

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Pleasure Hill House
Centre ID:	OSV-0004337
Centre county:	Louth
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Company Limited By Guarantee
Provider Nominee:	Declan Moore
Lead inspector:	Jillian Connolly
Support inspector(s):	Andrew Mooney
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 12 October 2017 09:30 To: 12 October 2017 17:00

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

Outcome 05: Social Care Needs
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 the third inspection of the centre. The inspection, prior to this, was conducted in January 2017 following an application by the provider to register the centre under the Health Act 2007. Compliance was identified with the regulations at this time and the purpose of this inspection was to identify if the provider had sustained the quality and safety of care provided.

How we gathered our evidence:

As part of this inspection, the inspector met with four residents. The inspector also met with staff, observed practices and reviewed documentation such as residents' personal plans, health and safety documentation and audits. Residents, management and staff facilitated the inspection.

Description of the service:

The designated centre is one house located in Co. Louth. Services were provided to male and female residents over the age of 18. The centre is operated by St. John of God Community Services Limited.

Overall findings:

Residents were observed to be comfortable within their home and staff were observed to engage with residents in a respectful and dignified manner. Residents

told the inspector that they were very happy with their home and how they were supported. Staff were observed to be knowledgeable of the needs of residents.

Overall, the inspector found that the health care needs of residents were met. However, work was required to ensure that residents had a comprehensive assessment of need to ensure that the supports were in place to meet their social care needs. There had also been a change to the risk management systems in the house. As a result, certain risks within the centre had not been adequately assessed.

Within this report, the inspection findings are presented under the relevant outcome. The action plan at the end of the report sets out the failings identified during the inspection and the action required by the provider to comply with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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 05: Social Care Needs

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were supported to engage in activities. However, the supports they required to ensure that their social care needs were met were not clearly identifiable and consistently provided. This resulted in an inconsistent approach to the opportunities residents had to maximise their personal development.

The inspector reviewed a sample of personal plans and found that there was a comprehensive assessment of the health care needs of residents. There was also a clear plan of care in place to meet identified needs. There was a tool in place for the assessment of residents' social care needs. Goals had been identified for residents' to achieve on an annual basis. However, the assessment was not consistently reviewed on an annual basis. Therefore, changes in need were not identified and personal plans were not reviewed in line with that change. For example, it was identified that a resident needed to move to a house which was more suited to their needs in June 2016. There was no information available in the personal plan to identify the supports that they may require for this to happen. The inspector was told by management that this was no longer a need. However, as there had been no review of the assessment, this was not reflected in the personal plan of the resident. The inspector found that the goals identified for residents were primarily one off, short term activities such as going to the cinema or on a day trip and not linked with the assessment of need. If a goal was achieved, there was no review of the effectiveness of the goal in the context of the residents' identified needs.

The inspector found that there were barriers for some residents in accessing community amenities. There was an absence of holistic supports in place identified to overcome

those barriers.

The inspector found that the impact of these deficits in the personal planning process resulted in an inequity in opportunities that residents had to engage in meaningful activities. On the day of inspection, the inspector observed some residents to be very active such as completing the shopping for the house or going swimming. However, there was one resident who engaged in very little activity and what was available was passive such as going for a walk. A review of daily records confirmed that this was an accurate reflection of the standard practice within the house.

Allied health professionals were involved in the assessment of residents' clinical needs and their recommendations were incorporated into the personal plans of residents.

Families were kept informed of the well being of their loved ones and attended circle of support meetings which aimed at reviewing the personal plan of the resident. However, these reviews did not consider the effectiveness of the personal plan.

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):

No actions were required from the previous inspection.

Findings:

The provider had systems in place which aimed to promote the health and safety of residents, visitors and staff. However, these systems were not consistently implemented in line with the policy of the organisation and did not identify all of the risks within the centre. Therefore, it was not clear if the control measures in place was effective in reducing the risk to individuals.

