

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Saimer View Community Group Home
Centre ID:	OSV-0002495
Centre county:	Donegal
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Jacinta Lyons
Lead inspector:	Stevan Orme
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 29 May 2017 08:40 To: 29 May 2017 16:45

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

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 09: Notification of Incidents
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:

Following a review of compliance across the Health Service Executive (HSE) in the Northwest (CHO Area 1), the Health Information and Quality Authority (HIQA) raised concerns with the HSE National Director, in relation to the significant and ongoing levels of non-compliance in centres operated by the HSE in CHO Area 1.

The Chief Inspector of Social Services required the HSE to submit a plan to HIQA which described the actions the HSE would take in order to improve the quality of life for residents living in the services in the north west, and both improve and sustain a satisfactory level of compliance across five core outcomes which related to social care needs, health and safety and risk management, safeguarding and safety management, governance and management and workforce.

In December 2016 the HSE submitted a governance plan to HIQA. The plan described the enhanced governance and leadership arrangements and actions that the HSE intended to take by 13 June 2017, in order to improve the overall levels of compliance and quality of life for residents in CHO Area 1.

In response to this plan, HIQA has developed a regulatory programme of inspections to verify the effectiveness of this plan in improving the quality of life for residents and to monitor compliance with the Health Act 2007 (Care and Support of Residents

in Designated Centres for persons (Children and Adults) with Disabilities Regulations 2013) (hereafter called the Regulations) and the National Standards for Residential Services for Children and Adults with Disabilities 2013 (hereafter called the Standards).

How we gathered our evidence:

During the inspection, the inspector met with three residents who lived at the centre and met with two staff members. The person in charge was not available on the day of inspection and the inspection was facilitated by the centre's Area Coordinator. In addition, the inspector reviewed documents such as personal plans, fire safety records, risk assessments, safeguarding plans, rosters, policies and procedures and staff personnel files.

Description of the service:

The provider had produced a document called the statement of purpose, as required by the regulations and the inspector found that the service was being provided as described. The centre was part of services provided by the Health Service Executive (HSE) in Donegal. The centre comprised of a six bedded bungalow which provided full-time and shared care residential services to adults with a disability. The centre was of a suitable design to meet the needs of residents and located in a local town with easy access to shops and amenities.

Overall findings:

The inspection was unannounced and focused on actions taken by the provider and person in charge to address the findings of the previous inspection, which had occurred on the 28 February 2017. The inspector did not look at all aspects of the service provided, with only seven outcomes reviewed as part of the follow-up inspection.

The inspector found that the provider had not put in place robust governance and management systems to ensure a safe and quality care service at the centre. Furthermore, the management arrangements in place at the centre had not ensured that all agreed actions were completed following the previous inspection.

The inspector found that the centre's governance and management arrangements had not ensured that one resident was protected from physical abuse by a peer, and that strategies for the management of another resident's behaviours of concern were implemented in a timely and effective manner.

Although the provider had introduced new risk management systems at the centre, the inspector found that these had not recorded all risks and scheduled audits had not occurred. Furthermore, governance arrangements had not ensured residents' personal plans were reviewed annually and staff had access to training in line with the provider's policies and residents' needs.

The inspector did observe that staffing arrangements had improved at the centre since the previous inspection. Residents now had access to nursing support during the week and additional staffing was available. However, the inspector found that although staffing had increased, which gave residents more opportunities to access

the local community, this had been introduced several months after the previous inspection and in response to a safeguarding issue, which related to one resident's behaviours of concern and not to increase opportunities for social activities.

The inspector further found during the inspection, that the person in charge had not ensured that all reportable incidents under the regulations were submitted to the Chief Inspector.

The inspector found that previous inspection findings, which related to evidence of damp at the centre, had been addressed.

Summary of regulatory compliance:

The centre was inspected against seven outcomes. The inspector found major non-compliance in four outcomes relating to social care needs, safeguarding, notifications to the Chief Inspector and workforce. Moderate non-compliance was found in two outcomes in regards to risk management and the centre's governance arrangements. Compliance was found in relation to the centre's premises.

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the action plan at the end of this report.

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

Outcome 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):

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

Findings:

The inspector found that although the person in charge had addressed the findings from the previous inspection, they had not ensured that all residents' personal plans were reviewed annually.

