Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St. Anne's Residential Services - Group M
Centre ID:	OSV-0005162
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Kieran Murphy
Support inspector(s):	Julie Hennessy
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 inform a registration decision. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
24 October 2016 16:00	24 October 2016 17:30
25 October 2016 09:00	25 October 2016 15:30

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

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 10. General Welfare and Development
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the third inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 19 May 2015 and the second on 3 November 2015. The purpose of this inspection was to follow-up on the high level of non-compliance identified at the previous inspection, where four of 18 outcomes were at the level of major non-compliance with a further five at the level of moderate non-compliance.

Description of the service:
The centre comprised one house located in a rural village. The centre provided care and support to five residents, two women and three men. All of the residents attended either work or a day service with one resident participating in a day service coordinated from the designated centre.

How we gathered our evidence:
Inspectors met and spoke with three of the five residents who currently lived in this centre. Inspectors also met the person in charge of the centre, staff and the

residential services manager. Inspectors observed staff practices and interactions with residents and reviewed residents' personal plans, training records, meeting minutes and the complaints log.

Overall judgment of our findings:
At the last inspection there had been 23 actions arising. There had been improvement evident on this inspection, particularly in relation protection of personal information (outcome 1), updating of statement of purpose (outcome 13), staffing (outcome 17) and the updating of policies (outcome 18).

Of the nine outcomes inspected two were at the level of major non-compliance:
Outcome 5: Social Care Needs
As on the previous two inspections it was again found that the designated centre did not meet the assessed needs of all residents. In particular, the centre failed to meet one individual resident's emotional or social needs.

Outcome 8: Safeguarding and Safety
There was evidence that incidents of challenging behaviour were having a negative impact on other residents in the centre. The behaviour support plans did not provide appropriate guidance for staff to identify and alleviate the cause of residents' behaviour that challenged. There was no review/oversight of these incidents by an appropriately trained and qualified professional.

In addition, a separate referral had been made for psychology support in relation to supporting residents who had a history of making false allegations. However, psychology support was not currently available.

There were also continued failings in relation to risk assessment (outcome 7), premises (outcome 6) and assessment of educational/training needs (outcome 10). This indicated that the current arrangements in place in relation to the governance and management of the centre were not satisfactory.

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

Findings:
The failing identified on the previous inspection in relation to residents' rights, dignity and consultation had been addressed.

On the last inspection personal information was not fully respected as healthcare information was being recorded in the communication diary. All personal healthcare information was now being maintained in the appropriate healthcare plans.

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

Findings:
As on the previous two inspections the designated centre did not meet the assessed needs of all residents.

As on the previous two inspections it was again found that the designated centre did not meet the assessed needs of all residents. In particular, the centre failed to meet one individual resident's emotional or social needs. Since the last inspection HIQA had sought reassurances from the service provider in relation to this inappropriate placement. The St Anne's Service acknowledged that this resident was inappropriately placed and their own service user review group "was recommending that this individual should also be recommended for transfer to separate living arrangements in new accommodation".

At the previous inspection, it was found that the review of the personal plan was not multidisciplinary. Since the previous inspection, multidisciplinary reviews had been held that informed residents' personal plans.

In September 2016 the service had undertaken its own internal review of the quality and safety of care provided to residents. In relation to person centred care this review found that "goals for residents needed to be broken down into achievable parts". This review also found that "goal setting was not clear". Inspectors reviewed personal plans and found that they were all up-to-date with "goals" for each resident identified for the coming year. In general, these "goals" reflected residents' individual interests, wishes and abilities. However, some improvement was required as the supports needed for residents to achieve the "goals" were not always identified. In addition, the timeframes whereby residents were to achieve the "goals" were also not always identified.

In relation to residents' assessed healthcare needs, care plans had been developed for identified for each healthcare need. These care plans were in the person centred planning folder. There was appropriate input from relevant healthcare professionals including dietitian and speech and language therapist. There was evidence that residents were supported to attend consultant specialists as required to manage assessed healthcare needs, including the consultant psychiatrist.

Judgment:
Non Compliant - Major

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
In general the location, design and layout of the centre was suitable for its stated purpose.

However, as on the previous inspections, it was identified that the carpet on the landing on the first floor required replacement. In September 2016 the service had undertaken its own internal review of the quality and safety of care provided to residents. This review had also identified that the carpet required replacement.

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

Findings:
Improvement was required in relation to infection control practices, fire safety arrangements and the process for risk assessment.

On arrival at the centre inspectors were informed that an outbreak of an infection was being actively managed. Staff had sought appropriate advice from infection control specialist. A comprehensive risk assessment was in place that identified the controls to manage this outbreak. However, other practices in relation to infection control required improvement. While there was a cleaning schedule in place, inspectors observed practices that were not in line with best practice including clean mop-heads being put in buckets of still water and Milton after they had been cleaned.

