## Centre name:
Adults Services Palmerstown Designated Centre 4

## Centre ID:
OSV-0003901

## Centre county:
Dublin 20

## Type of centre:
Health Act 2004 Section 38 Arrangement

## Registered provider:
Stewarts Care Limited

## Lead inspector:
Louise Renwick

## Support inspector(s):
Thomas Hogan

## Type of inspection
Unannounced

## Number of residents on the date of inspection:
18

## Number of vacancies on the date of inspection:
9
**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 2 day(s).

The inspection took place over the following dates and times

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

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<th>Outcome</th>
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Summary of findings from this inspection

Background to the inspection.

This was the fourth inspection of the designated centre, the purpose of which was to inform a registration renewal decision. The provider had been issued a notice of proposal to cancel and refuse registration in August 2017 due to high levels of non-compliance, the centre had been inspected again in December 2017 and significant failings had been identified during that inspection also. The aim of this inspection was to measure improvements, and verify the level of compliance with the Regulations.

How the inspectors gathered evidence.

The inspectors visited all units comprising the centre and spoke with 10 staff members during the two days of the inspection. Inspectors met with and observed 17 residents in their home environments over the two days of inspection. One resident was in hospital at the time of inspection, and there was one respite bed available during the two days. Inspectors also spoke with the person in charge, three local managers who were responsible for the individual units within the designated centre and a number of staff across each area.
Description of the centre.
Since the previous inspection, the provider had completed significant restructure works in the designated centre. Previously, the centre comprised of four units, two which had dormitory accommodation, one unit which had three self contained apartments and one bungalow. At this inspection, inspectors found the centre comprised of five apartments, one bungalow and two group living environments. These changes had occurred within the original buildings of the registered centre due to extensive buildings works undertaken by the provider. The centre was based on a campus in a suburban area of Dublin. There were 18 residents living in the centre on the day of inspection.

Overall judgement of findings.
Inspectors found that there were tangible improvements in the premises, which resulted in more positive living environments for residents in two units of the centre. The number of residents in two of the units had reduced which was having a positive impact, and allowed staff to have more time with residents due to increased ratios. These were two very obvious improvements in this centre since December 2017. While areas of non-compliance were identified on this inspection, inspectors acknowledged improvements across the outcomes since the previous inspection and were cognisant of the work of the management team in striving for improvement. For example, the levels of staff trained in key areas had increased since the last inspection, nurses had been assessed regarding competencies and given additional training in care planning and there was an improvement in the amount of information being recorded and quantified.

That being said, this inspection evidenced three major non compliances in the areas of workforce, governance and management and healthcare. A level of moderate non-compliance was identified in the area of residents' rights, dignity and consultation, safeguarding and safety, medication management and health and safety and risk management. Premises, which had previously been majorly non compliant were now substantially complaint with minor work needed to one apartment.

Overall, inspectors found some improvements in the level of compliance since the last inspection. However, the oversight of practice and the management and monitoring systems required significant improvement to ensure the service delivered was of good quality and in line with the Regulations and Standards and to effect tangible improvements in the lived experience of residents.

These findings are discussed in the body of the report and 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:
Since the previous inspection some improvements had been made to promote the privacy and dignity of residents and to protect their rights. However, further action was still needed in order for this outcome to be fully compliant with the Regulations and promote residents' rights.

Residents had all been given spacious private bedroom accommodation since the previous inspection. This was a significant improvement implemented by the provider and as such was allowing for more privacy and respect at times of personal and intimate care, and offered residents their own private space to spend time alone. Staff told inspectors that residents were sleeping better since this change, and the night time was more settled in the centre. Inspectors also found that in one unit of the centre practices of communal bed linen was no longer an issue, with residents having their own bed linen and towelling on the day of inspection.

In general, the inspectors observed that personal information was securely kept within residents' folders and private information in locked presses in the units of the designated centre. Information regarding daily personal care and support needs of residents was no longer found to be hanging on noticeboards or visible to visitors. Despite this, a review of incident, accident and near miss records identified that in the time since the last inspection, personal identifiable information relating to five residents availing of the service of the designated centre were found to have been inappropriately disposed of. This information was found by a third party and reported to the person in charge. This was not promoting the privacy of residents' personal information. This incident was
discussed with the staff team following the incident, to prevent a re-occurrence.