The inspector did not focus on all aspects of the outcome and centred on actions taken by the person in charge to address findings from the previous inspection.

Actions 1, 2 and 3

The previous inspection had found that personal plans did not reflect residents' assessed needs. In addition, residents' personal goals were not developmental in nature and did not reflect residents' personal preferences.

In the provider's action plan response, the provider had assured HIQA that by the 30 April 2014 they would:

- Ensure that residents' assessed needs were reflected in personal plans
- Ensure that healthcare assessment recommendations were reflected in residents' personal plans
- Ensure that safeguarding plans were reflected in residents' personal plans
- Reviews would assess the effectiveness of residents' personal plans and goals
- Reviews would be undertaken with the maximum participation of residents or their representatives
- Reviews would ensure that residents' goals were developmental, meaningful and reflect each resident's preferences

- Ensure that personal plans are updated following annual reviews and strategy meetings
- Updated personal plans would be communicated to staff at the centre

The inspector reviewed a sample of residents' personal plans and found that they had been updated following the previous inspection and reflected both residents' assessed needs and staff knowledge. The inspector found that personal plans were informative of residents' support needs and included healthcare and safeguarding plan recommendations, as well as information on any support required with personal care, behaviours of concern and activities of daily living.

The inspector found that although a personal plan annual review meeting had occurred for three residents at the centre, the person in charge had not ensured that reviews had been held for two residents. Records examined showed personal plan annual reviews had not occurred for over 24 months in the case of one resident and 18 months for the other.

Where personal plan reviews had occurred following the previous inspection, the inspector found that the effectiveness of the resident's personal plan had been assessed and discussion had occurred on all aspects of the resident's needs such as health, communication, social activities and relationships. In addition, the inspector found that residents' personal plans had been updated following annual reviews and strategy meetings relating to the safeguarding of residents and the management of behaviours of concern.

Records showed residents had been encouraged to attend their review meeting, and that the meeting was attended by their representative. The inspector found that residents' goals were both developmental in nature and reflected their interests; however, although goals identified the supports required, they did not give dates for expected achievement.

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

Findings:

The provider had ensured that the previous inspection's finding was addressed.

The inspector did not look at all aspects of this outcome, and focused on actions taken by the provider to address the findings of the centre's previous inspection.

Action 4

The previous inspection's findings had identified evidence of damp in the communal bathroom and sitting room.

In their action plan response the provider had assured HIQA that by the 30 April 2017 they would:

- Ensure that required works were completed to eradicate damp in the centre

The inspector was told by staff that maintenance work had occurred to prevent the reoccurrence of damp in the rooms including redecoration of affected areas. The inspector saw the completed works undertaken by the provider, and found no evidence of damp in the centre during the inspection.

Judgment:

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:

The inspector found that the provider had not addressed all actions from the previous inspection.

The inspector did not focus on all aspects of this outcome and centred on actions taken by the provider to address findings from the previous inspection at the centre.

Action 5

The previous inspection found the centre's risk management systems had not ensured:

- That risk assessments were updated to reflect all risks and reviewed in-line with agreed timeframes
- That control measures were implemented to mitigate against identified risks
- The emergency plan information related to the designated centre

- Recommendations from management audits were completed

The provider in their action plan response had assured HIQA that by the 30 April 2017 they would,

- Undertake a comprehensive review of all risks identified at the centre
- Ensure that the risk register was up-to-date, have dates for review and plan for the review of risks quarterly or more often if required
- Ensure that adequate control measures were put in place to mitigate identified risks
- Assess the effectiveness of fire safety arrangements at the centre
- Ensure there was a clear plan in place to respond to emergencies
- Introduce an annual plan of audits

The inspector found that the centre's risk register and risk assessments had been reviewed and updated since the previous inspection. The inspector found that risk assessment included control measures to mitigate risk and these reflected staff knowledge. However, the inspector found that an identified risk to residents from choking was not included in the centre's risk register.

The inspector reviewed the emergency plan which had been updated and reflected both arrangements in place at the centre and staff knowledge. Furthermore, records reviewed by the inspector showed that staff had completed regular weekly in-house checks on the condition of fire safety equipment.

