Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Peamount Healthcare B2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	05 March 2019
Centre ID:	OSV-0005765
Fieldwork ID:	MON-0026070

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The designated centre is located on a large campus in West County Dublin and is made up of three individual units. Residential care and support services are provided by the centre to 15 persons with disabilities. The three units are of similar layout and have an entrance hallway, large living and dining room, a kitchen area, a main shower room with toilet, a separate toilet, resident bedrooms, and in two of the units there are relaxation or quiet rooms. There is a staff team of nurses and carers employed in the centre along with a clinical nurse manager and person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
05 March 2019	09:30hrs to 18:00hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with nine residents who were availing of the services of the centre and spoke in detail with five residents. In addition, the inspector observed care and support that was being provided to residents by staff members. Overall, residents communicated high levels of satisfaction with the service they were in receipt of.

Capacity and capability

Overall, the inspector found that there was evidence of improvement and development by the registered provider across of a range of areas in this centre which resulted in enhanced outcomes for residents. A reconfiguration of services was recently completed and this centre was created and registered at that time. The units involved were previously included in other centres operated on the shared campus site. The inspector found that there were effective governance structures in place and there were clear lines of accountability. The centre was resourced appropriately to support the effective delivery of services to residents and there appeared to be a competent workforce employed. While the inspector found examples of improvement and development, there remained a number of areas of non-compliance.

A review of staffing arrangements found that there was an appropriate number and skill mix employed in the centre to meet the identified needs of residents. Staff duty rosters were maintained in an electrical format and contained all relevant information, however, they were not not labelled as 'planned' or 'actual' as required. A review of a sample of four staff files found that in the cases of two files reviewed some information was not maintained as required.

The training records of staff members were reviewed by the inspector and it was found that there were some deficits in the completion of mandatory training or refresher training. The person in charge outlined a training plan that was in place to address these identified deficits. While there was a staff supervision policy in place (dated April 2016), the inspector found that staff members were not in receipt of supervision on a monthly basis as required by this policy document. A review of supervision records demonstrated that 16 of the 32 staff employed in the centre had attended one supervision meeting each since September 2018.

The inspector reviewed the governance and management arrangements of the centre and found that overall, there was clear evidence that the management structures had strengthened in recent months. A new person in charge had been

appointed to the centre and the inspector found that they were very knowledgeable of the needs of residents, the strengths and weaknesses of the centre, and the relevant legislation, regulations and national policy. The person of charge was found to have significant responsibilities in other areas outside of the centre and the inspector was not assured that the centre was appropriately resourced in this regard. Some management systems in place were identified as requiring further development and improvement. There were no arrangements in place for the performance management of staff members employed in the centre.

The inspector found that there was an effective complaints process in place in the centre. There was a complaints policy (dated April 2017) and a complaints register. A review of complaint records found that no complaints had been made since the centre was registered. There were easy read procedures available to residents to provide guidance on the matter and there was information on display on independent advocacy services and how these could be accessed.

The centre's policies and procedures were reviewed by the inspector and it was found that all required policy documents were in place and available to members of the staff team. A number of policy documents were found not to have been reviewed and updated as required at least once every three years.

Regulation 15: Staffing

Staff duty rosters in place in the centre were not labelled as being 'planned' or 'actual' as required by the regulations. A sample of staff files were reviewed by the inspector and it was found that all required information was not contained in a number of the files reviewed. In one case a reference was not signed by the referee and in two cases there were gaps in the employment history of the staff members which were not accounted for.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of staff training records was completed by the inspector and it was found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined by the centre's policies and procedures. The deficits in training were as follows:

- one staff member had not completed training or refresher training in online fire safety
- two staff members had not completed training or refresher training in fire equipment
- one staff member had not completed training or refresher training in hand

hygiene
- one staff member had not completed training or refresher training in practical hand hygiene
- one staff member had not completed training or refresher training in infection control
- four staff members had not completed training or refresher training in basic life support, defibrillation and choking
- two staff members had not completed training or refresher training in safeguarding vulnerable adults and
- two staff members had not completed training or refresher training in children first.

One-to-one supervision meetings were not held with staff members as frequently as required by organisational policy. The content of supervision meetings was observed to be heavily focused on resident matters and was limited on areas such as staff development and improvement.

Judgment: Not compliant

Regulation 23: Governance and management

The person of charge was found to have significant responsibilities in other areas outside of the centre and the inspector was not assured that the centre was appropriately resourced in this regard. Management systems in place required development and improvement to ensure effective oversight of a number of key areas. There were no arrangements in place for the performance management of the staff team.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector found that there was an effective complaints process in place which was available in an accessible format and included an appeals procedure.

Judgment: Compliant

Regulation 4: Written policies and procedures

There were two policy documents which had not been reviewed and updated as

required at least once every three years. These were the policies on:

- the provision of behavioural support and
- health and safety, including food safety, of residents, staff and visitors.

Judgment: Substantially compliant

Quality and safety

The inspector found that overall, residents availing of the services of the centre were supported to experience reasonably satisfactory lives. While there was clear evidence available to demonstrate that progress and development of the service had taken place, there remained a number of areas which required further improvement to ensure that residents were provided with opportunity to live active and meaningful lives.