Interactions observed between staff and residents were warm and respectful throughout the inspection. Staff spoke to inspectors about the plan for the day, and informed inspectors that no plans would be made until residents were awake and had been consulted with. Staff in the apartments were encouraging all visitors to use the front door, and to ring the bell and wait for a response before entering. Along with these positive examples of improvement, some action were still in need of address. A female resident's bedroom had large window panes allowing clear view of her private bedroom from the corridor. The local manager had a short term plan to cover these windows with paper or art work. However, this was an issue previously in the centre and did not uphold the resident's privacy and dignity.

Some residents were cared for in a one to one, or two to one capacity. For two female residents with complex support needs there was a high number of shifts covered by male staff members, often agency staff members. These residents' intimate care plans indicated that supports were needed regarding female personal care. The provider was not ensuring the staffing was suitable and promoting the dignity of residents. This issues had been raised at a recent multidisciplinary team meeting. At the time of the inspection, the provider was actively recruiting new staff members in an effort to address this issue.

A review of a sample of resident finance records found that in the case of one resident who required full support in managing their finances inspectors found expenditure included toll bridge charges and parking charges. Similar findings were identified in the cases of two other residents and a total value of €22.10 was calculated as having been inappropriately spent from the three resident accounts. Assurances were provided by a senior manager that the accounts reviewed by the inspectors would be reimbursed for the amounts identified. One resident was found to have been supported by the staff and management team to open a personal bank account which was a positive step. However, the inspectors found that despite the many benefits this offered to the resident in question, the expected safeguards around this arrangement were not in place to ensure appropriate oversight of spending.

Overall, inspectors found that significant improvements had been made in providing private accommodation for residents, the use of personal bedding and towelling and the approach to promoting residents' rights, but some areas were still in need of address.

Judgment:
Non Compliant - Moderate

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

**Findings:**
Inspectors noted significant improvements overall in the provision of safe and suitable premises.

Since the previous inspection, the provider had undertaken refurbishment works in two of the units which had positively enhanced the living environment for residents. In these units each resident now had a private bedroom available, as well as improved communal areas. Laundry facilities were now available in these units, and some residents told inspectors that they really liked their new rooms and the changes to the centre overall. These two units were bright and airy, well decorated and offered residents a comfortable, clean place to live. Staff told inspectors that residents were sleeping better since the works were completed with less disturbance during the night due to private accommodation.

One unit had been reconstructed to consist of three apartments, and this had been in place at the time of the last inspection. These apartments were within a larger building that housed offices for staff employed by the provider. Inspectors saw that these apartments had been personalised and decorated as well as it was possible to promote a homely environment. These apartments provided temporary living environments for three residents, the purpose of which was to allow residents to experience living alone with increased staffing support with the aim of moving out into the wider community in the future. Inspectors found that these apartments were suitable for this temporary purpose.

The fourth unit of this centre had recently improved their garden area, with an accessible patio and seating area to the rear of the bungalow, and wheelchair accessible pathway around the garden. Staff informed inspectors that this had been gifted to the centre by family members and residents were enjoying the new garden area.

During the course of the inspection, inspectors were informed of a fourth apartment that was currently in use, and deemed as part of the original designated centre. Inspectors viewed this apartment, which was currently in use by a resident from a different designated centre, supported by a different staff team. This resident was asleep at the time and as such inspectors did not view the private accommodation or bathroom facilities available. However, inspectors did find that the apartment had not been adequately furnished, and rooms had not been arranged to provide adequate living space. For example, the living room had not yet been set up, and the living space consisted of a one room kitchen, dining, living room. Inspectors noted that this apartment had been in use for a number of weeks, and in its current format it did not fully meet the requirements of Regulation 17.
**Judgment:**
Substantially Compliant

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**Outcome 07: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Effective Services

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

**Findings:**
Inspectors found that the policies, procedures and practices for the identification, assessment and management of risk were poor, and not fully promoting the health and safety of residents, staff and visitors.

Inspectors reviewed the risk management policies and spoke with management and staff and reviewed a number of risk assessments. Inspectors found that policies were out of date and in need of review. While the policy content was good it was not followed in practice in the organisation.