The inspector found that the provider had introduced an annual schedule of audits which included health and safety practices at the centre. However, the inspector found no evidence that infection control audits had been completed in line with the provider's schedule which was also confirmed by staff at the centre.

Action 6

The previous inspection had found that not all staff had received infection control and hand hygiene training.

The provider had assured HIQA that by the 30 April 2017, they would;

- Arrange for staff to have both infection control / hand hygiene training

The inspector reviewed training records at the centre and found all staff had completed infection control and hand hygiene training.

Action 7

The previous inspection had found that fire evacuation drills had not been conducted at suitable intervals and involved all residents and staff at the centre.

The provider had assured HIQA that by the 30 March 2017.

- All residents and staff would have participated in a fire drill
- A plan of fire drills at suitable intervals would be in place

The inspector found that regular simulated fire drills had occurred which had involved all residents and a schedule was in place for drills at suitable intervals throughout the year. However, although staff knowledge reflected the centre's fire evacuation plan, the

inspector found that not all staff had participated in a fire drill from records examined and discussions with staff.

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:

The provider and person in charge had not ensured that residents were protected from abuse and that behaviours of concern were well managed. Furthermore, the provider and person in charge had not ensured that actions from the previous inspection were addressed.

The inspector did not look at all aspects of this outcome, and focused on actions taken by the person in charge and provider to address the findings of the previous inspection.

Action 8

The previous inspection had found that not all staff had received positive behaviour management training.

The provider had assured HIQA that by the 30 April 2017 they would arrange positive behaviour management training for all staff.

The inspector found during this inspection that not all staff had completed positive behaviour management training in line with the provider's policies.

Action 9

The previous inspection had found that not all residents who required behaviour support plans had them in place.

The provider had assured HIQA that by the 30 April 2017,

- All residents would have behaviour support plans in place which would be developed in

conjunction with a clinical psychologist

- The person in charge would ensure that behaviour support plans were communicated to staff.

The inspector found that residents' behaviour support plans had been updated, and reflected staff knowledge; however, they had not been reviewed in conjunction with a clinical psychologist.

Furthermore, the inspector reviewed accidents and incident records and found that a resident had displayed behaviours of concern to their peers and staff on six separate occasions over a six week period. The inspector found that the person in charge had not ensured that the residents' behaviour support plan was reviewed in a timely manner in response to these incidents. The inspector found that although the plan had been reviewed this had not occurred until after three incidents, of which two related to peer-to-peer abuse. Furthermore, the inspector found that a recommendation for additional staff was not agreed to be implemented until nine days after the review and resulted in a further incident towards the resident's peer. In addition, following the implementation date for additional staff, two further incidents of behaviours of concern had occurred and a review had not occurred to assess the ongoing effectiveness of the behaviour support plan to meet the resident's assessed needs.

Action 10

The previous inspection had found that not all staff had received 'safeguarding of vulnerable adults' training. The provider had assured HIQA that by the 30 April 2017, safeguarding training would be arranged for staff

The inspector reviewed training records which showed that not all staff had completed 'safeguarding of vulnerable adults' training at the centre in-line with the provider's policies.

Action 11

The previous inspection had found that residents' safeguarding plans had not been updated in-line with strategy meeting recommendations, and plans had not been reviewed against agreed timeframes.

The provider assured HIQA in their action plan response that by the 30 April 2017 they would;

- Complete a review of all safeguarding plans
- Ensure that all safeguarding plans were updated to reflect strategy meeting recommendations and recorded incidents
- Ensure that all safeguarding plans had identified review dates and were reviewed in-line with said dates.

The inspector reviewed safeguarding plans at the centre and found that they were not consistently reviewed following recorded incidents and that the person in charge had not ensured that residents were protected from abuse.

The inspector found from a review of the centre's accident and incident records that a resident had been a victim of physical abuse by one of their peers on five separate

occasions over a six week period. The inspector found that the person in charge; who was also the centre's 'Designated Safeguarding Officer', had not completed a preliminary screening and implemented a safeguarding plan to protect the resident until six weeks after the date of the first incident of physical abuse. The inspector noted that during this period a further three incidents of physical abuse towards the resident had occurred.

