fire drills shall be reviewed by the responsible person and corrective measures put in place.

Proposed Timescale: 30/06/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. Emergency lighting was not in place in five separate areas of the designated centre all of which contained emergency fire exits.

2. One exit was found to have been locked at the time of inspection and did not have an emergency break glass unit in place with keys for the exit door.

3. In one unit of the centre an emergency fire exit was found not to have appropriate signage in place.

6. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
The maintenance department shall ensure that all emergency exits are highlighted on the floor plans and are appropriately lit in compliance with the Code of Practice.
Where emergency break glass units are required the maintenance department shall fit them in compliance with the Code of Practice.
Where sufficient signage is not in place, the maintenance department shall fit the signage.

Proposed Timescale: 22/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An internal fire door in one unit of the centre was observed be inspectors not to have been in full working order.

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

Please state the actions you have taken or are planning to take:
The fire door shall be repaired. Daily fire safety checks shall be carried out to identify any maintenance concerns and shall be actioned immediately.

Proposed Timescale: 01/05/2018

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:
1. Residents were observed not to be supported with some behaviours of concern.

2. The inspectors were not assured that the rights of residents were protected in the application of restrictions and restrictive practices in the designated centre.

8. 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:
Training on positive behaviour support and appropriate responses to behaviour of concern shall be provided to all staff by a team of psychologists and behaviour nurse specialists.
The restrictive practice policy shall be reviewed to ensure procedures protect the rights of the residents. Where a restrictive practice is implemented which infringes on a residents human rights, a referral can be submitted to the Human Rights Committee.

Proposed Timescale: 01/08/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. The inspectors found that residents had not been protected from experiencing abuse.

2. 27 incidents identified by inspectors were found not to have been recognised as potential abuse by the registered provider or managed in accordance with the 'Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures' document (HSE, 2014). In addition, 32 of the 53 incidents were found not to have been reported by the registered provider to HIQA as required.

9. 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:
All incidents of abuse shall be reported to the Designated Officer for screening under the Safeguarding Vulnerable Persons at Risk of Abuse Policy. Interim safeguarding plans shall be developed to ensure residents are protected from abuse. All staff shall attend the Raising Awareness of Safeguarding Vulnerable Persons at Risk of Abuse sessions. Suspicions or allegations of abuse shall be reported to the Health Information and Quality Authority as required.

Proposed Timescale: 30/06/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. The inspectors found that a range of healthcare needs identified such as anemia, constipation, hypothyroidism, coeliac disease, hepatitis B, and obsessive compulsive disorder did not have healthcare support plans in place for residents.

2. A review of healthcare support plans which were in place for residents by the inspectors found that these plans overall did not provide sufficient for staff on how to support individual residents achieve best possible health outcomes.

10. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
Where a healthcare need is identified, a care plan shall be developed and the need shall be met. All existing care plans shall be reviewed to ensure that they are effective and provide sufficient guidance to staff on how best to support the resident to achieve best possible outcomes.

Proposed Timescale: 30/05/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that residents were not facilitated with required reviews by allied health professionals in accordance with their needs.

11. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
All residents shall have a MDT facilitated by the Director of Nursing to review the personal support plan and identify the needs of the residents. Where needs are identified, these shall be met. Outside these MDT's, the person responsible shall facilitate reviews by allied health professional.

Proposed Timescale: 30/06/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that sufficient action had not been taken in the designated centre to ensure that residents were supported to buy, prepare and cook their own meals.

12. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
All houses shall be provided with a budget for household shopping. Weekly meetings shall take place where menus are chosen by the residents. Where residents express an interest in buying, preparing and cooking their own meals, this shall be facilitated. There shall be continuous promotion and encouragement for residents to buy, prepare and cook their own meals.

Proposed Timescale: 30/06/2018

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of dietary intake records of residents by inspectors found that one individual had the same main meal each day for six day period sampled. Inspectors were not assured that all reasonable action had been taken to ensure that the resident's dietary intake was wholesome and nutritious.

13. Action Required:
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

Please state the actions you have taken or are planning to take:
The dietician and the CNS behaviour shall liaise with the resident and staff to develop a plan to respond to the residents selectivity and ensure the residents nutritional needs are met. A programme to encourage a more balanced diet shall be put in place. This shall be subject to ongoing review by the dietitian.

Proposed Timescale: 01/05/2018

Outcome 12. Medication Management

Theme: Health and Development

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

Medications were not administered to two residents as prescribed.

14. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
All residents shall receive their medications as per their kardex. Where this does not happen, a drug recording error shall be recorded and reported to the Director of Nursing for learning purposes to prevent reoccurrence. Where medications are no longer required, kardexes shall be updated. These incidents shall be reviewed for learning purposes and prevent reoccurrence.

Proposed Timescale: 01/05/2018

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:
There remained an absence of management systems in place in in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

15. 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:
There shall be a manager in each house within the designated centre who shall be responsible for the day to day management and governance of the house. The manager shall report to the Programme Manager on a weekly basis. The Programme Manager shall carry out regular walk around visits and audits on progress.

Proposed Timescale: 30/05/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
An annual review for 2017 was found not to have been available at the time of inspection. An annual review for 2016 was available, however, in the absence of a completion date it was not clear if this was prepared in the previous 12 months.

16. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
An annual review of the care and support within the designated centre shall be carried out and made available to residents, family members and within the designated centre. The publication date shall be included in the review.

Proposed Timescale: 30/05/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
1. One unit of the designated centre was found not to have a unannounced six monthly visit completed as required.

2. The inspectors found that the reports of the unannounced six monthly visits were not completed to a high standard. Concerns identified at the time of inspection were not raised as part of the unannounced visit process and as a result were not satisfied that the restructured management arrangements had resulted in sufficient oversight of the designated centre.

17. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
1. All units in the designated centre shall have unannounced six monthly visits.
2. The HIQA Template shall be used to carry out the six-monthly visit. Findings of visits shall be discussed with the person in charge and programme manager in developing an action plan. The Chief Executive and the Director of Care shall receive monthly reports on findings and themes within the audits.

Proposed Timescale: 01/05/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

requirement in the following respect:
1. The inspectors found that appropriate staff numbers and skill mix was not in place in one unit of the designated centre to meet the assessed needs of residents and the safe delivery of services during night time hours.

2. One unit of the designated centre was found to operate below stated minimum staffing levels on approximately one day each week.

18. 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:
The person in charge, with the Workforce Planning Office, shall review the number of staff of the designated centre to ensure they are appropriate to the assessed needs of the residents. Where a deficit is identified, the Person in Charge shall submit a business case to the Director of Care and the staff needs shall be provided.
The person in charge shall plan rosters to ensure the staffing levels are maintained. Where there is a deficit in the staffing required, agency staff shall be utilised until the deficit can be filled.

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Significant gaps were found in staff training in all mandatory training categories.

19. 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:
An audit shall be carried out by the Training and Education Department. Where gaps are identified, staff shall be trained.

Proposed Timescale: 30/09/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors found that arrangements in place in the designated centre for the formal supervision of staff was not satisfactory.

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

Please state the actions you have taken or are planning to take:
The persons in charge shall provide formal supervision to all frontline staff on a quarterly basis or more frequent if required. The Programme Manager shall ensure that supervision is completed within the timeframe as per policy.

Proposed Timescale: 30/05/2018