The provider was aware of the poor and inconsistent risk management practices, and was in the process of creating a new risk role within the organisation as a way to address this. However, risk as a part of the day to day life of residents was in need of review locally. On the day of inspection inspectors did not find that residents living in this centre were exposed to high levels of risk. However, in the absence of effective systems and oversight there was potential for the safety of residents, staff and visitors to be compromised.

Risk management was seen as a separate part of the monitoring and oversight of this centre, and as such there was a disjointed approach to the review of practice including adverse events, and the management of risk. While there was a system for recording accidents, incidents and adverse events, improvements were still required regarding the review of adverse events and learning gained. The review of adverse events and their analysis was not done in a risk based proactive manner in line with policy and best practice. The inspectors were told a new form was being introduced the week of inspection which sought evidence that the local manager had identified actions to be taken following individual incidents or adverse events.

While some units had a "risk register" listing risks that were managed such as fire, choking and use of aids, these registers were not comprehensive and were not a true reflection of all known risks and their control measures. Some local managers had completed risk assessments on behalf of residents that were of a good standard and guided safe care and support. However, this was not consistent across all areas and for all known risks. Where risks had been identified and assessed, the deficits in staffing in
some units of the centre was resulting in some of the control measures to alleviate risks not being in place. For example, on the day of inspection a resident who required two staff did not have this in place. Overall, inspectors were not assured that the system to identify and manage all risks was robust.

Inspectors reviewed the fire safety systems in place and found that there was an adequate detection and alarm system in place. This was evidenced as being checked and serviced regularly and residents were supported to practice fire drills. Response times to drills were good and action had been taken when areas for improvement were noted. The buildings were equipped with fire fighting equipment and fire doors were in place.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
While there was evidence of some improvements in the area of safeguarding and protection of residents there remained shortcomings and, as a result, the systems in place did not fully ensure that all residents were in receipt of a safe service. The inspectors found that measures in place in the designated centre did not protect residents from experiencing harm.

A review of incident, accident and near miss records for the period of December 2017 to March 2018 (inclusive) found that a total of 70 incident records were logged. Five of the incidents recorded were found by the inspectors to meet the definitions of alleged abuse. Three of these incidents were found to have been managed in accordance with the Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014) document; however, two incidents were found not to have been. In addition, only one of the five incidents had been reported to HIQA as required. The inspectors were not assured that the systems in place for the recording of follow up to such incidents was effective or reliable. Discrepancies were identified in registers maintained in the centre when incident, accident and near miss records were compared.
to safeguarding logs.

The inspectors spoke with four staff members with regards to safeguarding and protection of residents and found that overall, there was evidence of improvements in staff knowledge in this area. Despite this, one staff member spoken with did not know what to do in the event of witnessing or suspecting the abuse of a resident. In addition, the staff member confirmed that they had never completed training in the area of safeguarding vulnerable adults and could not identify who the designated safeguarding officer was for the area. The provider was working on increasing the amount of staff who had completed training in the area of safeguarding, and while this inspection showed a greater number of staff had been trained, there was still a number of staff that required this.

A review of a sample of safeguarding plans in place in the designated centre found that some were of a poor standard and provided limited guidance for the reader on how to safeguard the residents concerned. In the case of two plans, when asked what specific safeguarding actions are being taken, the document states to "...follow the safeguarding plan...", i.e. the safeguarding plan was referring to itself and providing no supportive guidance in addition to this.

There were a number of residents living in the centre who had additional supports needs regarding their behaviour. On review of documentation, inspectors found that there were policies in place for the provision of behaviour support, and the use of restrictive interventions. Inspectors found that the policy on the provision of positive behaviour support was in need of review and updating. Inspectors found that while there was evidence of some good practice regarding supporting residents with these additional needs, overall there was an inconsistent approach to the supports available. For example, some residents had behaviour support plans or behaviour support guidelines from 2017, and others had "reactive strategies" to guide staff on how to de-escalate a situation. Some residents were linked in with a psychologist and others had only recently been referred and were awaiting appointments. While the content in the plans and strategies were satisfactory, the advice could not be consistently followed with the current staffing issues. For example, the provision of familiar staff, or two staff on duty from 0800 to 2130. Inspectors determined that additional multidisciplinary supports were also required to ensure a holistic approach. For example, occupational therapy to assist the staff team in the delivery of sensory based activities, and speech and language therapy for assistance with communication.