The inspector reviewed the completed safeguarding plan following the preliminary screening which had recommended increased staff levels; however, the plan did not include timeframes for when this was to occur. In addition, when additional staffing was introduced to safeguard the resident, a further incident of physical abuse from their peer occurred, and there was no evidence of a review into the effectiveness of the plan to protect the resident from abuse in light of this event.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

The inspector found that the person in charge had not informed the Chief Inspector of all events required under regulation.

The inspector reviewed accident and incident records maintained at the centre as part of the inspection. During this review, the inspector found that three incidents of peer-to-peer abuse had not been reported to the Chief Inspector in line with regulatory requirements.

Judgment:

Non Compliant - Major

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

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 inspector found that the centre's governance and management arrangements did not support the delivery of a safe and quality care service. In addition, the inspector found that not all actions had been addressed from the previous inspection.

The inspector did not focus on all aspects of this outcome and centred on actions taken by the provider to address the findings of the previous inspection.

Action 12

The previous inspection had found that staff did not receive regular supervision from the person in charge.

The provider had assured HIQA that by the 30 April 2017 that they would;

- The person in charge would complete 'Personal Development Plans' (PDPs) with all staff
- The person in charge would develop a schedule to ensure all staff received regular supervision

The inspector found that the person in charge had commenced PDPs with staff which had included discussions on the staff member's developmental and training needs from records reviewed. However, staff were not aware of when the person in charge would meet them again to discuss or review their PDPs.

Action 13 and 15

The previous inspection had found under action 13 that the centre's management systems had not ensured the provision of safe and quality care services. In addition, in both action 13 and 15, the inspection had found that team meetings had not occurred at suitable times to provide staff with an opportunity to discuss the service and raise concerns.

The provider had assured HIQA that by the 30 April 2017, they would do the following;

- The person in charge would ensure that a schedule of audits is completed
- The person in charge would ensure that actions from said audits would be addressed in a timely manner
- The person in charge would ensure internet access was available at the centre to aid staff communication with them
- The person in charge would ensure regular staff meeting and staff supervision
- The person in charge would sign the visitors' book and reflect their presence in the centre on the roster

The inspector found that governance and management arrangements in place at the centre did not ensure safe and quality care services were provided. The inspector found the person in charge and provider had not ensured that concerns which related to the safeguarding of residents and the management of residents' behaviours of concern were addressed in a timely manner in line with the provider's policies.

Although the inspector found that an annual schedule of audits had been introduced at the centre, records reviewed showed that audits had not been completed such as audits of complaint management, residents' personal plans, medication and infection control.

The inspector noted that internet access was available at the centre following the previous inspection; however, although on order, a laptop had not been provided for staff at the centre to facilitate communication with the person in charge or provider.

The inspector found that regular team meetings had commenced at the centre and an annual schedule was in place. Staff told the inspector that they found the person in charge to be approachable and had no reservations in raising concerns with either the person in charge or the provider's representatives. However, the inspector found that agreed team meeting actions such as the use of additional staff to meet residents' social activity needs had not been implemented.

The inspector did find that following the previous inspection, the person in charge had commenced formal supervision arrangements with staff, known as PDPs. Staff told the inspector that they discussed both their developmental and training needs with the person in charge and this was reflected in records sampled. However, staff were not aware of when they would meet the person in charge again to discuss or review progress with their PDPs.

The inspector reviewed the centre's visitors' book and found that the person in charge was regularly at the centre which reflected staff knowledge. However, the inspector found that the person in charge had not consistently reflected their presence at the centre on the roster.

Furthermore, the governance and management arrangements in place at the centre had not ensured that the previous inspection's findings were addressed in-line with agreed timeframes such as staff training and annual resident personal plan reviews. In addition, the provider had not ensured that all notifiable events were submitted to the Chief Inspector in accordance with regulation.

Action 14

The previous inspection had found that the centre had not received six monthly unannounced provider visits as required under the regulations. In response to this finding, the provider had assured HIQA that by 30 April 2017, a schedule for unannounced visits would be in place.

The inspector found that the provider had completed a six monthly unannounced provider visit to the centre following the previous inspection, and a copy of the visit report was available on the day of inspection.