The general welfare and development of residents was reviewed by the inspector and it was found that while there had been some developments and improvements in this area, further progress was required to ensure that high standard care and support was provided. Residents were supported to engage in day services, however, activities engaged in were primarily campus and centre based and the inspector found that there were limited opportunities for engagement in meaningful community based activities or for the development of valued social roles. Residents were at times observed to be unoccupied and disengaged due to the absence of activities to partake in. The person in charge outlined strategies which were introduced to address this issue which included the involvement of an activities coordinator and the completion of quality of life assessments for each resident. The inspector found that these measures were at an early stage of development and had yet to have a significant impact on the lived experience of residents.

The inspector completed a full walk through of the centre in the company of the clinical nurse manager. The centre was found to be clean and well maintained throughout. There was one minor area which required repairs identified in one resident bedroom and a maintenance request was observed to have been created in response to this by the manager. Each resident had their own bedroom and there was adequate space and storage available for residents.

Fire precaution arrangements were reviewed by the inspector and some deficits were noted with regards to fire containment. While there were fire doors in place throughout the centre, self-closing mechanisms were not installed on these doors. The inspector found that fire drills were not completed on an regular basis and noted an 11 month period between drills carried out in one unit of the centre. Personal emergency evacuation plans were in place for residents and were found to provide clear guidance on how to support residents in the event of a fire or other emergency.

The inspector reviewed medication management arrangements and found that medications were stored safely and securely in the centre. A review of medication cabinets found a number of medications which did not contain expiry dates. A sample of two residents' prescriptions and medication administration records were reviewed by the inspector and in both cases, it was found that medications that had been prescribed were not recorded as having been administered. The management team had not previously been aware of this matter and it was confirmed that no drug error incident forms were completed. Capacity and risk assessments for the self-administration of medication by residents were found not to have been completed as required.

Safeguarding and the protection of residents was reviewed and the inspector found that residents were satisfactorily protected while availing the services of the centre. Staff members, managers and the person in charge demonstrated awareness and knowledge of the types of abuse and the actions that were required to be taken in response to suspicions or allegations of abuse. Residents spoken with informed the inspector that they felt safe and knew how to report any concerns that they may have. There were intimate care plans in place for residents who required them and there was a designated officer appointed to handle any allegations or concerns should they arise.

Regulation 13: General welfare and development

Opportunities for engagement in occupation and recreational activities were primarily centre and campus based. Residents were observed spending prolonged unoccupied periods within the centre and there was a lack of opportunity for engagement in community based or socially valued activities.

Judgment: Not compliant

Regulation 17: Premises

Overall, the inspector found that centre was clean, well maintained and suitably decorated.

Judgment: Compliant

Regulation 28: Fire precautions

Satisfactory fire containment measures were not in place in the centre as self-closing mechanisms had not been fitted to the centre's fire doors. Fire drills were

not completed on a regular basis in all units of the centre.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

A number of medications were found not to have expiry dates listed. Prescribed medications for two residents were found not to have been recorded as having been administered by staff. The management team had not been aware of this prior to the inspection and no medication error forms had been completed. Risk and capacity assessments relating to the self-administration of medication by residents were not completed.

Judgment: Not compliant

Regulation 8: Protection

The inspector was satisfied that residents were safe while availing of the service of the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Peamount Healthcare B2 OSV-0005765

Inspection ID: MON-0026070

Date of inspection: 05/03/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC will ensure that all rosters will be labelled "Planned" prior to approval and will then be labelled "Actual" following approval by ADON. • All staff files to be reviewed by the HR manager to ensure that all references are signed by the referee and all gaps in the employment history are explained. • This will also apply to all future employees.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff will have completed their Fire Training on 15/05/2019 • Hand Hygiene is now at 100% compliance. • Infection Control will be completed on 15/05/2019 • Basic life support and defibrillation and choking will be completed on 08/07/ 2019. • Safeguarding training will be completed on 11/07/2019. • Children first Training is now 100% complaint. Supervision plan for centre is now in place and will be conducted twice yearly and more often if necessary. Supervision session will be focussed on staff development including PDP.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A new PIC has been recruited for the centre and will commence 17th June 2019. This will enhance the oversight of the centre.
• A system is in place that includes supervision, Personal Development Plans and Personal Improvement Plans where required.
• Peamount will develop a performance management policy and procedure in conjunction with the HR Director.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Given below policies will be updated:

• The Prevention and Management of Behaviours Policy is currently under review, in conjunction the HSE.
• The Health and Safety Policy has now been updated and will be implemented during May 2019.
• Food safety of residents, staff and visitors policy is curretly under review.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The Residents' Interests Checklists will be reviewed and community based activities will be explored with the residents according to their personal wishes and preferences.
• Home based activities including supporting residents in the preparation of food will take place.
• Peamount will organise regular community-based activities for residents with the

support of the key worker.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Peamount will install self-closing mechanisms on fire doors. Peamount will apply to HSE for funding for this project.
• Fire Drills will be completed twice yearly on the day shift and twice yearly on the night shift over the 12 month period.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• The Pharmacist has now included the expiry date on all medication dispensed and this is checked weekly in the centre.
• All nurses will read and sign the Medication Management Policy.
• CNM will carry out weekly audit to ensure all medication errors are recoded and managed efficiently.
• Risk and capacity assessments relating to the self-administration of medication by residents will be completed.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/11/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/11/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on	Substantially Compliant	Yellow	29/04/2019

	duty during the day and night and that it is properly maintained.			
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/07/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	11/07/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	17/06/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	31/07/2019

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/07/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the	Substantially Compliant	Yellow	30/04/2019

	case of fire.			
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/04/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Not Compliant	Orange	31/08/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief	Substantially Compliant	Yellow	31/08/2019

	inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			