

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | St Laurence |
| Centre ID: | OSV-0005644 |
| Centre county: | Cork |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Enable Ireland Disability Services Limited |
| Lead inspector: | Caitriona Twomey |
| Support inspector(s): | Carol Maricle |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 15 |
| Number of vacancies on the date of inspection: | 1 |

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: 15 November 2017 09:15 To: 15 November 2017 18:00

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |

Summary of findings from this inspection

Background to the inspection:

This was the first inspection of this centre carried out by the Health Information and Quality Authority (HIQA) since the change in service provider. This unannounced, one day inspection took place to monitor regulatory compliance and to determine the progress being made against an action plan submitted to HIQA on 22 June 2017. The centre was inspected against the core outcomes (with the exception of medication management) and others identified as relevant on the day.

Description of the service:

The centre is located on the outskirts of Cork city. The centre was registered to accommodate up to 16 residents. The centre comprised a main house with 10 single bedrooms, nine self-contained apartments and a separate four-bedroomed house. The centre provided a service for people with physical disabilities and neurological conditions; many also had an intellectual disability.

How we gather our evidence:

As part of the inspection, inspectors met with seven people living in the centre, the person in charge, the person participating in management, and members of the staff team. Inspectors reviewed documentation including personal plans, healthcare plans,

training records, fire safety information, staff meeting minutes, risk assessments and a report completed by the provider following an unannounced inspection of the centre.

Overall judgment of our findings:

The majority of residents reported that overall they were happy living in the centre however staffing shortages were referenced frequently. Those wishing to live in the community were unclear as to the current status of the plans to achieve this goal. Residents were happy to meet with inspectors and appeared comfortable in their surroundings. Staff told inspectors that they felt well supported in their roles by the person in charge and person participating in the management, however were uncertain regarding the wider governance and the medium to long term arrangements for the centre.

On the day of inspection, it was identified that some of the actions outlined on the action plan submitted to HIQA in June 2017 were still in progress. An updated action plan was provided to inspectors on the day. The management team advised that residents' healthcare needs had been prioritised since the change in service provider. This was evident throughout the inspection.

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

- outstanding multidisciplinary assessments and limitations on residents' opportunities to participate in preferred, meaningful activities (outcome 5),
- improvements required in relation to risk assessment and fire safety in the centre (outcome 7),
- the centre's statement of purpose (outcome 13), and
- identified workforce issues (outcome 17).

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

A representative of the provider and the person in charge attended a feedback meeting in the HIQA head office the week following the inspection.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

This was the centre's first inspection by the Authority.

Findings:

Residents were consulted with, and participated in, decisions about the supports they received. The rights, dignity and consultation of residents was promoted at the centre. Staff were observed to be respectful in their interactions with residents.

Inspectors spoke with a number of residents during this inspection. Some residents told inspectors that they were satisfied with how they lived their life. They spoke about their daily routines, preferences and friendships. Examples were given of staff respecting residents' choices and supporting residents' wishes to be as independent as possible. The person in charge outlined work being undertaken with each resident regarding informed decision making. Some residents told inspectors that they wanted to live in the community. While these plans were at an advanced stage, the governance of these planning arrangements was not clear. This is also referenced in Outcome 14.

The person in charge told the inspectors that residents no longer participated in group meetings regarding the running of the centre and put forward the reasons for this. She told inspectors that she maintained an open-door policy for all residents to visit her when they so chose. This meant that residents often dropped by and raised ideas, questions and concerns with her directly. She acknowledged, she needed to review how she recorded these conversations in the absence of residents' meetings.

There was a complaints management system in place. An inspector reviewed the system put in place since the commencement of the year and found that the system ensured that complaints were welcomed, acted upon, investigated and outcomes determined. The satisfaction of the complainant following the resolve of the complaint was recorded.

The person in charge was aware of patterns and trends of complaints, although this analysis was not in written format. Some of the templates used for the management of complaints were those pertaining to a previous service provider. Where complaints or concerns were shared with the inspectors on the day of the inspection, these were reported to the person in charge in agreement with the residents. The person in charge committed to reviewing these concerns in accordance with organisational policy.