Since the last inspection the personal evacuation plans had been updated to outline the assistance that residents would need in the event of an evacuation in addition to their mobility status. However, as identified on the previous inspection the evacuation route

from the second floor included accessing an external stairwell via an exit on the first floor. A risk assessment had still not been completed on the access to this external stairwell from outside. In addition, a fire risk assessment had not been completed by a suitably qualified person to demonstrate that the arrangements in place for containing the spread of smoke and fire in the event of a fire were adequate.

Inspectors reviewed the incident reporting system from January 2016 to October 2016.There had been five reported incidents including residents threatening staff and verbal abuse by residents of other residents.

For residents who had been identified as being at risk of falling, a screening tool had been developed which was comprehensive and identified key risk factors. However, where the screening tool identified a risk of falls, a risk assessment was not being completed. Therefore, the measures required to prevent falls for each individual were not clearly identified.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
As was found on the previous inspection, as a result of the inappropriate mix of residents in the centre it was not demonstrated that residents were being adequately protected from injury and harm by their peers.

Residents who required support to manage their behaviour had care support plans in place. However, improvement was required to behaviour support plans. The plans had been prepared by the previous person in charge and staff including an approved assessor in therapeutic management of aggression and violence (TMAV). The behaviour support plans had been developed without input from an appropriately trained and qualified professional. Therefore, the behaviour support plans did not provide appropriate guidance for staff to identify and alleviate the cause of residents' behaviour

that challenged.

The recording and monitoring of incidents of concern were being maintained. This included individual recording of any incidents on charts recording the antecedent to the behaviour, the behaviour itself and the consequences of the behaviour (ABC charts). Inspectors saw records for 73 recorded incidents from January 2016 to October 2016. The incidents involved verbal aggression including shouting at other service users, shouting at staff, threatening other service users and threatening staff. There was no review/oversight of these incidents by an appropriately trained and qualified professional. In addition a separate referral had been made in August 2016 for psychology support in relation to supporting residents who had a history of making false allegations. However, psychology support was not currently available.

There was evidence that these incidents of concern were having a negative impact on other residents living in the centre. For example, there were recorded incidents of other residents engaging in self injurious behaviour in response to incidents of concern. In addition, safeguarding plans, drawn up in consultation with the safeguarding officer for the service, were currently in place for all residents to protect them in their own home. Staff described to inspectors that due to the incidents in the house some residents preferred to stay in their room rather than the kitchen or sitting room areas.

A risk assessment was in place relating to the hazard of "challenging behaviour", dated 12 July 2016. This hazard had been rated as a "low risk". In the context of the severity of the incidents and the impact on other residents this risk assessment was not an accurate reflection of this hazard.

It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. There were five incidents submitted to the Chief Inspector since April 2016. Documentation in relation to these incidents were seen during the inspection. One of these incidents had been reviewed by the designated officer responsible for the protection of vulnerable adults in the service. This incident had been referred as a safeguarding concern to the Health Service Executive in accordance with the policy for the protection of vulnerable adults.

A risk assessment was in place relating to the hazard of "bullying/harassment" and "peer-to-peer abuse", dated 12 May 2016. The additional named control for this hazard was "service user placement review". A "person centred needs assessment for residential placement form" had been completed (no date). This identified that the resident "was not appropriately placed". However following this assessment the hazard rating had been reduced. In the context of the severity of the incidents and the impact on other residents this risk assessment was not an accurate reflection of this hazard.

At the previous inspection, not all staff who worked in the centre had received appropriate training to support residents when they engaged in behaviour that is challenging. On this inspection records indicated that all staff had received the appropriate training.

Since the last inspection written guidance was now in place in relation to the use of as required (PRN) medicine. This guidance was sufficiently clear to ensure that all staff

were clear in relation to when to administer the medication and had been approved by the prescriber of the medication.

Judgment:
Non Compliant - Major

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
It could not be demonstrated that each resident had a comprehensive assessment of their social and personal development needs.

At the previous inspection, a comprehensive assessment of residents' training, education and personal development needs had not been completed for all residents. Similarly on this inspection a comprehensive assessment of training and personal development needs was not in place for all residents. As a result, it could not be demonstrated that each resident had a comprehensive assessment of their social and personal development needs.

However, all of the residents attended either work or a day service with one resident participating in a day service coordinated from the designated centre. Some residents had completed training courses in third level colleges and were being supported to undertake further education.

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

Findings:
There was a written statement of purpose that accurately described the service provided in the centre.

The statement of purpose described the service and facilities provided to residents, the management and staffing and the arrangements for residents' wellbeing and safety. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre.

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

Findings:
The current arrangements in place in relation to the governance and management of the centre were not satisfactory.