There was a centre specific safety statement, risk management policy and risk register. The risk register provided an overview of the individual risks to residents. The policy of the organisation was that if a risk was unacceptable, control measures were required to be reviewed to identify if they reduced the level of risk. However, this was not consistently occurring in practice. For example, it was identified that the risk of a resident engaging in inappropriate behaviour was unacceptable. Control measures had been identified but had not been reviewed to see if they reduced the risk. The inspector also found that assessments for known risks to residents were not reviewed following an adverse event, such as a fall. However, the inspector found that if an adverse event occurred the appropriate immediate action was taken. There was also an absence of

oversight of the clinical and operational risks in the centre. The inspector was verbally informed of risks such as the requirement to keep the entrance gate closed and the decision to not fill staff gaps in the roster with unfamiliar staff due to the needs of the residents. However, these risk based decisions were not supported by a robust assessment. Assessments for the supports needed to evacuate residents in the event of the fire did not include their medication, which had associated risks.

The inspector identified an adverse event which had not been reported through the system of the provider. Therefore, it was not clear if the appropriate action had been taken. The inspector requested that the provider review this and the provider confirmed, the day after the inspection, that it was being reviewed by the appropriate professionals.

The inspector observed the centre to be clean and there were procedures in place to ensure that this was standard practice.

There were fire management systems available in the centre. There was an emergency plan in place and measures such as 'a grab bag' to ensure that staff had access to relevant resources, if required. Staff informed the inspector of the housekeeping practices such as unplugging electrical items at night. The house had a fire alarm, fire extinguishers and emergency lighting. Records demonstrated that they were serviced at appropriate intervals by external contractors. The provider had also installed fire doors and self closers in pertinent locations. Staff had received training in the prevention and management of fire. Staff were aware of the procedure to be followed in the event of a fire. Fire drills had occurred and considered the lowest compliment of staffing.

Judgment:

Substantially Compliant

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The inspector observed residents to be comfortable within their environment and in the presence of staff. Staff had received training in the prevention and response to abuse. There were also policies and procedures in place to support this training.

The supports residents required to ensure their intimate care needs were met were documented in their personal plans.

Positive behaviour support was required in the centre. The inspector found that effectiveness of the supports provided were not reviewed to assess if all efforts were made to identify and alleviate the cause of a resident's behaviour. For example, residents had plans in place which had been developed by the appropriate allied health professionals. Some plans had not been reviewed in the 12 months prior to the inspection. There were key behaviours identified in these plans which were aimed to be reduced. The inspector found that there was insufficient documentation maintained, if these behaviours were exhibited, to identify if all efforts had been made to identify and alleviate the cause of residents behaviour.

Restrictive practices were applied in the centre. They were supported by the appropriate assessment and reviewed by the organisation's committee. Each time they were applied, a record was maintained to demonstrate that it was the least restrictive practice and applied for the shortest duration of time.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found that the health and well being of residents was promoted in the centre. This was supported by an assessment of their healthcare needs.

Residents had regular access to their General Practitioner (GP) and a variety of health care professionals if required. This included psychiatry, occupational therapy and physiotherapy. Residents were also supported to attend the optician, dentist and chiropodist.

The inspector found that staff were knowledgeable of the supports to be provided to residents.

The menu was planned on a weekly basis and the inspector found that it was varied. The inspector observed the centre to have plenty of fresh produce. Residents were

assessed by the relevant allied health professionals for their nutritional needs. Staff were aware of the supports residents required. Residents were supported to have their weight monitored at appropriate intervals.

The inspector found that residents' wishes in respect of their end of life care had been recorded.

Judgment:
Compliant

Outcome 12. Medication Management

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

Theme:
Health and Development

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

Findings:

There were policies and procedures in place which promoted safe medication management practices. Medication was stored in a secure location.

The inspector reviewed a sample of prescription records and found that they contained all of the necessary information. This included the name and date of birth of the resident, the name of medication, the dose to be administered and the times in which they were to be administered. A sample of administration records demonstrated that they were administered at the time prescribed. The maximum dosage for PRN medicines (medicines only taken as the need arises) was stated. There was supporting guidance in place for the circumstances in which PRN could be administered.

There was a system in place for the receipt and return of medication from the pharmacy.

Residents had been assessed for their ability to self administer medication.

Judgment:
Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure

that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

There were systems in place for the oversight of the care and support provided to residents.

There was a clear management structure in place. The frontline manager of the centre held the post of clinical nurse manager 1. They reported to the person in charge and had the responsibility for 3 designated centres. The person in charge held the post of clinical manager 3 and had the responsibility for four designated centres. They had commenced their role in the centre two weeks prior to the inspection. Inspectors confirmed that they met the requirements of the regulations. The person in charge reported to the director of care and support who reported to the regional director. The regional director was the contact person for HIQA. There were clear reporting structures in place in which each of the pre mentioned met to review the operation of the centre.