Judgment:
Compliant

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):

This was the centre's first inspection by the Authority.

Findings:

Each resident had a personal plan however multidisciplinary assessments had not been completed for all residents on the day of inspection. Where personal plans had been updated, some had a limited focus. Each resident had opportunities to participate in meaningful activities; however, there was evidence that residents' preferences were limited by staffing and other resource issues.

An individual care plan had been developed for each resident living in the centre. This plan incorporated residents' health, personal and social care needs. There was evidence that residents and, if appropriate, their representatives were involved in the development and review of their personal plans. On meeting with inspectors, some residents reported their involvement in their plans. Residents' signatures further evidenced their participation.

The provider had developed a system by which each resident's personal plan would be reviewed by multidisciplinary professionals working in the centre. On the day of inspection, the person in charge advised that reviews had been completed for the majority of residents. Inspectors reviewed a personal plan that had been reviewed. It was evident, given the risks and support needs identified for the person, that not all of the appropriate professionals had been involved in the review. For example, it was stated on the review document for a person who was prescribed a modified diet, and

had additional significant communication support needs, that speech and language therapy input was not needed.

The person in charge informed inspectors that complementary multidisciplinary assessments were in progress at the time of the inspection (for example, relating to transport). Inspectors were advised that once completed these would be incorporated into each resident's individual plan. The person in charge also advised that there were weekly meetings involving the multi-disciplinary professionals working in the centre. Records of these meetings were provided. However, on review of residents' individual files there was no evidence of these meetings or their impact on residents' care and support.

The person in charge reported that a keyworker system had been introduced in the centre. One of the main objectives of this initiative was to support residents in the development and progression of their own individualised goals. Inspectors reviewed documentation in the centre that evidenced that this process has begun. On the day of inspection there did not appear to be a structure in place around this, with resident and keyworker meetings occurring at irregular intervals, and personal planning goals often not discussed. The provider advised that the need for improvements, specifically in relation to review of personal planning goals, had been identified and had a completion date of the end of that month. The provider provided an updated action plan for the centre which outlined the next stage of this process which was to plan Circle of Support meetings for each resident in the new year.

Each resident had opportunities to participate in meaningful activities that were appropriate to their interests and preferences. The person in charge reported that a schedule of activities had been introduced in one of the communal areas of the centre. Residents' participation was recorded in individual activities logs. Residents also reported their involvement in a variety of community based activities that were meaningful to them. However, a number of residents also referenced the need to wait, at times for a couple of days, to access the community when they wished. The person in charge advised that transport had been discussed at a meeting with residents in late August 2017. One of the documented outcomes of the meeting was an agreement as to what activities would receive priority for transport bookings. The person in charge outlined that residents could use taxis which they pay for using their personal funds. During discussion with inspectors, the provider representative agreed that transport in the centre required further review. The impact of staffing on activities is outlined under Outcome 17.

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):

This was the centre's first inspection by the Authority.

Findings:

The design and layout of some of the premises was suitable and homely for some of the residents. However, for other residents it was not.

An inspector asked a resident's permission to visit their apartment and consent was given. The inspector saw that the apartment was appropriately furnished, homely and nicely decorated. The resident reported their satisfaction with their home, advising they had everything they required and could contact staff when they needed to. The inspectors visited a home in another part of the centre where four residents lived. This house also presented as homely and inviting.

There were three residents living in the area that was adjoined to the main building. Their bedrooms were situated on hall corridors. This meant that residents had to pass by the offices of staff on their way to bathroom, shower facilities and other rooms. There were no signs to indicate to staff and visitors that they were entering the home of these individuals and which rooms were for general use and which rooms were solely for the use of the residents. There was no kitchen accessible to the residents, although they did have use of a dining area. The living room, although large in size and well decorated, contained furnishings that were not homely, for example training materials were stored there on the day of the inspection. The person in charge and person representing the provider acknowledged that the kitchen and living space was not suitable and required formal consideration and re-design. They had partially addressed this issue for one of the residents and there was a time bound costed plan that was near completion on the day of the inspection. However, there was no clear plan in place to demonstrate how the provider would address this issue for the remaining residents.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

This was the centre's first inspection by the Authority.

