

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Anne's Residential Services - Group L
Centre ID:	OSV-0005159
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Provider Nominee:	Michelle Doyle
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 11 April 2017 11:00 To: 11 April 2017 14:30

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

Outcome 05: Social Care Needs

Summary of findings from this inspection

Background to the inspection:

This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 16 June 2015, the second on 19 October 2015 and the third inspection on 16 August 2016. It was found on all three inspections that the designated centre did not meet the assessed needs of all residents as there was an unsuitable age mix of residents in the centre. In particular the centre failed to meet one individual resident's emotional, social or developmental needs in an acceptable and age-appropriate way.

Following the inspection in August 2016 a meeting was held on 23 November 2016 with the management of HIQA and representatives of the Daughters of Charity Disability Support Services namely, the assistant chief executive officer and the residential services manager.

At that meeting the service acknowledged that placement was inappropriate and that the service had escalated this issue to the Health Services Executive (HSE) at regional level. The purpose of this inspection was to follow-up the on the single issue of whether progress had been made in relation to the placement issue.

In addition, it is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. There were seven such issues submitted to the Chief Inspector since August 2016. Documentation in relation to these incidents was also reviewed during the inspection. All incidents had been "screened" by the designated officer and a safeguarding plan approved following each incident.

Description of the service:

The centre comprised two houses located five minutes apart near the town centre.

The centre could provide care and support to nine residents, two of whom were “actively retired”.

In relation to governance of the centre the person in charge was a registered nurse in intellectual disability. Since the last inspection her remit had been reduced and she was person in charge for two centres in the same town. Since the last inspection HIQA had been notified that the residential services manager had left the organisation and an interim appointment to this position had been made.

How we gathered our evidence:

The inspector visited only one of the two houses and met with the two of the residents who currently lived in this centre. The inspector also met the person in charge of the centre, staff and the assistant chief executive officer. The inspector observed staff practices and interactions with residents and reviewed some residents’ personal plans and meeting minutes.

Overall judgment of our findings:

Despite a number of multidisciplinary case review meetings in relation to this resident’s placement since the last inspection, there was no definitive plan place to resolve this inappropriate placement.

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.

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):

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

Findings:

As on the previous three inspections it was again found that the designated centre did not meet the assessed needs of all residents as there was an unsuitable age mix of residents in the centre.

In particular, the centre failed to meet one individual resident's emotional, social or developmental needs in an acceptable and age-appropriate way. Since the last inspection a meeting was held on 23 November 2016 regarding this issue with the management of HIQA and representatives of the Daughters of Charity Disability Support Services namely, the assistant chief executive officer and the residential services manager. At that meeting the service acknowledged that placement was inappropriate and that the service had escalated this issue to the Health Services Executive (HSE) at regional level.

Minutes of a case review meeting on 20 December 2016 in relation to this resident's placement were made available to the inspector. This meeting involved members of the multidisciplinary team including senior management of the service, care staff, a representative of the national advocacy service, family members and representatives of the service funder, the Health Service Executive (HSE). A further case review meeting was held on 21 February 2017. However, minutes of this meeting were not available. Following these meetings, there was no definitive plan in place to resolve this inappropriate placement.

The service provider had ensured that a formal annual review of the quality and safety

of care of the service had taken place in January 2017. This report had identified as an area of concern that "this centre is not currently meeting the needs of all residents". The service had also undertaken a six monthly review of quality and safety in December 2016 and had also identified that there was a placement issue that required a transition plan to be implemented.

As was found on the previous inspections, as a result of the inappropriate mix of residents in the centre, it was not demonstrated that residents were being adequately protected from injury and harm by their peers. It is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. There were seven such issues submitted to the Chief Inspector since August 2016. Documentation in relation to these incidents was also reviewed during the inspection. All incidents had been "screened" by the designated officer and a safeguarding plan approved following each incident.

There was evidence that these incidents were having a negative impact on older residents in the centre who required a quieter environment. All four residents in the house now had safeguarding plans in place with input from the designated officer. Three of the residents had risk assessments in relation to "safety in (their) own home". The hazard in this risk assessment had been graded as a high risk. One resident had been referred for counselling to reduce their "current exposure to tensions in the house".

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:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Company Limited by Guarantee
Centre ID:	OSV-0005159
Date of Inspection:	11 April 2017
Date of response:	02 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:

The designated centre did not meet the assessed needs of all residents.

1. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is

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

suitable for the purposes of meeting the assessed needs of each resident.

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

The ACEO has communicated with the HSE in respect of the transfer of one resident. This case was on the agenda to be discussed on the 26th April 2017 at the CHO 8 Residential Executive Committee Meeting to approve funding however the A/Manager of Disability Services has spoken to the ACEO indicating that while the meeting went ahead no approval for funding to proceed with the plan has been given. The HSE stated that they will continue to work with the general manager to progress this transfer. Due to the lack of progress this case was discussed at the Service Executive Meeting 2nd May 2017 and the CEO will write to the HSE in relation to same. The case will be further reviewed at the next Service Admission, Discharge Transfer meeting on the 9th May 2017.

An independent advocate continues to communicate with the resident in respect of this issue. Safeguarding meetings were held on the 25th April 2017 in respect of three of the residents and the next review is the 24th May 2017.

Therefore at this time the service has no further agreement on a date to transfer this resident. The service will continue to communicate with the HSE in respect of this case and update HIQA and the resident as soon as any new information is provided.

Proposed Timescale: 30/05/2017