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):

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

Findings:

The inspector found that the centre had not consistently ensured staffing arrangements met residents' assessed needs. In addition, the provider and person in charge had not ensured that all actions from the previous inspection had not all been addressed.

The inspector did not look at all aspects of this outcome, focusing on actions taken by the person in charge and provider to address the findings of the previous inspection.

Action 16

The previous inspection had found that nursing support as described in the centre's statement of purpose was not provided due to staff vacancies. The provider had assured HIQA that by the 20 March 2017, a nurse would be rostered at the centre for two days a week.

The inspector found that the provider had ensured that nursing support was available to the centre for two days a week. Furthermore, the inspector was told that to meet residents' assessed needs, nursing support had increased from eight to 15 hours per week. However, although nursing support had been put in place, the inspector found that this had not occurred until after the agreed timeframe on the 12 April 2017.

Action 17

The previous inspection had found that weekday staffing levels did not facilitate residents accessing community activities of their choice. The provider had assured HIQA that by the 30 April 2017, that adequate staff would be on duty during the week to meet residents' assessed needs.

The inspector found that adequate staffing was in place on the day of inspection to meet residents assessed needs. Staff told the inspector that an additional staff member was rostered each weekday and this enabled residents to do more activities of choice.

However, the inspector found that although additional staffing was agreed in a team meeting on the 15 March 2017, it was not reflected in rosters sampled until 8 May 2017. In addition, the inspector found that the additional staffing, although introduced, had not occurred to facilitate increased community access but in response to safeguarding concerns and the management of one resident's behaviour of concern at the centre. The inspector further found from a review of resident's activity records prior to the 8 May 2017, that residents had continued to only engage in activities at home or access the local community as a group activity.

Action 18

The previous inspection had found that the centre's roster had not reflected staff on duty on the day of inspection. The provider had assured HIQA that by the 20 March 2017, the roster would reflect staff on duty at the centre.

The inspector reviewed the centre's roster and found that it reflected staff on duty on the day of inspection. However, the inspector found that the roster did not consistently show the person in charge's presence in the centre.

Action 19

The previous inspection had found that staff personnel files did not contain all information required under Schedule 2 of the regulations. The provider had assured HIQA that by the 30 April 2017 all information required, apart from Garda Vetting, would be in place. Furthermore, the provider assured HIQA that proof of Garda vetting for all staff would be in place by the 30 June 2017.

The inspector reviewed a sample of staff personnel files and found that that they were still not in compliance with the requirements of Schedule 2 of the regulations and did not contain.

- Proof of qualifications for three staff members
- An employment contract for one staff member

Action 20

The previous inspection had found that staff at the centre did not have up-to-date training in-line with residents needs. The provider had assured HIQA that by the 30 April 2017 arrangements would be put in place for staff to receive manual handling and epilepsy awareness training.

The inspector reviewed training records and found that not all staff had received up-to-date epilepsy awareness and manual handling training.

Judgment:

Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Stevan Orme
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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002495
Date of Inspection:	29 May 2017
Date of response:	22 June 2017

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

The inspector found that not all residents' personal plans had been reviewed annually.

1. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

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

Annual Reviews have been completed for all residents.

Proposed Timescale: 09/06/2017

Theme: Effective Services

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

The inspector found that a resident's agreed personal goals did not include expected timeframes for achievement.

2. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Personal Goals now include an identified person and a timeframe for achievement.

Proposed Timescale: 16/06/2017

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 inspector found that the centre's risk register did not include all identified risks. In addition, the inspector found that the centre had not completed infection control audits in line with the provider's annual audit schedule.

3. Action Required:

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

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

The Centres Risk Register now contains all identified risks. Completed May 30th 2017. An Infection Control Audit has been completed for this Centre. Completed 14th June 2017

Proposed Timescale: 30/05/2017

Theme: Effective Services

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

The inspector found that not all staff had participated in a simulated fire drill at the centre.