Overall, the approach to the management of behaviours that challenged required improvement both in the policies and procedures as well as the practical supports and plans for residents. Inspectors met a clinical nurse specialist in behaviour support who was recently employed by the provider who discussed the plan with inspectors for updating both policies within a framework of holistic support for residents who present with behaviour that can be challenging for the service. A new referral process was also planned along with training for staff in the area of supporting residents proactively and positively. These changes would positively affect residents who were being supported with behaviours regarding their contact with the clinical team, their care planning and review and oversight of the supports by the clinical team.
While some restrictions had reduced since the last inspection, there remained use of environmental and physical restraints in the centre and use of psychotropic medication in the management of behaviours. Inspectors found that clear catalogues reflective of all restrictive practices in use in the designated centre were not maintained, nor clear evidence of alternative measures tried. For example, locked exit doors even when residents had two staff to support them on a daily basis and no evidence of alternatives tried that were less restrictive.

**Judgment:**
Non Compliant - Moderate

### 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:**
The inspectors were not assured that residents were adequately supported to achieve, sustain and enjoy the best possible health. Areas of significant regulatory improvement were identified at the time of inspection.

A review of daily fluid and nutritional intake for a sample of residents identified a number of concerns. In the case of one resident, a minimum daily fluid intake of 1,700 milliliters was assessed as being required; however, on two sample dates of records viewed by the inspectors the resident had a total intake of 1,300 milliliters on one occasion and only 800 milliliters on another occasion. With regards to nutritional intake, on one day the resident had only one meal recorded in a 24 hour period. In the case of another resident who was described by a staff nurse as being "at risk of weight loss", a review of a sample daily intake found that in one 24 hour period a total intake of 1,100 milliliters were recorded and the resident had no dietary intake recorded after their lunch until the next morning.

In the case of a resident who had percutaneous endoscopic gastronomy feeding system in place, the inspectors found that conflicting recommendations were in place on the resident's file with regards to daily hydration requirements. A 'hydration assessment' on file (dated October 2017) stated a requirement of 2,202 milliliters in a 24 hour period for this resident; however, a review of a sample of four dates found that on none of these occasions was it recorded that the resident received the required amount. An 'enteral feeding regimen' on file (dated April 2018) indicated a requirement for 700 milliliters of feed and 1,000 milliliters of flushes in a 24 hour period. When these recommendations
were compared to the sample dates it was found that the resident received the recommended amount on three of the four dates reviewed by the inspectors. The inspectors requested immediate assurances from the registered provider regarding these findings and the acting director of nursing met with the inspectors at the time of the inspection and stated that they were fully assured that the residents in question were in receipt of sufficient fluid and dietary intake.

While the person in charge assured inspectors that residents' needs and risks in relation to food and fluid was well managed, given the risk associated with this, the repeated non-compliance in this area and the focus on nutritional risk highlighted in the provider's own assurance reporting mechanisms, this was a concern. A stronger recording and checking system was required to clearly evidence that residents' needs and daily requirements were being consistently met and monitored, and the most up-to-date advice was being followed by staff.

A review of wider healthcare provisions found that residents generally had good access to medical practitioners. All residents availing of the services of the designated centre had been seen by a medical practitioner within the 12 months preceding the inspection as part of an 'annual medical review'. Despite this, five residents did not have an internal health check list completed by members of the staff team. There was evidence of some improvement in access to allied health professionals in the time since the last inspection. 'Multidisciplinary meetings' were taking place on a regular basis and additional allied health professionals were recruited to the service to strengthen the range of supports available.

Staff members spoken with demonstrated improved knowledge of the healthcare needs of residents and responses to emergency healthcare scenarios involving medical conditions of residents in their care. Despite this, a review of healthcare support plans in place found that some identified healthcare needs such as psychosis, epilepsy, and constipation did not have plans in place to guide staff. In cases of healthcare needs which did have plans in place, these were found not to satisfactorily guide staff practice. For example, in the case of a resident with an identified healthcare need of bronchitis, a review of the support plan in place by the inspectors found that it did not include any long term management or support strategies for this condition. The plans in place were found to be sources of definitions of the associated conditions or healthcare needs and did not outline how residents were to be supported to achieve and maintain the best possible health outcome.