The inspector found that the provider had suite of audits in place, which were conducted in the centre. This included areas such as fire safety, medication and personal plans. There had also been unannounced visits conducted by the provider and reports generated from these visits. The centre had a quality enhancement plan in place. The purpose of this was to compile all of the actions arising from audits, the unannounced visit by the provider and HIQA inspections. The inspector found that any actions arising from the audits were addressed or in the process of being addressed. However, the plan was primarily document focused and did not identify if the systems in place were effective and resulted in a positive outcome for residents. For example, it identified that assessments need to be updated but not if the assessments identified all residents needs and the supports they required. Fundamentally, they did not identify if the systems resulted in positive outcomes for residents.

There had been an annual review of the quality and safety of care in the centre. This included the views of residents and/or their representatives.

Judgment:

Substantially Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff

have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

The inspector observed that there were sufficient staff on duty on the day of inspection. At the commencement of the inspection, inspectors were informed that three staff were required during the day and one staff at night to meet the needs of residents. However, the number of staff identified in the Statement of Purpose was insufficient to ensure that these staffing levels could be maintained. As a result, relief staff were required at times. The inspector was informed that management made the decision, at times, to reduce the staffing levels as opposed to utilising unfamiliar staff. Therefore there was not always sufficient staff to ensure that the social care needs of residents could be met.

The inspector was provided with a copy of the training records and found that staff had completed all mandatory training such as manual handling.

Staff received formal supervision on a regular basis. Team meetings also occurred which were used as a forum for communication, review and learning.

The inspector did not review staff files on this inspection.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jillian Connolly
Inspector of Social Services

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Company Limited By Guarantee
Centre ID:	OSV-0004337
Date of Inspection:	12 October 2017
Date of response:	07 November 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

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

Personal plans did not consistently identify the supports that residents required to maximize their development.

1. Action Required:

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

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

1. Personal plans will be reviewed to ensure that supports, required to address the identified goals, are clearly identified and documented.

Proposed Timescale: 14/12/2017

Theme: Effective Services

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

The assessment of need was not consistently reviewed following a change in need.

2. Action Required:

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

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

1. All social goal assessments of need will be reviewed and interventions evaluated to ensure that they are addressing the current needs of the resident.

2. Going forward, as residents' needs and circumstances change, social goal assessments/reviews will document the changes and identify how those changed needs will now be addressed.

Proposed Timescale:

1. 14/12/17
2. 30/06/18

Proposed Timescale: 30/06/2018

Theme: Effective Services

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

Reviews of personal plans did not consistently identify the effectiveness of interventions.

3. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1. The effectiveness of planned interventions, in all Personal Plans, will be evaluated, documented, and interventions modified/replaced if not found to be effective

Proposed Timescale: 20/12/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management systems were not consistently implemented in line with the policy of the organisation and did not identify all of the risks within the centre.

4. 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:

1. A risk assessment will be conducted of operational, clinical and environmental risks within the centre and control measures documented and implemented as required.

Proposed Timescale: 20/12/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The effectiveness of the positive behavior supports provided were not reviewed to assess if all efforts were made to identify and alleviate the cause of a residents behaviour.

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:

1. Behaviour Support Plans will be reviewed to ensure that there are sufficient

appropriate interventions in place to reduce the cause of a resident's behaviour, and that they are effective or modified/replaced if they are not

Proposed Timescale: 20/12/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Management systems did not identify if the supports in place were effective and resulted in a positive outcome for residents.

6. 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:

1. The PIC will review Personal Plans to ensure that the actions identified in this Action Plan have been implemented.
2. An audit schedule will be developed and implemented by the PIC to regularly review that the supports in place are effective and result in positive outcomes for residents

Proposed Timescale:

1. 20.12.17
2. 15.01.18

Proposed Timescale: 15/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The number of staff identified in the Statement of Purpose was insufficient to ensure that the staffing levels required could be maintained.

7. 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:

1. The Statement of Purpose will be amended to include the actual WTE used within the designated centre to include for annual leave and training.

Proposed Timescale: 13/11/2017