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:	Drogheda Unit Sean O'Hare
Centre ID:	OSV-0002530
Centre county:	Donegal
Type of centre:	Health Act 2004 Section 38 Arrangement
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:	4
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:	To:
18 April 2017 08:45	18 April 2017 19:30

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 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), 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 this area.

The Chief Inspector of Social Services in HIQA required the HSE to submit a plan to HIQA which described the actions the HSE would take, in order to improve the overall safety and the quality of life for residents living in the services in this area, and to improve and sustain a satisfactory level of compliance across five core outcomes of concern which related to social care needs, risk management, safeguarding and safety, 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 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 spent time with five residents living at the centre and met with five staff members. In addition, the inspector reviewed documents such as personal plans, risk assessments, safeguarding plans, behaviour support plans, 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. The inspector found that the care and support provided to residents was as described in this document, although the centre's management structure was not as described in the statement of purpose on the day of inspection. The centre was a congregated setting attached to a community hospital for older people and located close to local shops and amenities. The centre was part of the Health Service Executive (HSE) services in Donegal and provided both full and part-time residential services to adults with a disability.

Overall findings:
The inspector found that the centre's management arrangements were not in compliance with the regulations as the provider had not ensured that appropriate arrangements were in place to cover a planned absence of over 28 days by the centre’s person in charge.

Furthermore, the inspector found that although the centre had addressed the majority of actions from the previous inspection, actions relating to fire safety were still outstanding. In addition, the inspector found that the centre's governance and management arrangements had not ensured that the findings from the provider’s own internal quality assurance systems had been addressed in-line with agreed timeframes.

The inspector reviewed residents' personal plans and activity records and found that following the previous inspection, residents had more access to a range of centre and community-based activities which reflected their assessed needs. Throughout the inspection, the inspector observed that residents appeared comfortable and happy with the support received from staff. In addition, the inspector found that staff were knowledgeable of residents’ needs and had access to related training.

The inspector found that the centre's design did not meet residents' private accommodation needs, under Schedule 6 of the regulations, and identified improvements that were required to the centre's state of repair. In addition, the inspector found that the provider had not fully assessed the effectiveness of fire safety arrangements to protect residents from risk.

Furthermore, the inspector found that the staff roster did not meet the needs of residents as reflected in documents reviewed. Staff personnel records were not in compliance with the requirements of Schedule 2 of the regulations.

Summary of regulatory compliance:
The centre was inspected against six outcomes. The inspector found major non-compliance in four outcomes relating to the premises, risk management, fire safety, governance and management, and workforce. Moderate non-compliance was found in two outcomes relating to residents' social care needs, safeguarding and the management of behaviour that challenges.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that although residents' personal plans were comprehensive and reviewed annually, they did not, in all cases, show the involvement of either the resident or their representatives and did not reflect all supports provided.

The inspector reviewed residents' personal plans which included information on support needs in areas such as 'being safe', mobility, medication, healthcare, personal care and behaviour that challenges. The inspector found that personal plans were up to date, reviewed annually and reflected both staff knowledge and observed practices. The inspector found that residents' personal goals reflected their likes and assessed needs. Furthermore, goal planning records reviewed by the inspector included named staff supports and agreed timeframes for achievement.

However, the inspector found that review meeting minutes did not consistently show whether residents or their representatives had participated in the review. Furthermore, review minutes examined did not, in all cases, demonstrate an assessment of the personal plan's effectiveness in meeting all of the resident's needs, including the achievement of personal goals. In addition, the inspector found that personal plans were not available to residents in an accessible format reflective of their needs.

The inspector reviewed daily notes and activity records and found that activities available to residents had increased since the previous inspection. The inspector found that residents had accessed a range of activities both within the centre and local community which reflected their assessed needs. However, the inspector found that residents' agreed weekly activity schedules were not consistently reflected in activity

records reviewed.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Following the previous inspection, the inspector found that the centre had made improvements to support residents' right to privacy and the centre's premises. However, the inspector found improvements were required to the condition of the premises, and the centre's design did not meet residents' private accommodation needs.

