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:	Esmonde Gardens
Centre ID:	OSV-0001855
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Aidan's Day Care Centre Limited by Guarantee
Lead inspector:	Noelene Dowling
Support inspector(s):	Liam Strahan
Type of inspection	Announced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	4

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 following an application to vary registration conditions. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 December 2017 09:00	13 December 2017 19:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre which is designed to provide care for adult residents of mild and moderate intellectual, physical disability
The centre was inspected in 2014 to inform a registration decision and again in November 2015 in response to an urgent application to vary the conditions.

This inspection was undertaken in response to a further and again urgent application by the provider to vary the conditions of registration for the centre. Namely, the addition of a new premises to the accommodation comprising the centre. This was necessary as one of units which comprised the centre and was leased privately was no longer available to the provider form August 2017. This application does not alter the number of residents who will be accommodated in the centre.

This occurrence necessitated two residents having to vacate their homes with minimal notice and no alternatives available. It was of concern that this matter was not notified in a timely manner to HIQA.. Vulnerability in relation to this particular lease arrangement had been raised at the inspection in December 2015. In view of

this and in line with the regulatory process the provider was requested to attend a cautionary meeting with HIQA at which the concerns of the Chief Inspector were outlined. The provider was requested to provide a detailed report outlining how they intended to support the residents in the absence of a premises and plans to secure a new unit.

This was duly received and progress was monitored in the intervening period. The inspection found that the provider had implemented a robust supportive plan in conjunction with the residents and their families, which had served to mitigate the negative impact for the residents while seeking a new unit.

A new proposed unit was procured which was suitable and well equipped for the residents and an application to register was duly made. This premises was under the auspices of local authority which provides increased security of tenure for the residents.

This was the second such variation required in this centre since it original registration with an emergency variation required also in November 2015.

All documentation including a revised Statement of Purpose and the application for the variation was forwarded to HIQA prior to this inspection.

How we gathered our evidence:
Inspectors met with seven residents and spoke with five. They indicated they were very happy with their homes and lived with their friends. The residents who were moving in to the new proposed unit stated that they were very shappy with the house , and really looked forward to moving in. In particular the residents were very happy that this would be a full seven day service and they would no longer have to leave the home every Friday and move into another unit which had been the case previously.

The inspectors also observed residents routines and found that they had a lot of choice in these and staff supported them individually.
The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspectors also reviewed a number of residents questionnaires which expressed their satisfaction with the care provided.
The inspectors met with the team leaders of the units, staff and the person in charge .

Description of the service:

The statement of purpose states that the service would support residents with mild to moderate intellectual disability, physical care needs and dual diagnosis.
Care practices and admission processes required some review and future planning to ensure the changing needs of residents as identified would be met by the provider.

The arrangements for the specific variation were found to be suitable.

The centre comprises of two residential units and one standalone self-contained apartment .The latter was not occupied at the time of this inspection.
All the units are suitable for purpose and located in a large town within close proximity to all services and facilities.

Overall judgment of our findings:

Ten of the outcomes required were inspected against. In addition; inspectors reviewed the providers compliance with the 12 actions identified following the previous inspection. Of these four had been fully completed, five actions had not been addressed satisfactorily. These included evidence of crucial training for agency staff, evidence of adequate recruitment of agency staff and changes to polices. One significant action was only finally resolved at the time of this inspection which was 18 months following the agreed time scale. This was the availability of a seven night service for a resident in the centre. These findings may indicte that the provider requires to familiarise themselves more fully with the legal framework for registration and the requirement to adhere to conditions attached.

These matters were discussed at the provider meeting in July 2017 and at the feedback to the inspection. The centre is due for renewal of its full registration in June 2018.

While there were governance arrangements in place, these required review to ensure the systems are effective and suitable. These pertain primarily to the role of person in charge which requires review due to the number of centres and additional services for which the person is responsible. This is not withstanding the obvious commitment evident. Evidence of good practice was found in the following areas:

• Residents had good access to health care and allied health and psychosocial clinicians which supported their wellbeing and development (outcome 5)

• Residents had very good access to social events and meaningful activities of their choice which promoted their quality of life (Outcome 5)

• Medicines management systems were safe and frequently reviewed (outcome

• Individual rights were promoted (Outcome 1)

There were some improvements required in the following areas:

• Safe and suitable admission processes

• Risk management systems

• Safeguarding systems

• Timely and definitive planning to address the obvious changing needs of residents to include the number of residents living in one unit.•

• Recruitment practices and training for agency staff used.