Findings:

Not all components of this outcome were reviewed. There were systems in place regarding risk assessment and some improvements were required. Aspects of fire safety management required improvement.

The management team maintained a centre risk register and some improvements were required. Some of the generic hazards listed required a review of their scoring as risks were over-estimated. The person in charge agreed to attend to this during, and following, the inspection. The inspectors identified some hazards at the centre that had not previously been identified and required risk assessment, for example human resource issues, delays in transitions to the community, and lack of cooking facilities for one group of residents. The updated action plan completed by the provider indicated that a review of the risk policy, risk register, and incidents and accidents was to be completed by a health and safety officer by the end of November 2017.

Inspectors reviewed a sample of individualised clinical risk assessments pertaining to residents and these were comprehensive. However, the current status of the risk was unclear as it was identified that a number of the controls outlined had not yet been implemented. As such the risk posed by these hazards to residents on the day of the inspection was unclear. The person in charge and person participating in management told inspectors that they had identified falls as a significant hazard in the centre and as a result had introduced system-wide interventions to address this with good effect.

There were systems in place at the centre to protect residents in the event of a fire. The centre had a fire alarm system in place and this was inspected at quarterly intervals. There was emergency lighting in place, also inspected at quarterly intervals. Residents had personal emergency evacuation plans. There were extinguishers available for staff to use in the event of a fire. Staff and residents participated in fire drills. Staff maintained daily and weekly fire checks of fire safety systems. There were evacuation procedures in place.

However, despite the above systems in place gaps were found. The inspector identified a month in the year prior to the inspection that staff had not recorded weekly fire safety checks at the detached house. The record presented to the inspector of a fire drill that had taken place in the previous six months at this same house had results that were concerning. An inspector reviewed a series of fire drills for a separate unit and the results were also concerning. For example, equipment used to aid evacuation was not used correctly. The measures at the apartments for the containment of fire were not clear. A report on fire safety compliance of one of the units contained a number of recommendations and the management team were not entirely clear about the status of these recommendations. The person in charge informed the inspectors that she was at the time of the inspection proposing updated evacuation procedures that would address some of the issues outlined above. However, such was the seriousness of these issues, the inspectors asked the person representing the provider to submit written assurances following the inspection that the centre was in compliance with the relevant regulations. The information received did not fully satisfy the requirements of the regulations and the provider was asked again to submit additional written assurances. At the time of the finalising of this report, the information provided, in its totality, did not provide adequate assurances that the centre was fully in compliance with the regulations.

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| <p>Judgment: Non Compliant - Moderate</p> |

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):
This was the centre's first inspection by the Authority.

Findings:
Measures to protect residents being harmed or suffering abuse were in place in the centre. Records indicated that staff had received training in relation to the safeguarding of vulnerable adults. The person in charge also acted as the designated officer. Staff spoken with by inspectors were clear on the process to implement in the event of an allegation, suspicion or disclosure of abuse. Where concerns of a safeguarding nature were raised with inspectors, the person in charge responded appropriately.

Information included in the risk register and discussions with members of the staff and management team indicated that no residents living in the centre presented with behaviours that challenge. There was a policy in place on the use of restrictive practices. Occupational therapy and physiotherapy assessment and review was evident where restraints were in use to support the postural needs of residents. On the day of inspection it was evident that the staff team promoted a restraint-free environment.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

This was the centre's first inspection by the Authority.

Findings:

There was evidence to suggest that each person was supported to achieve and enjoy the best possible health while living in the centre. The management team reported that this had been a key area of focus since they became the provider of the designated centre. In that time the number of nurses providing direct support in the centre had increased by 75%.

There was a clear and comprehensive clinical care plan contained in each resident's individual care plan. Healthcare recording templates, such as body maps and weight records, had been introduced as appropriate to the assessed needs of the residents. However, it was not always clear how often these records were to be completed.