4. 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:

1. All Staff have participated in a simulated fire drill with the exception of one staff who is currently on leave.
 2. The staff member who is on leave will participate in a drill on return to work.
1. Completed 16.06.2017 2. July 31/07/2017 or sooner if staff returns to work

Proposed Timescale: 31/07/2017

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 inspector found that not all staff had received positive behaviour management training

5. Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

1. All Staff have received positive behaviour management training with the exception of one staff who is currently on leave.
 2. The staff member who is on leave will receive this training on return to work.
1. Completed June 6th 2017 2. 31/07/ 2017 or sooner if staff member returns to work

Proposed Timescale: 31/07/2017

Theme: Safe Services

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

Residents behaviour support plans had not been reviewed by a clinical psychologist and

updated following incidents of concern.

6. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Residents Support Plans have been reviewed and signed off by a Clinical Psychologist and will be updated following incidents of concern going forward.

Proposed Timescale: 06/06/2017

Theme: Safe Services

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

The person in charge had not investigated incidents of physical abuse towards a resident by one of their peers in line with the provider's policies which had resulted in further incidents of abuse occurring.

7. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

All incidents of physical abuse towards a resident by one of their peers will be preliminary screened, and submitted to the Safeguarding team and an initial safeguarding plan produced as part of this process.

All Staff will be informed of the safeguarding plan and these will be implemented in the designated Centre in conjunction with positive behaviour support plans.

Proposed Timescale: 30/06/2017

Theme: Safe Services

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

The inspector found that not all staff had received 'safeguarding of vulnerable adults' training.

8. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

1. All Staff have received safeguarding of Vulnerable Adults training with the exception of one staff who is currently on leave.
2. The staff member who is on leave will receive this training on return to work.
1) Feb 14th 2017 2) 31/07/2017 or as soon as the staff members return to work.

Proposed Timescale: 31/07/2017

Theme: Safe Services

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

The inspector found that one resident had not been protected from incidents of physical abuse by a peer.

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:

All incidents of physical abuse towards a resident by one of their peers will be preliminary screened, and submitted to the Safeguarding team and an initial safeguarding plan produced as part of this process.

All Staff will be informed of the safeguarding plan and these will be implemented in the designated Centre in conjunction with positive behaviour support plans.

Proposed Timescale: 31/07/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

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

The person in charge had not notified the Chief Inspector of all incidents of alleged , suspected or confirmed abuse of any resident.

10. Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

A review of all reported accidents and incidents since January 2017 was completed and all incidents of alleged, suspected or confirmed abuse has been notified to the Chief Inspector.

Proposed Timescale: 18/06/2017

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:

The inspector found that the centre's governance and management arrangements had not ensured a safe and quality care service provided to residents and in-line with regulatory requirements.

11. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

A Staff Nurse is on site 15hrs per week.

Regular monthly Staff meetings are held in place.

Two staff are on duty each evening to ensure safety and provide individual opportunities for socialization.

Proposed Timescale: 11/05/2017

Theme: Leadership, Governance and Management

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

Although Personal Development Plans had commenced for staff at the centre, a schedule on dates for further formal supervision was not available to staff and the inspector .

12. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements 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.

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

A Schedule of dates for further formal supervision has been completed and staff have been informed of same. This schedule is available in the designated Centre for Inspection.

Proposed Timescale: 02/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider had not ensured that additional staffing was consistently available to meet residents assessed needs.

13. 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:

Additional Staff is now consistently available to meet the residents assessed needs.

Proposed Timescale: 05/05/2017

Theme: Responsive Workforce

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

The person in charge had not ensured that staff personnel files contained all documents required under Schedule 2 of the regulations.

14. 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:

1. The person in Charge will ensure that information and documents as specified in Schedule 2 are obtained for all staff.

2. Garda Clearance documentation will be made available for Inspection.

1. 31/07/2017 2. 30.08.2017

Proposed Timescale: 30/08/2017

Theme: Responsive Workforce

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

The roster did not consistently show when the person in charge had been present at the centre.

15. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The Roster is updated daily to ensure that it identifies when the person in charge is present at the centre.

Proposed Timescale: 30/05/2017

Theme: Responsive Workforce

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

The person in charge had not ensured that staff had accessed training in line with residents assessed needs.

16. 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:

1. Manual Handling Training was provided on 25/05/2017 for all Staff. Four Staff were unable to attend on this date.
2. Further training has been organised for June 19th 2017 and June 22nd 2017
3. Staff who are on leave will attend this training on return to work.

Proposed Timescale: 31/07/2017