• Availability of staff to support residents whose needs and wishes for daytime activities may be changing.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities)

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The action from the previous inspection had been resolved.

The previous inspection found that a residents' dignity and quality of life was compromised by virtue of the fact that one resident had to leave their own residential home each Friday and move to another designed centre to stay in another resident's room until Monday morning.

This has now been resolved and the resident will be given a seven-day service in her own home once this new application has been granted. However, it is of concern that this had taken two years to achieve. While there is lack of clarity as to the precise reasons for this delay the provider failed to inform the regulator of this delay.

The lease arrangements for the previous premises had been of concern. On the day of this inspection the inspector saw the new lease for the Local Authority unit which provides greater security of tenure. The proposed residents had signed the lease.However there was no oversight or involvement of the provider in this lease arrangement. Given the care and support needs of the residents this was necessary.The matter was rectified at the time of inspection following concern expressed by inspectors.

Inspectors also observed that residents were obliged to take their entire personal files, which contained very private and sensitive information, each day to the various day services. Inspectors were informed that this was for the purposes of good communication. However, the practice while historical, was excessive, undignified and presented a risk to the confidentiality of this information.

However, in other respects it was evident that the management and staff promoted residents' dignity, personal development choice and participation in how they lived their lives with the levels and type of support determined by their different needs.
There was evidence that the residents and their representatives were actively involved in the running of the centre and their lives within his. This included decisions regarding their own health care, financial affairs. Residents were supported with their medicines and encouraged by staff to make good choices and decisions for themselves. A number of residents attended their general practitioner (GP) alone if they wished and discussed the outcomes with staff on return.

Inspectors observed that staff understood the residents' means of expression including non-verbal clues and were able to respond to their expressed preferences. There were communication cards used to help residents communicate and ensure they were aware of the day-to-day activities and which staff were on duty.

A very detailed communication passport had been devised for a resident with the help of family and speech and language therapist. External advocates had been sourced as needed.

The residents who were moving back to the proposed new unit were fully involved in all decisions regarding furnishings, decoration and living arrangements. There were no complaints recorded at the time of this inspection.

Residents had their own bank accounts and withdrawals were made with staff support as needed. A number were supported and encouraged to have saving accounts for their own personal aims such as holidays. All monies given for residents use were dated and the expenditure was recorded and receipted with satisfactory oversight.

Judgment:
Substantially Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
While issues remain in the content and quality of the annual reviews held for residents inspectors were satisfied that the action from the previous inspection had been resolved.

However, in one unit it was apparent that the residents' needs were complex and changing due to age and illness. While the care provided at this time was suitable inspectors were concerned that there was no definitive and reasonable forward planning evident to reduce the numbers of residents, which is seven, and thereby help to address and support these changing needs.

From a sample of five personal plans, medical records and daily records of residents reviewed it was evident that residents had very good access to a range of multidisciplinary assessments and interventions which informed their personal support plans .There included speech and language therapy, sensory assessments, physiotherapy, occupational therapy, and mental health services. Inspectors found that staff were prompt to identify and seek any additional supports needed for the residents.

However, a review of the admission procedure and assessment undertaken in relation to an admission which had taken place in 2017 demonstrated poor practice in pre-admission assessment and decision making. Due to this provider was unable to ensure that the centre was suitable to meet the complexity of the assessed needs of a resident. While this has also been resolved the manner in which the decision was made was not helpful to the resident concerned. This could have placed the resident and the stability of the placement at risk.

Where residents had specific additional physical and medical care needs fulltime nursing care was provided and evidence based assessment tools were used where necessary for falls, nutrition or pressure areas. These were updated following any changes in the resident’s status and satisfactory support plans were implemented.

Reviews were held frequently and changes to the support plans were made following these. However, the reviews as seen by inspectors did not consistently provide a comprehensive overview of the totality of residents' lives and assessed needs. They were not informed by the multidisciplinary interventions and assessments.