A review of a sample of residents' files contained documented evidence of staff facilitating residents' attendance at medical appointments as required. There was also documentary evidence of staff supporting residents to access health information and wider public health initiatives. The person in charge advised that the development of a health action was in progress for each resident. Inspectors reviewed documentary evidence to support this. There was a hospital passport in place for each resident living in the centre.

Food provided in the centre was nutritious, appetising and varied. Residents' choice regarding food was promoted and facilitated. Some residents had access to, and made use of, their own cooking facilities. Meals and snacks were prepared and made available in the main house to all residents of the centre.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

This was the centre's first inspection by the Authority.

Findings:

There was a statement of purpose in place and while this set out a significant amount of information required by the regulations, it failed to set out all of the required information.

The provider had committed to reviewing the statement of purpose in an action plan submitted to HIQA in June 2017. This action had been implemented. In accordance with the regulations, the statement contained the aims, objectives of the designated centre. It also stated the facilities and services to be provided to the people living there.

However, an accurate description of all governance arrangements was not set out, for example, post-holders involved in the management of the centre were not included in the diagram outlining the management structure in the centre. On the day of inspection aspects of the service provided and outlined by the person in charge were not consistent with some of the information in the statement of purpose. This included staffing support being provided to a former resident and the possibility of an emergency admission of three people living elsewhere in the city (this had not occurred). The statement of purpose did not include the information set out in the certificate of registration.

According to the six monthly inspection report completed by the provider in June 2017, the statement of purpose was to be updated in December 2017.

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):

Findings:

There were systems in place to ensure the safety and quality of care provided to residents. However aspects of the governance of the centre were not clear.

There were systems in place for the auditing of practice at the centre. An inspector viewed a comprehensive audit of medicines management errors in the year of the inspection. This analysis clearly set out the trends and patterns arising from errors. The management team could articulate clearly their plans to address these trends and there was evidence to show that training had taken place addressing areas of concern. An inspector observed a second audit of risk identification at the centre. This audit was not as formal and did not contain a resultant action plan. Not all of the management team

were aware of these findings, however a person involved in the management of the centre committed to reviewing same following the inspection. There was evidence that staff files had been audited to check compliance with Schedule 2 of the regulations.

There was evidence to show that meetings took place regarding aspects of the running of the centre. The inspectors viewed a log of meetings that had occurred in the 12 months prior to the inspection and these meetings demonstrated how issues such as safety, food hygiene, training and day-to-day practice were discussed. However, the regularity of some of the meetings was not clear. Decisions taken at meetings were not always followed up at the next meeting. The meetings did not adequately demonstrate the input of care staff into the running of the centre. Some of the attendees at the meetings represented other service providers.

An action plan was submitted to HIQA in June 2017. On the day of the inspection the provider gave an updated version of this action plan which had been reviewed in September and October 2017. There was evidence of progress made in the majority of areas. Any incomplete actions were due for review at the end of November 2017.

A six monthly unannounced inspection had been completed in June 2017. A copy of this report, which included an action plan, was provided to inspectors following the inspection. The majority of actions generated to address issues identified in areas including residents' rights, social care needs, health and safety, and safeguarding had been completed. This was consistent with inspectors' findings on the day. Outstanding actions were not due to be completed until dates following the inspection. The person representing the provider was aware of their responsibility to compile an annual review, in line with the regulations. This was also outlined in the centre's action plans.

The person in charge was in post since December 2016. Both the person in charge and person participating in management shared a clear vision of the centre and were clear about the aims and objectives of the service. They both were qualified and experienced managers. Residents could identify the person in charge. Inspectors spoke with staff who were clear on the responsibilities of their own roles and the lines of accountability in the centre.

Inspectors found that some of the governance arrangements of the centre were not clear. There were other service providers taking a lead role on areas such as human resources, risk management and transitions to the community. This was not adequately set out in the statement of purpose nor in a memorandum of understanding between the providers. All staff working in the centre were implementing the policies of another service provider.

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):

This was the centre's first inspection by the Authority.