**Judgment:**
Non Compliant - Major

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**Outcome 12. Medication Management**

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The inspectors found that while there were improvements noted in the area of medication management in the time since the last inspection significant non-compliances were identified as part of this inspection.

A review of a sample of prescriptions and medication administration records was completed by the inspectors and it was found that in the case of one resident a medication prescribed to have been administered on four occasions daily had not been administered on three of the four occasions on the day prior to this inspection. In addition, a medication error was identified by the inspectors for this resident which the management team had not previously been aware of. A medication prescribed for night time administration had been recorded as having been administered in the morning time and the morning time medication was not recorded as having been administered. Similar findings were identified at the time of the last inspection.

Staff members spoken with demonstrated appropriate knowledge and awareness of the actions to taken in response to a medication error. A review of medication errors found that two were recorded as having occurred in the timeframe since the last inspection. While in one instance, a medication error was found to be a significant risk to a resident involved, there was evidence of learning from this event and measures had been taken to minimise the likelihood of reoccurrence.

The inspectors reviewed medication storage arrangements and found that they were secure. A sample of medications contained within drug presses and trollies were checked and found to be within the listed expiry dates.

A review of documents relating to the self-administration of medication by residents was completed by the inspectors. Only seven residents were found to have capacity assessments completed at the time of this inspection.

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:**
While the provider had brought about significant and positive changes in relation to the physical living environment for residents, there remain on-going barriers to the provider's ability to bring about compliance with the Regulations overall, to result in positive and consistent changes in the quality of the care and support being offered to and experienced by residents.

In the five months since the previous inspection, progress in relation to improving the key areas of the management of risk, the review of incidents and safeguarding measures, medication management and staffing and resources was not sufficient. There remained non-compliances in these areas as evidenced in this report. While there was stronger management structures in place and an emergence of improved processes and systems, there remained an absence of strong and effective management systems to deliver a good service in line with Regulations.

There was a stronger management structure in place with all three units of the centre having an appointed local manager to oversee the care and support being provided. These three local managers reported to the overall person in charge. While this was an improved structure, the staffing issues and wider organisational management systems did not empower local managers to be fully accountable, and to bring about positive changes in the lived experience of residents.

The provider had not ensured that adequate staffing resources were in place across all units of the designated centre and this was impacting on the three managers ability to lead and manage their individual units. Staffing deficits resulted in managers needing to cover front line shifts themselves. Over the two days of inspection, all three managers were involved in covering front line staffing deficits. Until the provider had more stable and stronger staff teams in place, it would remain a challenge for all persons managing the centre overall to bring about tangible improvements, and fully implement proposed plans and changes for compliance. At the time of the inspection, the provider had begun an active recruitment campaign in order to address the staffing deficits in the centre. Some candidates had been successful and were going through the recruitment process.

While inspectors appreciated that the provider had drastically improved the environment in two of the units inspectors were not assured that the centre was being operated in line with its statement of purpose and function, with a clearly defined focus and foresight. Granted, the campus was in the process of change, however on the day of inspection, one part of the designated centre was being used as an apartment. Inspectors viewed parts of this apartment during the inspection, and found a resident from a different designated centre was asleep in bed at the time and was being supported in this apartment by day services staff. It was not clear on the day of inspection who was responsible for the management of one of the apartments. In
discussing this with the management team, inspectors found that it had not yet been clearly decided who this apartment would serve or who would be responsible for its management. The wider management team had plans for the apartment, but it had not been described in the statement of purpose and the responsibility of its management had not been decided.

The provider had conducted an annual review in 2017 inclusive of all services and facilities offered by the provider. However, information in relation to this designated centre was inclusive of two pages, and did not fully comment on the quality and safety of care and support on offer. There was an improvement to the systems of carrying out unannounced visits to the centre, with the assistance of an external auditor. That being said, some of the units had not been reviewed in the previous six months. For example, one unit last had an unannounced visit in July 2017. On review of two concurrent unannounced visits, inspectors found that some of the same issues arose, and had not been adequately addressed. For example, the creation of a daytime and night time evacuation plan was identified as required in an unannounced audit in Dec 2017, and again in March 2018.

Overall, inspectors acknowledged that the provider and management team had been working on improving processes and systems and in strengthening the monitoring and oversight of the care and support in the designated centre. However, consistent and strong oversight and governance was not yet in place, and tangible improvements across critical key areas had not yet been achieved to improve the quality of life and lived experience of residents.