However, from a review of other documentation, speaking with staff and residents, the inspector was satisfied that the necessary care and supports were delivered and residents' development was considered. Personal plans were reflective of the residents’ overall needs, wishes and social aspirations and were comprehensive in issues such as health, nutrition, safety, communication, behaviour, training, family supports and social inclusion.

There was evidence of the full participation of residents and relatives where appropriate in the planning decision making and review process.

The social care needs of the residents were very well identified and supported by staff . They had access to a variety of day-care arrangements, which were suited to their

wishes, needs, ages and interests. Training included life skills gardening, cookery, Some worked at local garden centres and were rightly proud of their achievements in crafts, which decorated their homes.

They had good access to the local community, went shopping, to religious services and concerts, coffee shops and the pub and participated in local charity events.

Judgment:
Substantially Compliant

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:
Inspectors primarily reviewed the proposed new unit to the existing designated centre which was subject of the application. The other two units had previously been found suitable for purpose and continued to be so. One of these was leased from a community housing association and had a lengthy lease agreement.

Inspectors found that the location, design and layout of the unit was suitable for its stated purpose and would meet the needs of the residents. This unit was located a short drive from the other units within this designated centre, as well as the day service that the intended residents attend. It was intended that the unit will have its own transport. The unit was also located near the beach, which staff reported as being a place of interest to residents.

Residents had seen the unit and had been included in discussions with the provider in relation to the opening of this unit.

The unit presented as homely. On entry it was found to be warm and inviting. There was a sitting room which contained comfortable furnishing, a television, an open fireplace and pictures on the wall. There was a kitchen which was recently refurbished with a fitted kitchen, certified gas boiler, domestic white goods and a table and chairs.

A stairs led to the first floor where there were two bedrooms and a shared bathroom. One bedroom had fitted wardrobes, while fitted wardrobes were on order for the second bedroom. The shared bathroom had a shower, sink and toilet. It was recently

refurbished. Another stairs led to the second floor where there was to be one resident bedroom and bathroom and a staff sleepover room with en suite facility. The resident's bedroom contained fitted wardrobes. The resident's bathroom contained a bath sink and toilet and had been refurbished.

The process of personalisation had begun as residents prepared for transition into this unit. One resident had brought bed clothing and posters while a television and DVD player had been bought in for another resident who enjoys having their own access to these.

Throughout the premises there was new flooring, as well as freshly painted walls and doors. Based on the fitted wardrobes in each room there appeared to be adequate storage space provided. The staff room contained a medicines safe. The house manager also informed inspectors that there was a house safe on order to store any belongings that residents would like secured. The plan was for this to be installed into the staff room.

A contract was in place with the landlord detailing responsibilities in relation to maintenance of the premises.

There was access to a private back garden. Currently this was overgrown. Both the house manager and person in charge independently described plans for this to be decked and for new fencing to be installed. This was planned for the week following inspection and given the weather conditions this was reasonable.

The installation of required emergency lighting and fire alarms had taken place and is considered under Outcome 7.

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:
At the last inspection a number of actions had arisen under this outcome. These were not completed in their entity.

The first of these actions was that "the risk management policy in place did not contain

adequate guidance on the hazard identification and risk management including the risks specified by the regulations". Inspectors reviewed the policy and found that the registered provider had made no change. The policy did not contain three of the four risks required by regulation 26, was not centre specific and had not been reviewed during the interim period. However, in practice inspectors noted that the person in charge had implemented a risk register , emergency information and detailed guidance for staff including emergency procedures. While this mitigated the risk to residents it remained that the registered provider had not fulfilled their obligations, as outlined in regulation 26.

This guidance was seen to be implemented within the risk register and individual risk assessments for environmental and residents individual risks .These assessments were regularly reviewed and updated with new risks. The risks listed were pertinent to the centre's needs and to individual needs. However in one instance a mitigating intervention (HACCP training) had not been implemented fully. In other cases the mitigation was dependent on resident's familiarity with the risk. Inspectors also identified a risk that had not been placed on the risk register (the use of an open fire). A house manager explained that while there were open fires in some of the homes these were not in use. They also agreed that if this practice were to change they were aware of the need to risk assess such a change.

There had been a limited number of incidents within the centre. These were seen to be documented and a summary was collated for overall review. The person in charge discussed how such an overview was undertaken; however the number of incidents was low and did not therefore lend itself easily to trend analysis.