The centre was a congregated setting located within a community hospital and provided residential support to residents either on a full or part-time arrangement. The centre comprised of three dormitory style shared bedrooms which accommodated either two or three residents in each. Although privacy screening was provided for each resident around their bed, adequate private accommodation was not available to residents in-line with Schedule 6 of the regulations due to the centre's design.

The inspector observed that following the previous inspection, improvements had been made to the physical condition of the premises such as repairs to bedroom floor tiles and the centre's adapted bath. However, the inspector observed wear and tear to building such as;

- uneven corridor flooring
- stained bathroom flooring
- missing bathroom wall tiles with exposed pipe work
- flaking window and window sill paintwork.

Judgment:
Non Compliant - Major

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 although residents were kept safe at the centre, management systems had not ensured risks were managed in-line with agreed assessments and the effectiveness of fire safety arrangements had not been fully assessed.

The centre was equipped with fire safety equipment including fire extinguishers, fire alarms, magnetic closures on fire doors, fire call points, smoke detectors and emergency lighting which records showed were regularly serviced by an external contractor. However, the inspector observed that the fire door in the dining room did not close effectively, and although reported the provider's maintenance department, works had not been completed to date.

The centre's fire drill records showed that regular simulated evacuations were conducted. This was further reflected in discussions with staff. However, records examined for 2016 and 2017 did not evidence that simulated drills had been carried out evacuating all residents at the same time under minimal staffing conditions. Furthermore, records examined for the same period did not show whether a part-time resident who accessed the centre had participated in a simulated fire drill.

The centre's fire evacuation plan was prominently displayed throughout the centre and reflected staff knowledge. However, records showed that one staff member had not received up-to-date fire safety training, in-line with the provider's policy. Furthermore, the inspector found that an accessible version of the centre's fire evacuation plan was not on display for residents to access. The inspector reviewed residents' 'Personal Emergency Evacuation Plans' (PEEPs) which were up to date and reflected residents' assessed needs and staff knowledge.

The centre had an up-to-date safety statement and risk register, with associated risk assessments, which were regularly reviewed and reflected staff knowledge and observed practices on the day. However, arrangements for nursing cover were not in-line with a risk assessment reviewed by the inspector, which related to residents' healthcare needs and accessing community activities. Furthermore, the inspector found that risk assessments did not reference or provide a rationale for restrictions at the centre such as key pads on entrance doors to the centre

In addition, the inspector found that risk control measures such as staff completing breakaway technique' training had not been completed in-line with agreed timeframes.

The inspector reviewed the centre's infection control procedures and observed that hand

hygiene information was displayed in the kitchen and communal bathrooms. In addition, hand santisers and segregated waste disposal facilities were available. However, records showed that not all staff had received up-to-date hand hygiene training. Records further showed that one staff member had not received up-to-date manual handling training in-line with the provider's policy.

Judgment:
Non Compliant - Major

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 inspector found that residents were safeguarded from the risk of abuse and supported in the management of behaviour that challenges, although practices were not consistently in-line with the provider's polices.

The inspector reviewed residents' safeguarding plans which were comprehensive, regularly reviewed and updated. Furthermore, the inspector found that staff knowledge reflected safeguarding plans examined. However, although the inspector noted that, in the main, safeguarding concerns were reported to the centre's designated safeguarding officer in-line with the provider's policy, one concern had not been reported until eight weeks after the event.

Residents' behaviour support plans included a description of the behaviour and both proactive and reactive management strategies. The inspector found that behaviour support plans reflected both staff knowledge and observed practices on the day. Plans were developed by staff in conjunction with a senior psychologist; however, the inspector found that plans did not record when they were implemented and dates when the plan's effectiveness would be reviewed. The inspector found that staff currently delivering care and support to residents had received positive behaviour management training.

The centre maintained a restrictive practice register which showed when agreed

interventions were used and the duration of their use. The register reflected both staff knowledge and residents' personal plans and risk assessments.