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:
The number of skill mix of staff was not appropriate to meet the needs of residents and was still in need of address by the provider.
Due to the high number of vacant posts, the use of agency staffing was high. This was impacting on the provider's ability to ensure a stable staff team in all units and continuity of care to residents. Some agency staff had very limited knowledge on the day of inspection about the care and support needs of the residents in their care. While inspectors accept that the process of recruitment can take time, at the last inspection in December 2017 the provider had outlined that a recruitment process for social care workers was underway. On this inspection, inspectors found staffing was still an ongoing issue for this centre, with over 12 vacancies needing to be filled at the time of report writing. This had a direct impact on the oversight and management of the units, with three local persons in charge working on the roster during the inspection to cover the deficits in nursing and care staff.

Even with the interim measure of agency staffing inspectors found that on the day of inspection, two of the units in the centre was operating below the minimum amount of staffing that had been identified as required.

One unit had a stable and consistent staff team, with the addition of a daily agency staff to work one to one with a resident with dementia. The suitability of an unfamiliar and often different agency staff working with a resident with dementia had not been considered. However, staff in the unit took measures themselves to swap with agency staff for periods of the day to support the resident. On the day of inspection the local manager of this unit was required to cover the nursing care in another area that they were responsible for due to staffing issues there.

The issue with staffing was resulting in residents' daily routines being affected, and opportunities to go out into the community. For example, for one resident this could mean not leaving the apartment for the day, as two staff were required to support social outings. As previously mentioned, the provider had begun a recruitment campaign in order to address the staffing deficits in the designated centre.

Staffing rosters of the planned hours and actual hours worked were not adequately maintained. This resulted in it being unclear what staff worked in what location on a given date. Inspectors also noted there was still a reliance on the campus model to deal with staffing by transferring staff between units and centres to cover staffing deficits.

While improvement had been made in the number of staff trained in mandatory areas, gaps were still identified in the provision of mandatory training for staff as not all staff had completed training in the areas of safeguarding vulnerable persons, fire safety, manual handling, the management of aggressive behaviour or hand hygiene.

As part of the assurance reporting mechanisms submitted to the Chief Inspector, the provider had committed to completing competency assessments on staff nurses, care staff and persons in charge within the service. While all nursing staff had been assessed and plans put in place to support any areas in need of address, care staff in this centre had not been assessed at the time of the inspection. Similarly, a robust supervision system had not been implemented to ensure all staff were appropriately supervised in line with the assurance report given to the Chief Inspector.
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:

Louise Renwick
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003901</td>
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<tr>
<td>Date of Inspection:</td>
<td>23 and 24 May 2018</td>
</tr>
<tr>
<td>Date of response:</td>
<td>17 August 2018</td>
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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:

The provider had not ensured that female residents' dignity was respected through the provision of intimate care with the current staffing in place.

The provider had not ensured the living environment promoted privacy for all residents, or that personal information had been securely maintained or disposed of.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The provider had not ensured residents' rights were fully upheld in relation to their day to day spendings.

1. **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:**
a. A recruitment campaign has commenced targeting staff with particular areas of expertise. This recruitment campaign will continue to run until the vacancies in the area are filled. Complete by 30/09/2018

b. The windows in the apartment shall be covered with coloured adhesive to restrict view from the corridor of the resident’s apartment. Complete by 08/08/2018

c. The appropriate disposal of confidential information has been highlighted to staff. Complete by 31/01/2018

d. Residents have been provided with Contracts of Care which detail the charges incurred by residents. A procedure has been agreed detailing the waiver process. The Finance Policy shall be reviewed to ensure staff have clear guidance on charges incurred by residents. Complete by 30/09/2018

**Proposed Timescale:** 30/09/2018

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**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 provider was not providing an adequate living environment for residents in the fourth apartment, and had not met the requirements of Schedule 6.

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

**Please state the actions you have taken or are planning to take:**
The apartment shall be furnished to meet the requirements of Schedule 6

**Proposed Timescale:** 08/08/2018
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:
There was an absence of a robust system in place for the identification, assessment and management of risk overall.

3. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

a. An external review of risk management processes within the organisation shall take place. Complete by 30/09/18

b. All local managers shall be trained on the identification, assessment and management of risk. Complete by 31/12/2018

c. The Risk Management Policy shall be reviewed. Complete by 30/09/2018

d. A Head of Risk and Quality shall be appointed to oversee risk within the designated centre and the organisation. Complete by 13/09/2018

Proposed Timescale: 31/12/2018

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 have up to date knowledge and skills to positively support residents who manage their behaviour.

4. 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:
All staff supporting residents who present with behaviours of concern shall receive training on how to support these residents.

Proposed Timescale: 30/09/2018
**Theme:** Safe Services

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

It was not evident that alternatives had been considered and trialled in place of restrictive interventions, and that all restrictions were used for the least duration possible.

5. **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:**

A Review of the restrictive protocol shall take place by the Restrictive Practice Committee to ensure that all alternatives have been trialled.

**Proposed Timescale:** 31/08/2018

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**Theme:** Safe Services

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

The provider had failed to ensure effective and consistent safeguarding systems were in place to protect all residents from harm.

6. **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 will be reviewed to ensure that safeguarding systems are effective and consistent. Safeguarding systems will be reviewed as part of an organisational review of risk management processes.

**Proposed Timescale:** 31/10/2018

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**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Some identified healthcare needs did not have plans in place to guide staff. Some healthcare plans in place, were found not to satisfactorily guide staff practice.

7. **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:**
Health care plans will be updated to ensure they guide staff practice.

**Proposed Timescale:** 31/10/2018

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge could not demonstrate that all residents with specific limits in relation to their food and fluid intake received adequate amounts in line with their own individual needs and plans.

**8. Action Required:**
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident’s individual dietary needs and preferences.

**Please state the actions you have taken or are planning to take:**
The Hydration and Nutrition Policy will be reviewed. All nurses will attend MUST training. All residents will have a MUST assessment completed. Following this only individuals where food record charts will be maintained in these areas will be:
- a) MUST 2 and MUST 1
- b) Metabolic diets – to monitor exchanges/day and prescribed protein free products.

All residents with MUST 1 or 2 will be referred to the dietician.

**Proposed Timescale:** 30/08/2018

**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:**
Medicine had not been administered as prescribed for a resident.

**9. 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:
Where medication is found to not have been administered, the pathway for responding to medication errors shall be followed, including, ensuring medical advice is sought and followed, the incident is reported on the National Incident Management System and to the Director of Nursing for performance monitoring.

**Proposed Timescale:** 15/08/2018

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents had been assessed in relation to their ability to self administer medicine.

10. **Action Required:**
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
All residents will be assessed to administer their medication.

**Proposed Timescale:** 30/08/2018

**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:
Management systems and oversight had not been sufficiently strengthened to ensure the service delivered was of good quality, safe, in line with residents' needs and meeting the requirements of the Regulations.

11. **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:
Management systems will continue to be reviewed to ensure they are sufficiently robust to ensure good governance. This shall include; regular executive management and care management meetings; reviewing and training on the supervision process to ensure that it addresses staff underperformance; outsourcing registered provider audits to ensure that they are independent; ensuring all responsible persons have a
management qualification and carrying out competency assessments with all staff.

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The number of staff working in the centre was inadequate, and the provider had not ensured all shifts were covered where there were gaps on the staffing roster.

#### 12. **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 required staffing complement has been reviewed. A recruitment campaign is ongoing to fill vacant positions. In the interim, agency staff are used to fill gaps on the roster. A protocol has been developed for booking of agency staff. This has been communicated to all local managers and is being monitored by the Workforce Planning Manager.

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**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Planned and actual rosters were not well maintained and did not clearly show who was on duty on a given day.

#### 13. **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:**
All local managers shall be instructed to maintain actual planned and actual rosters for their area on a given day.

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<th>Proposed Timescale: 08/08/2018</th>
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**Theme:** Responsive Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in required fields.

14. 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 take place of training needs within the designated centre. Where staff are identified as needing training, they will be trained.

Proposed Timescale: 30/08/2018
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A robust system of supervision across all units had not been achieved.

15. 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 supervision process will be reviewed to ensure it is robust. Monitoring of the supervision process will take place to ensure it is consistent across the designated centre.

Proposed Timescale: 30/09/2018