The centre had access to vehicles. These were subject to testing, as required. Staff files demonstrated that management seek assurance that staff were licensed to drive. Where staff had learning permits the need to obtain a drivers licence was listed as a staff development goal.

There was an infection control policy available within the centre. The new unit that was being added as part of this application to vary had been fitted out with colour coded kitchen boards and a suitable laundry machine. In another unit there had been an action following the last inspection which required separation of laundry and sluice facilities. The provider's action plan response after the previous inspection had stated that this would be completed by 29 February 2016. During inspection it was evidenced that this had been completed in the weeks preceding this inspection.

In relation to the new unit;
- fire fighting equipment (blanket and extinguishers) had been supplied and certificates were available to demonstrate that these had been serviced
- emergency lighting had been installed and certified, and
- a monitored fire and security alarm system had been installed.

A certificate of compliance with fire regulations had been signed by a professional fire compliance officer stating that they "confirm that all required fire safety works have now been carried out".

In relation to the existing units;

- fire safety equipment had been serviced in November 2017
- emergency lighting had been serviced in November 2017, and
- fire alarm systems in the other units had been serviced in November 2017.

Records were maintained for units to record fire safety checks. These included daily checks within functioning units to ensure the means of escape were unobstructed.

Personal emergency evacuation plans were in place to assess each resident's needs in relation to emergency evacuation. In the case of the new unit escape may involve exiting via two flights of stairs. Residents intending to live here were mobile and exit doors were fitted with thumb screws for easy exit. In another unit several residents used wheelchairs. This had been accounted for within their personal emergency evacuation plans.

Records demonstrated that all 15 staff involved in the residential care of residents had undertaken fire safety training since October 2016. Service level agreements were in place with one agency, which included an undertaking that agency staff were to have fire safety training. However the centre did not have access to evidence of such training in relation to this agency. There was also no evidence that agency staff had familiarisation training with potential fire response needs for this particular service. This had also been an action following the last inspection.

Records demonstrated that quarterly fire drills were being conducted in each unit. These drills were based on scenarios discussed with residents. These scenarios covered a range of potential situations within units or the vehicles attached to the units – with attention being paid to road safety in the event of a vehicle being evacuated. Records were kept in relation to what happened during drills and where there had been delays in evacuations this was reviewed. It was noted that staff were communicating with residents to enable them to understand the importance of such drills.
Each resident's bedroom had a map noting where exits were located.

There was an emergency folder which contained responses to a number of scenarios, such as loss of electricity, gas leaks, storms and loss of heating. This folder contained contact numbers according to each risk. This folder also detailed where residents could be taken in the event that a centre needed to be evacuated.

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

Findings:
Overall the systems for the protection of residents were satisfactory but some improvements were required in the consistent management of risk in this area.

The poorly assessed admission referred to in outcome 5 social care resulted in significant safeguarding concerns, which initially the provider did not have the capacity to address.

It is acknowledged that this was rectified by the provider with the support and intervention of a number of agencies. Systems were put in place and suitable arrangements was made to safeguard the resident ultimately and inspectors acknowledge that considerable work was undertaken to achieve this.

In addition to this, residents in one unit had been significantly impacted on occasions by the behaviour of others. A specific and detailed safeguarding plan was required in order to prevent and manage this but this had not been devised to minimise the impact or risk.

While this plan was not in place staff were able to inform inspectors of the strategies used and they were very aware of the impact and risks to the resident.

The policy on the use of restrictive practices had been revised and such practices were minimal, reasonable and reviewed. However, on a number of occasions a physical intervention had been used. The precise intervention was not recorded and the intervention was not prescribed for the resident as part of the behaviour support plans so this it could be monitored effectively. PRN (administered as required) medicines were seen to be used on a small number of occasions. These were correctly prescribed, used only as prescribed, monitored and overseen and reviewed by the prescribing clinician.

Overall, there was good access to behaviour support and interventions from behaviour specialist and mental health services. Staff were familiar with the strategies and demonstrated empathy in relation to the behaviours presented and the needs of residents with additional mental health needs. Records indicated that staff had received training in preventative strategies and the management of behaviours. Staff were found to have understanding and competence in supporting these residents.