The inspector found that staff, currently providing support to residents, had received up-to-date safeguarding of vulnerable adults training and, staff knowledge was in-line with the provider's policy. Furthermore, the inspector observed that information on the centre's safeguarding policy was displayed prominently throughout the centre and included photographs of designated safeguarding officers.

Residents were unable to speak to the inspector about the support they received at the centre. However, the inspector spent time with residents and observed that they appeared both happy and comfortable with the support they received from staff. In addition, the inspector spoke to a resident's relative at the centre who said that their relative was well cared for and they were happy with the care provided. In addition, the inspector observed staff providing support to residents in a respectful and timely manner in-line with their assessed needs.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The provider had not ensured that appropriate arrangements were in place to cover a planned absence of over 28 days by the centre's person in charge. Furthermore, although governance and management systems were in place at the centre, they had not ensured that the findings of the previous inspection and the provider's own quality assurance system were addressed in-line with agreed timeframes.

At the time of inspection, the provider had not ensured that an appropriately qualified full-time person in charge was in place to cover a planned absence of six months by the centre's person in charge. The provider had put arrangements in place through the appointment of an acting Clinical Nurse Manager - Grade 2 (CMN2) based at the centre until a person in charge was appointed.

The inspector reviewed audit systems in place at the centre which included the monitoring of accidents and incidents, use of restrictive practices, health and safety and fire safety arrangements. However, the inspector found that audits were not consistently carried out in-line with the provider's policies.

Furthermore, the inspector found that the audit and governance arrangements in place had not ensured that findings from the centre's inspection were addressed, such as ensuring the effectiveness of fire safety arrangements.

In addition, the inspector reviewed the centre's internal quality improvement plan and found that actions had not been addressed in-line with agreed timeframes; such as, arrangements for the management of residents' finances and the compliance of staff personnel files with both schedule 2 of the regulations and the provider's policies.

The provider had completed six-monthly unannounced visits at the centre and copies of the reports were available. However, the inspector found that identified actions; such as, ensuring nursing support was available to facilitate residents' healthcare needs while engaged in community activities and referrals to behavioural therapists, had not been completed in-line with the agreed timeframes.

Staff told the inspector, that the acting CNM2 was based at the centre, which was reflected on the centre's roster and team meeting minutes. Staff told the inspector that they attended regular staff meetings facilitated by the CNM2. This was reflected in meeting minutes examined. Staff told the inspector that they found the CNM2 to be approachable and available as and when required. In addition, staff told the inspector that they would not have any reservations in bringing concerns to the CNM2's attention. However, although staff were aware of the provider's intention to introduce 'personal development plans' for staff, no formal supervision arrangements were in place for staff at the centre.

The inspector found that an up-to-date annual review on the care and support provided at the centre had been completed and was available on the day of inspection.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
The inspector found that the centre's staffing arrangements, as set out in the statement of purpose, were not reflected on the day of inspection or in-line with risk assessments. In addition, the inspector found that staff records did not comply with the requirements of Schedule 2 of the regulations.

The inspector found that although the centre had both a planned and actual roster, the roster was not reflective of staffing on the day of inspection as two of the four care assistants rostered were not present in the centre. The inspector was told that one care assistant was at a local hospital due to a resident's admission, while the second care assistant was working in a neighbouring designated centre due to staffing shortages.

Furthermore, the inspector noted a risk assessment which required two nurses to be available at the centre to facilitate residents' healthcare needs when accessing the community was not being fully reflected in the centre's roster. The inspector found that over an eight day period between the 10 April 2017 and 18 April 2017 there were only three occasions when a second nurse had been allocated to meet residents' needs. The inspector also found that on the planned roster for the period 19 April 2017 to 07 May 2017, a second nurse had only been allocated on eight occasions.

The inspector reviewed a sample of five staff personnel files and found that they did not contain all documents required under Schedule 2 of the regulations including;

- employment histories
- proof of Garda vetting
- employment contracts
- copies of qualifications and nursing registrations.