Findings:

There are enough staff to ensure the safety of the residents, however the contingencies in place to cover staff on leave are insufficient. Gaps were identified relating to staff attendance at refresher sessions in mandatory training. While the requirements of Schedule 2 of the regulations were met in relation to a sample of staff files, there was insufficient information available regarding volunteers and people working in the centre as part of a particular employment scheme.

People living in the centre and staff spoke to inspectors about their perspectives on staffing arrangements in the centre. Some had concerns about staffing numbers, others raised concerns about staff availability throughout the day. Staff identified absenteeism (including the inability to cover this leave) and the provision of off site staff support to a former resident as contributing to this challenge. The management team told inspectors that the staffing ratio as set out in the statement of purpose was an accurate reflection of the needs of the residents. However, they acknowledged that on a day to day basis issues such as staff absenteeism impacted the allocated ratio. Management were confident that this did not impact negatively on the safety of residents in the centre, however there was an acknowledgement that there was potentially an impact on residents' ability to engage in preferred and meaningful activities, especially those occurring offsite. The management team spoke about a new staff rota which had been developed with staff input and was due to be implemented in January 2018. The management team stated that overall there were staff retention and recruitment issues at the centre, some of which they believed were a result of the current governance arrangements of the centre.

A sample of staff files were reviewed by inspectors and were found to contain all of the information required as outlined in Schedule 2 of the regulations. A training matrix was reviewed by inspectors. There was evidence that this was reviewed and updated at regular intervals. While most mandatory training was up to date, the records reviewed indicated that 25% of staff required refresher training in manual handling, while 50% of the staff team required refresher training in the management of behaviour that is challenging. The management team spoke about the introduction of a supervision system in the centre for all staff. Those providing supervision have received related training. It was unclear what policy staff were implementing in the delivery of supervision. Inspectors were informed that there is currently no performance management system in place.

There were volunteers working in the centre. Although there was evidence of garda

vetting, not all of the information required as outlined in Regulation 30 was available. There was also insufficient information available regarding people working in the centre as part of a particular scheme.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caitriona Twomey
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

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| Centre name: | A designated centre for people with disabilities operated by Enable Ireland Disability Services Limited |
| Centre ID: | OSV-0005644 |
| Date of Inspection: | 15 November 2017 |
| Date of response: | 14 February 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 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment had not been completed for all residents living in the centre.

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

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

The completed assessments of need and MDT input for 2017 will now be added to each resident's personal plan. 9 have been completed, 6 are outstanding
Outstanding AON's and individual MDT'S will be completed and recorded on personal plans.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

There was evidence that reasonable resources were not in place to meet the personal goals and preferences of residents.

2. Action Required:

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

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

A structured review of each residents activities/goals will take place to enhance the outcomes for each resident

Transport and access to accessible transport will be risk assessed. A plan is in place to agree the purchase of new suitable vehicles via the tender process to address the current transport needs of residents

Circle of support and keyworker meetings will be structured and enhanced to support activities in the community

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

The review of personal plans did not always involve all of the appropriate multidisciplinary professionals

3. Action Required:

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

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

Recommendations and reports from additional professionals outside of the in house Occupational Therapy and Physiotherapy will be included in the assessment of need as appropriate and recorded on personal plans

Proposed Timescale: 31/03/2018

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The layout and design of parts of the centre were not homely and did not promote residents' dignity.

4. Action Required:

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

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

1. A review of the studio section of the premises has taken place and is available to residents every day as a communal space, with team leads present and scheduled activities. Residents are choosing soft furnishings and decoration to enhance this studio as well as moving the television and piano to create a more homely space for residents.
2. A plan is also being developed to move the existing kitchen to the room next to this studio space. Costings for this will be submitted for approval by end of March 2018
3. Signage will be put in place to denote resident's personal living space to enhance privacy and dignity.

Proposed Timescale: Point 1 and 3 End February 2018, point 2 End March 2018.

Proposed Timescale: 31/03/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Some hazards required formal identification and risk assessment.

5. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

The following risks have been completed:

1. Staffing (now closed risk)
2. Delays in transition to the community
3. Lack of cooking facilities

Full review of risk register Environmental and Clinical will be done by End of March 2018

Proposed Timescale: Risks 1 to 3 Completed

Risk Register Review End March 2018

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

The documentation reviewed on the day of the inspection and following the inspection did not confirm fully that the centre had effective fire safety management systems in place.

6. Action Required:

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

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

An internal fire consultant's report is currently being actioned.

Work recommended in this report will be completed by end of March 2018 and signed off by the Fire Consultant after completion.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

The containment arrangements for fire in the single occupancy apartments was not sufficiently set out in writing.

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:

1. All existing PEEPS for residents in the single occupancy dwellings will be reviewed to reflect evacuation times and methods of evacuation. The findings from this review will

be assessed by the fire consultant to decide on the need for any further containment within these dwellings.

2. All residents are checked hourly during the day and two hourly at night.

3. All residents are issued with personal alarms.

Proposed Timescale: Action 1. April 2018, Action 2 and 3 complete

Proposed Timescale: 30/04/2018

Theme: Effective Services

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

The records maintained of fire drills did not assure the inspectors that staff and residents were aware of the procedures to be followed in the case of fire.

8. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

All local fire evacuation policies have been reviewed and re-issued to all staff. All individual PEEPs have been updated for residents in the main house and the 4 bedroomed dormer bungalow, PEEPs for residents in the single occupancy dwellings will be further reviewed to reflect concerns as above.

Additional fire drill has taken place in detached bungalow. All mandatory training is up to date. Drills will be carried out every quarter and training to continue for 2018

Proposed Timescale: 30/04/2018

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not contain all of the information set out in Schedule 1 of the regulations and did not accurately describe some services and management structures in the centre.

9. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Statement of purpose will be revised to show ongoing partnership with the previous provider and the HSE.

Proposed Timescale: 28/02/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The personnel involved, and details of their roles and responsibilities, were not clearly defined for all areas of service provision in the centre.

10. Action Required:

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

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

The role of the current provider/previous provider and HSE to be outlined in updated Statement of Purpose document.

Proposed Timescale: 28/02/2018

Theme: Leadership, Governance and Management

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

Staff meeting records did not adequately demonstrate that all support staff were facilitated to have input into the running of the centre. Decisions taken at staff meetings were not always followed up at subsequent meetings.

11. Action Required:

Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

Two general meeting minutes were not in the folder on the day of the inspection (due to oversight)

A full schedule of meetings for Nurses/Staff/Team leads will be agreed for 2018 and any actions will be allocated to a person responsible and followed up at subsequent meetings.

Proposed Timescale: 14/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

The contingencies in place to cover staff annual or sick leave in the centre were insufficient.

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:

A relief panel is in place with a recent recruitment of 3 new staff to add to the existing compliment of 28 regular and relief staff.

Agency staff are available.

The required absence of staff to support a resident off site has now ceased.

Proposed Timescale: 14/02/2018

Theme: Responsive Workforce

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

The information required as set out in Schedule 2 was not available for staff working in the centre as part of a particular employment scheme.

13. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

All Schedule 2 information will be compiled for the identified employment scheme and held for review by the supervisory authority for that scheme.

An on site supervision program will be put in place for the participants of this scheme.

Proposed Timescale: 31/03/2018

Theme: Responsive Workforce

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

A significant number of staff had not received mandatory refresher training.

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:

Manual handling training completed in December 2017

Behaviours that Challenge training to be completed every quarter by qualified instructor to be completed by December 2018

Proposed Timescale: Manual Handling training completed.

Behaviours that Challenge training to be run every quarter up to December 2018

Proposed Timescale: 31/12/2018

Theme: Responsive Workforce

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

The roles and responsibilities of volunteers in the centre were not set out in writing.

15. Action Required:

Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing.

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

Two volunteers on site have signed contracts in relation to their role and responsibilities as volunteers.

Proposed Timescale: 14/02/2018

Theme: Responsive Workforce

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

The supervision arrangements in place for volunteers was not clear.

16. Action Required:

Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

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

The two volunteers have been added to the supervision schedule to commence January, 2018

Proposed Timescale: 31/01/2018