As part of the planning process for the admission to the additional premises, a specialist assessment had been undertaken to review and manage potential risk in this area and this was satisfactory.

The policy on the protection of vulnerable adults had, as required at the previous inspection being reviewed to ensure it was in accordance with the national guidelines.

Concerns identified were seen to be reported and managed in accordance with this policy. The provider representative was the designated officer and had undergone the training in the revised policy. All staff had training in the safeguarding according to the records available.

The residents who could communicate with inspectors stated that they felt safe, could and would let staff know if anything was wrong.

Judgment:
Substantially Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Inspectors found evidence that resident's healthcare needs were very well supported. Residents could attend at a practitioner of their choice and had access both in the centre and in the surgery according to their wishes. Some of the residents had a good understanding of their own health care needs and one resident told inspectors of the healthy eating and weight loss plans they had embarked on to good effect.

There was evidence from documents, interviews and observation that a range of allied health services were available and accessed in accordance with the resident's needs and changing health status. These included occupational therapy, physiotherapy and psychiatric and psychology services. Chiropody, dentistry and opthalmatic reviews were also attended regularly by the residents.
Healthcare related treatments and interventions were detailed and staff were aware of these. Such interventions were revised annually or more often as required. Inspectors saw evidence of health promotion with regular blood tests, vaccinations, medication reviews, and gender specific screening pertinent to the needs of the residents.

Inspectors found that there was a cohesive approach to the monitoring of health care, evidence of timely response by the staff and a detailed health summary report was maintained by staff. This included any risk of the development of pressure areas. Fulltime nursing care was provided in one house as this was dictated by the needs of

the residents.

The documentation indicated that all aspects of the president's health care and complexity of need was monitored and reviewed. Nutrition and weights were monitored and specific vulnerabilities were noted and acted on such as falls risks or specific dietary needs.
There were protocols in place for the management of epilepsy or head injury and staff were clear on these protocols.
Meals are cooked in each of the houses with the support of staff and residents went shopping for their foods again with the support of staff. Dietary intake was monitored and the advice of dieticians and speech and language therapists was sought as needed. Assistive crockery and cutlery was available to support the residents to remain independent.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
The policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory although none were being used at the time of this inspection. There were appropriate documented procedures for the handling, disposal of and return of medication.

Inspectors saw evidence that medication was reviewed regularly by both the residents GP and the prescribing psychiatric service. All medication was safely stored and there were systems for checking in and receipt of medication. Regular audits of medication administration and usage were undertaken by the person in charge and the pharmacist. Additional food supplements were used only if prescribed by the GP. There was a protocol in place for the use of emergency medication. A small number of medication errors were noted and the remedial actions taken by the person in charge were seen to be appropriate and prompt.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose require amendments to satisfactorily detail the care and support need to be provided. This was forwarded following the inspection and stated that the service would support residents with mild to moderate intellectual disability physical care and dual diagnosis. It was found to be centre-specific and compliant with the requirements of the regulations and detailed the care needs and service to be provided.

Care practices are currently in line with the statement.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
Inspectors were not assured that the current management arrangements were satisfactory to ensure the ongoing safe and effective delivery of care despite the obvious commitment of all concerned.

The arrangements for the person in charge to carry out the function effectively were not entirely suitable. The person was suitably qualified and very experienced. However, the post holder was also responsible for 3 other residential units and a number of day-care services and held a senior post in the organisation. The arrangements for the role of person in charge were the responsibility of the provider.

While there was very effective care provided by the team leaders in the units, they hold significant responsibility and have no protected time to undertake the responsibilities delegated to them. These include convening and holding residents' annual reviews, supervision of staff , convening of team meetings and oversight of residents' care. This is especially evident in the larger high dependency unit. The person in charge had not been able to attend a team meeting in this unit between March 2017 and the week prior to the inspection.

The findings of the report in relation to lack of satisfactory admission processes, regulatory responsibilities in adhering to the condition of registration, security of tenure for residents and future planning for changing care needs as detailed under outcome 5 social care indicate that the current management systems were reactive as opposed to strategic. Quality management systems were in place however, the effectiveness of the auditing systems was not demonstrated. While each incident or untoward event was individually managed as it occurs there was not currently a system for learning and further avoidance of potential problems.