The inspector reviewed training records and found that staff had access to mandatory training in-line with residents' needs. Furthermore, staff knowledge and observed practice reflected residents' assessed needs as found in personal plans, risk assessments and behaviour support plans sampled by the inspector.

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 report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002530
Date of Inspection:	18 April 2017
Date of response:	11 May 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:
Annual reviews did not consistently evidence an assessment on the effectiveness of the personal plan to met the resident's needs.

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

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

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:
The new annual review template will be implemented for 2017 reviews.
The effectiveness of personal goals and nursing interventions will be reviewed and documented.

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that residents' agreed weekly activity schedules were not consistently reflected in records sampled.

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

Please state the actions you have taken or are planning to take:
The current activity schedules were introduced on a trial basis on the 22.03.17, there is a daily commitment to follow the schedule.
Adherence to the schedule has been emphasised by the A/CNMII who is monitoring this on a daily basis.

Proposed Timescale:
4.05.2017 Completed and on going

Proposed Timescale: 04/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan review meetings did not consistently show the involvement of either the resident or their representatives.

3. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
1. Person Centred Plan discussions and meetings added to each resident’s weekly

activity schedule with a focus on documenting residents' and / or representatives attendance and discussions including goal setting and goal progress.
2. The new annual review template will be implemented for 2017 reviews the level of involvement and participation of residents and their representatives will be documented.

Proposed Timescale:
1. Completed 4.05.2017 2. Dec 31st 2017

Proposed Timescale: 31/12/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not available to residents in an accessible format.

4. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
Person Centred Plans are available in accessible format using a photo album approach but were not shown to inspector on the day of inspection. The paper based Person Centred Plans are stored in the residents personal plan folder and the accessible Person Centred Plans stored in the residents bedrooms.

Proposed Timescale:
Completed 4.05.2017

Proposed Timescale: 04/05/2017

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 inspector observed wear and tear to building such as;

- Uneven corridor flooring
- Stained bathroom flooring
- Missing bathroom wall tiles with exposed pipe work
- Flaking window and window sills paintwork

5. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
1. A Comprehensive list of all maintenance repairs has been forwarded to the Maintenance Department.
2. All Maintenance Work will be completed.

Proposed Timescale:
1. Completed 4.05.2017 2. July 31st 2017

Proposed Timescale: 31/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the dormitory style and multi-occupancy bedrooms, the premise's design did not provide adequate private accommodation for residents.

6. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
1. An Option appraisal will be completed to identify options for more appropriate accommodation for the residents.
2. A Communication Plan will be drawn up to ensure there is consultation with residents, their representatives and key stakeholders.
3. A Consultation period will commence to discuss the options available and to agree on the most appropriate option.
4. A suitable building will be identified, proposed works will be identified and completed and an application made to the authority for registration.
5. Transition Planning will be completed in conjunction with residents and their representatives.
6. Residents will transfer to the new accommodation.

Proposed Timescale:
1. June 30th 2017 2. July 31st 2017 3. September 2017 4. March 31st 2018 5. July 31st 2018 6. September 30th 2018

Proposed Timescale: 30/09/2018

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:
Risk management systems in place at the centre had not ensured that :

- Staffing levels were in-line with risk assessments
- Staff training was in-line with risk assessments
- Risk assessments did not reference or provide a rationale for restrictions in place at the centre

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

Please state the actions you have taken or are planning to take:
1. A Review of the Risk Register with regard to Staffing Supports will be completed by the Person in Charge.
2. A Review of the Staff training schedule has been completed for 2017, to ensure all staff training has been planned.
3. Risk assessments now include a rationale & protocol for restrictions in place at the centre.
4. A fire evacuation drill was completed on 24.04.2017 and included a person who avails of respite who had not previously participated in a drill.
All residents and staff have now participated in a fire drill.

Proposed Timescale:
1. May 19th 2017 2. Completed 4.05.2017 3. Completed 4.05.2017 4. Completed April 24th 2017

Proposed Timescale: 19/05/2017
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 received hand hygiene training.