At the previous inspection, four of 18 outcomes were at the level of major non-compliance with a further five at the level of moderate non-compliance. Of the nine outcomes where failings had been indentified these had been now addressed in four of the outcomes namely, protection of personal information (outcome 1), updating of statement of purpose (outcome 13), staffing (outcome 17) and the updating of policies (outcome 18). However, two of the nine outcomes remained at the level of major non-compliance, namely the inappropriate placement of a resident (outcome 5) and safeguarding (outcome 8). There were also continued failings in relation to risk assessment (outcome 7) and premises (outcome 6). This indicated that the current arrangements in place in relation to the governance and management of the centre

were not satisfactory.

At previous inspections, the arrangements in relation to the person in charge were not satisfactory due to the extensive remit of the person in charge. This resulted in insufficient oversight of the quality and safety of care and support provided in the centre. On this inspection the remit of the role of the person in charge remained unchanged from the previous inspection as there was still a remit for four designated centres. However, there was a new person in charge at the time of the inspection being inducted into the centre and was being mentored in relation to her new role. The new person in charge fulfilled the criteria of person in charge in terms of background and experience and said that she had committed to completing a management qualification.

Since the previous inspection a new residential services manager had been appointed to the service in February 2016. In addition the "link" nursing manager who had been in post at the time of the previous inspection had also been replaced. Inspectors were informed that the current nursing manager was in post on secondment from another service managed by the Daughters of Charity Services.

The provider had ensured that a six-monthly unannounced visit had taken place in the centre on the safety and quality of care and support provided in the centre. Inspectors reviewed the report from the most recent visit dated 6 September 2016. A number of failings identified on this inspection had also been identified by the provider, including failings relating to the care planning and "goal" setting for residents lives. However, further improvement was required to ensure that the unannounced visit adequately assessed key aspects of the safety and quality of care and support provided. In particular, this review of quality and safety of care did not identify that one resident was inappropriately placed in this designated centre.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Based on the assessed needs of residents, there were sufficient staff with the right

skills, qualifications and experience to meet those needs.

The house manager was part-time (17.5 hours per week) and worked the remainder of the week in another centre 10kms away. She outlined that there was now a full complement of staff in this centre.

The person in charged confirmed that there had been a high turnover of staff in this centre. For example two of the staff on the first day of inspection, while experienced in the area of care provision had only worked in this centre for a short time. In the context of a high number of recorded incidents of concern this turnover of staff could potentially impact on residents receiving continuity of care and support.

Since the last inspection there were records available to show that all agency and relief staff who worked in the centre had appropriate training in place.

Judgment:
Compliant

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
Since the previous inspection all required policies procedures and guidelines were available.

Judgment:
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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0005162
Date of Inspection:	24 and 25 October 2016
Date of response:	05 December 2016

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:
The centre was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents 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 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The Person in Charge will review the risk assessment relating to the hazard of "challenging behaviour", dated 12 July 2016, and ensure the hazard is an accurate reflection in the context of the severity of the incidents and the impact on other residents.

Following HIQA inspection the CNM3 and Person in Charge reviewed and updated the risk assessment in place relating to the hazard of "bullying/harassment" and "peer-to-peer abuse", November 2016, for all residents to ensure it reflected the context of the severity of the incidents and the impact it was having on all residents. An assessment of needs and service user questionnaire were also completed for one resident and following this an MDT was held on the 25th November to discuss the placement and the emotional and social needs of the Resident.

A case conference meeting with the HSE Case Manager for Disabilities Primary Care Area 1 and 2 was held on 02/12/2016 to discuss an appropriate placement to meet the needs of an individual Service User. Alternative providers are being considered as part of action plan from meeting.

The placement of this Service Use will be discussed at the next Admissions, Discharges and Transfers (ADT) meeting on December 6th 2016

At the request of HIQA updated action plan in relation to this issue was re-submitted by St Anne's Service.

Proposed Timescale: 06/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some improvement was required as the supports needed for residents to achieve the "goals" were not always identified. In addition, the timeframes whereby residents were to achieve the "goals" were also not always identified.

2. 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:
Each service users care plan will be audited /reviewed by the PIC or CNM3 involved in the delivery of care. Where there is evidence that goals are not based on an assessment of the service users needs or wishes, this will be revised and appropriate goals will be set, with a named responsible person to support the service user in

achieving the goal. Goals will be broken into steps, to aid achievement for the service user. The responsible person will report on progress to the person in charge at the monthly team meeting.

The Person in charge supported by the Clinical Nurse Manager 3 will review service users goals with the key workers in the centre and will name a responsible person who will be responsible for the implementation of each service users goals. Goals will be broken down into small steps to ensure achievement for the service users. The PIC will keep the Clinical Nurse Manager 3 updated on progress at their monthly meetings

Proposed Timescale: 28/02/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The carpet on the landing on the first floor had not been replaced.

3. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
The carpet will be replaced to an appropriate standard.

Proposed Timescale: 20/01/2017

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 process for risk assessment required improvement. In particular, access to the fire escape from the outside area and the process for falls risk assessment.

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:
Registered Provider and Person in Charge in consultation with the Fire Manager to complete a PEEP and a risk assessment for all service users for the evacuation from the house.

Person in Charge will ensure that the falls screening tool and risk assessment are completed on each service user.

Proposed Timescale: 06/01/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practices in relation to infection control required improvement. While there was a cleaning schedule in place, inspectors observed practices that were not in line with best practice including clean mop-heads being put in buckets of still water and Milton after they had been cleaned.

5. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
The Person in Charge and infection control Liaison Nurse to discuss at next house meeting the importance of infection control within the house. They will go through the household cleaning standards, in particular the correct cleaning procedure of cleaning mop-heads.

Proposed Timescale: 20/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire risk assessment had not been completed in the centre to demonstrate that the arrangements in place for containing the spread of smoke and fire in the event of a fire were adequate.

6. 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:
A fire risk assessment was completed and a plan will be costed with the Director of Logistics to address the outstanding works required.

Proposed Timescale: 16/01/2017

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 behaviour support plans had been developed without input from an appropriately trained and qualified professional. Therefore, the behaviour support plans did not provide appropriate guidance for staff to identify and alleviate the cause of residents' behaviour that challenged. There was no review/oversight of these incidents by an appropriately trained and qualified professional.

7. 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:
The ACEO has commissioned a review of all behaviours and plans within the centre. This is currently being undertaken by the Clinical Psychologist. A full report will be submitted to the CEO and ACEO by 15/12/2016

CNM3 will review all behavioural support plans with the PIC to ensure all staff meet all service users individual needs and behaviours that challenge. Any incidents that arise will be reviewed on a weekly basis by the PIC and CNM3 collaboratively.

Proposed Timescale: 15/12/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A referral had been made for psychology support in relation to supporting residents who had a history of making false allegations. However, psychology support was not currently available.

8. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
All allegations will be notified to the Designated Officer within the centre. They will follow the formal Safeguarding Process.

Interviews for a Psychologist took place in early December. There was a successful candidate. They are currently being processed by HR.

Proposed Timescale: 13/03/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that these incidents of concern were having a negative impact on other residents living in the centre.

9. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
The Person in Charge and CNM3 to review risk assessment relating to challenging behaviour and safeguarding plans for all residents

The CNM3 and Person in Charge reviewed and updated the risk assessment for violence and aggression towards staff and peers. An assessment of needs and service user questionnaire were also completed for one service user and following this an MDT was held on the 25th November to discuss the placement of the service user.

A case conference meeting with the HSE Case Manager for Disabilities Primary Care Area 1 and 2 was held on 02/12/2016 to discuss an appropriate placement to meet the needs of an individual Service User. Alternative providers are being considered as part of action plan from meeting.

The Quality and Risk Officer met with the PIC on 28/11/2016 to review risk assessments regarding challenging behaviour and violence and aggression.

Proposed Timescale: 02/12/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A robust assessment was not in place to establish each resident's educational, employment or training goals

10. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
The Person in Charge will review Care Plans and PCP's to ensure goals reflect training

educational and development as per access to training and development policy DOCS070
The PIC will ensure that the key worker will link with day services in relation to the setting and monitoring of goals.

Proposed Timescale: 28/02/2017

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:
Further improvement was required to ensure that the unannounced visit adequately assessed key aspects of the safety and quality of care and support provided. In particular, this review of quality and safety of care did not identify that one resident was inappropriately placed in this designated centre.

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

Please state the actions you have taken or are planning to take:
The Nonimee Provider will review the audit completed and ensure actions outstanding or issues identified in previous audits are reflected and an update provided. The Quality and Risk Officer will complete an annual report by 23/12/2016 as part of Governance and Management.

Proposed Timescale: 23/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two of the nine outcomes remained at the level of major non-compliance, namely the inappropriate placement of a resident (outcome 5) and safeguarding (outcome 8). There were also continued failings in relation to risk assessment (outcome 7) and premises (outcome 6) This indicated that the current arrangements in place in relation to the governance and management of the centre were not satisfactory.

12. 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:
A new PIC has been employed since August 2016. They are currently over four centres. There are Governance meetings with all PIC's and CNM3's. There is individual supervision provided by the CNM3 and Nominee Provider. Individual actions are in place to address the issues above. The ACEO meets with the Nominee Provider monthly to discuss local issues. There are Local Manager meetings held every quarter.
The non compliances highlighted will be escalated to the CEO via the corporate risk register.

Proposed Timescale: 31/12/2016