The provider nominee was suitably qualified and experienced. Reporting structures were evident and it was noted that that the team leaders provided very detailed and resident focussed monthly reports to the board of management. A quarterly report was provided by the provider's representative.

Other systems for oversight were also in place including monthly meeting with the team leaders.

There were two unannounced inspection undertaken in 2016 by the provider which were detailed and actions identified were addressed. One had taken place in 2017. An annual review of the quality of care for 2016 was available. The views of residents and their representatives were included in this and they were positive about the service.

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 action from the previous inspection had not been resolved satisfactorily. Inspectors found that the provider had continued on occasion to employ a number of agency staff without verifying the agreed documentation with the agency concerned. While there was no evidence on this occasion that the agency staff did not have the required documentation and or training this had been problematic in the past for the provider. While at this time agency staff were not used frequently they had been used for significant periods during the year.

A review of files for staff employed directly by the provider indicated overall compliance with some gaps in staff information such as no last employer reference, and an unsigned reference and some unexplained gaps in employment histories.

Inspectors were satisfied that the skill mix of staff was suitable for the needs of the current and proposed residents. Full-time nursing care was required in one unit and this was provided and seen to be beneficial to the residents.

However the availability of staff at specific times was not consistently satisfactory. While the service was described as full time it was not available twenty-four hours to residents during the week. For example, Inspectors found that the arrangements for residents in the high support unit to be able to simply stay at home and not attend day care on a given day were entirely dependent on staffing. For example, it was described to inspectors that if a resident simply wished to remain at home this necessitated a second resident remaining back in the unit in order to allow a day service staff to support them. The provider was requested to review this in the context of the changing needs of the residents.

The new proposed unit to which the application pertains will operate on a full-time basis and additional staff were sourced for this unit. This planning has also taken account of the need for a suitable gender mix of staff in the unit.

Staff employed directly by the provider had access to training in protection of vulnerable adults, fire safety, patient handling and crisis intervention. Records of these were presented to inspectors and seen to be up to date. Staff who administered medicines had access to safe administration of medicines training; staff without this training were not allowed to administer medicines. As stated under outcome 7 health and safety number of staff required food safety and hygiene training. The person in charge described that audits of training are undertaken on a file-by-file basis.

Records demonstrated that new staff were subject to monthly appraisal while on probation (first six months of employment) with a delegated supervision system in place included annual supervision /appraisals for staff. This had commenced but was

not yet fully implemented. Where supervision records were on file they were seen to be appropriate with residents care, staff training and development needs the focus.

Additional supervision was also seen to be on file where/when needed. For example , where medicines errors had occurred this resulted in additional supervision and training and reassessment.

Judgment:
Non Compliant - Moderate

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:

Noelene Dowling
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 St Aidan's Day Care Centre Limited by Guarantee
Centre ID:	OSV-0001855
Date of Inspection:	13 December 2017
Date of response:	10 January 2018

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents' dignity and privacy was compromised by having to take their complete personal records with them each day to day services.

1. Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
To ensure that the resident's dignity and privacy is not been compromised a fit for purpose communication file between day service and residential will be devised containing all the relevant information and documents necessary to provide a person centre service to each resident.

Proposed Timescale: 31/05/2018

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:
Admission assessments and processes were not satisfactory to ensure the care required could be provided according to the residents' assessed needs.

Residents changing needs and the number of residents living in one unit with complex needs required future planning.

2. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Admissions: For all future admissions to a designated centre the person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to the admission.

Further assessments will be carried out to reflect changes in need and circumstances, on an annual basis or more frequently as required. .

The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place and the centre is suitable to meet the complex needs of each resident, as assessed in accordance with the comprehensive admissions assessment.

Future Planning to meet the changing needs of the residents: The Service Provider is aware of the changing needs of the residents due to age and illness. To forward plan to support and address these changing needs the following actions have commenced:-

· In the event that a resident simply once to stay at home or is unwell to attend their day services resources will be allocated from their day service to support and care for

them in their home.

· In the event that a resident expires in the designated centre their placement will not be filled with another individual which will reduce the number of residents residing in this home and thereby help and address and support the changing needs in this home.

· In the event that the resident's needs are as such that they can longer be cared for in their home collaboration will take place the resident, family, HSE and service provider to facilitate an alternative suitable home that will meet the needs of the individual.