8. 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:
Hand hygiene training has been scheduled for Staff.

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 the dining room fire doors did not close effectively.

9. 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:
The Provider Nominee will follow up directly with Maintenance to ensure this work is completed.

Proposed Timescale: 30/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drill records examined did not show that evacuations had occurred involving all residents and under minimal staffing conditions. In addition, records did not show whether a part-time resident had participated in a fire drill at the centre.

10. 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. An evacuation was completed on 24.04.2017 and included one respite person who had not previously been involved in an evacuation. All residents and staff have now participated in a fire drill.
2. Easy read fire evacuation protocol displayed and discussed at residents meeting.

Proposed Timescale:
1. Completed 24.04.2017 2. Completed 4.05.2017

Proposed Timescale: 04/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that one staff member had not received up-to-date fire safety training in-line with the provider's policy.

11. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Fire Training has been scheduled for one staff to attend on May 10th 2017 with further dates scheduled for all staff to the end of the year.

Proposed Timescale: 10/05/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that behaviour support plans did not record when they were implemented and planned dates to review their effectiveness.

12. Action Required:
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:
The Acting CNM2 will ensure that all positive behaviour support plans include the date of implementation and dates for planned reviews to assess their effectiveness.

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 safeguarding concerns had been addressed in-line with the provider's policy.

13. 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:
The Acting CNM2 will ensure that all safeguarding concerns are addressed in line with

the provider's policy.
All Safeguarding plans have been reviewed.

Proposed Timescale:
Completed 4.05.2017

Proposed Timescale: 04/05/2017

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 provider had not ensured that appropriate arrangements were in place to cover a planned absence by the centre's person in charge.

14. Action Required:
Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

Please state the actions you have taken or are planning to take:
The Person in Charge is currently on extended leave, an acting Clinical Nurse Manager has been appointed to the designated Centre. A Person in Charge (Clinical Nurse Manager 2) was appointed as an interim arrangement however that Person does not have an appropriate management course under the regulations. The Provider is providing an appropriate course and this will be completed by August 2017.

Proposed Timescale: 31/08/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Formal supervision arrangements were not in place for staff.

15. 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 for Personal Development Plans for Staff has been drawn up.
All PDPs will be completed by June 30th 2017.

Proposed Timescale: 30/06/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre's governance and management systems had not :

- Ensured that management audits were carried out in-line with the provider's policies
- The findings for the centre's previous inspection were addressed within agreed timeframes
- The findings of the provider's own internal quality assurance systems were addressed with agreed timeframes

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

Please state the actions you have taken or are planning to take:
1. Management audits will be completed as per provider s policy.
2. Findings from previous inspection will be completed.
3. Findings from Providers own internal quality assurance system will be completed.
4. All Staff have reapplied for garda vetting and this will be placed in staff files when received.

Proposed Timescale:
1,2 & 3: June 30th 2017 4. Sept 30th 2017

Proposed Timescale: 30/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff personnel files did not contain all documents required under Schedule 2 of the regulations.

17. 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:
A re- audit of staff files will be completed and deficits in files will be documented and all staff will be made aware of the need to submit the required documentation.
All staff have reapplied for Garda Vetting and we are currently waiting on the return of

vetting for 5 staff.
Employment history has been completed for all staff but requires review to ensure that all gaps are accounted for.

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre's roster did not reflect staffing arrangements on the day of inspection.

18. 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:
All Nursing Staff have been informed of the importance of maintaining an accurate roster.
Any staff who are allocated to accompany residents to hospital will be documented on the roster as such.
A Memo was circulated to all nursing staff regarding same and this was also discussed at the local governance meeting.

Proposed Timescale:
May 5th 2017 Completed

Proposed Timescale: 05/05/2017

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found that staffing arrangements were not in-line with a sampled risk assessment.

19. Action Required:
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

Please state the actions you have taken or are planning to take:
A Review of the Risk Register with regard to Staffing Supports will be completed by the Person in Charge.

Proposed Timescale: 19/05/2017