· The service has had meetings with Wexford County Council, HSE and approved housing bodies with a view to seeking suitable accommodation to relocate residents in the service whose needs are changing and becoming more complex. Collaboration and discussion in relation to this will be facilitated at PCP meetings with both residents and family members.

Proposed Timescale: 31/12/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Not all mitigating actions listed within the risk register were being implemented as directed by the provider's own risk register.

3. Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
The provider will ensure by auditing and reviewing the risk register that all mitigating actions contained within the risk register are being implemented and the risk control measures are proportional to the risk identified. In doing so, ensuring that these risk control measures do not impact adversely on the resident's quality of life.

Proposed Timescale: 31/05/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not contain adequate guidance on hazard identification and management including the risks specified by the regulations.

4. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The provider will review the current risk management policy and ensure that there is adequate guidance on hazard identification and risk management including the risks required by regulation 26. (Risk management Procedures)

We will ensure that there are systems in place in the designated centre for the assessment, management and on-going review of risks, including a system for responding to emergencies using our risk assessment tools.

Proposed Timescale: 31/05/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Agency staff had not received training in fire safety and management as required by regulation 28. (4) (a).

5. 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:
The provider will ensure that arrangements are in place for all staff including agency 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 as required under regulation 28 (4).

Proposed Timescale: 28/02/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
On occasion a physical intervention was used which was not detailed or outlined in the behaviour support plans to ensure it was in accordance with required guidelines.

6. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Two MAPA instructors will prescribe a person centred technique to minimise harm to themselves and others. The principle of low level holding will be an individualised prescription and will provide for the care, welfare, safety and security of the individual.

Proposed Timescale: 31/01/2018

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Adequate documented safeguarding plans were not in place to protect residents from the impact of the behaviours of others.

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

Please state the actions you have taken or are planning to take:
The provider will ensure that staff are adequately trained in abuse to safe guard residents and prevent, detect and respond to abuse.

Ensure that each resident is supported by their key worker to develop the knowledge, self-awareness and understanding and skills needed for self-care and protection.

That adequate safeguarding plan's are put in place to protect residents from the impact of the behaviours of others.

Residents have access to advocacy services and information about his/her rights.

Proposed Timescale: 30/04/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The arrangements for the person in charge to have responsibility for more than one unit were not satisfactory.

8. Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
The Service Provider has reviewed the role of the current Person In Charge and the arrangements for the Person in Charge to carry out the role effectively taking into account her current duties and responsibilities which extend into a number of day services. The following arrangements are being implemented to ensure the systems are effective and suitable:-

· A senior staff member has been assigned to oversee and manage the day to day operations of all day service units. This will be in effect from 17th January 2018. This will enable the PIC to support the team leaders more effectively. Ensure staff supervision, attend residents annual reviews and team meetings. Oversight of residents care.

· Two senior staff members are undergoing formal training the 24th, 25th & 26th January 2018 in the QQI Managing People with Professional Development Programme. (QQI Qualification Level 6 In Managing People) with a view to meeting the requirements for a PIC.

· A Clinical Nurse Manager in one of the designated centres has expressed an interest in becoming the Person in Charge for the designated centre in which she is currently the PPIM. This individual will undertake the relevant training in line with regulations including the training outlined above. When the appointment of PIC is completed and accepted by HIQA this will alleviate the workload and responsibility of the current PIC for this designated centre.

· A number of Senior Staff have also expressed an interest in engaging in the required training to fulfil the role of PIC in the future. The service provider will endeavour to support these individuals in completing the required training and experience in relation to regulation.

· The provider nominee has secured the training services of HCI to complete onsite training for Register Provider Nominee and Person in Charge on the 22nd January 2018. This training will be provided in line with the HIQA National Standards & Regulations.

Proposed Timescale: 30/06/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Effective overall management systems had not been put in place by the provider. Systems to ensure that the legal and regulatory requirements of the provider are

adhered to, and in so doing provide effective on-going care for residents require to be improved..

9. 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:
The provider nominee is fully committed to engaging in training to ensure that she is fully familiar and aware of the legal framework for registration and to meet the requirements of the Health Act 20017 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities).

The provider nominee has secured the training services of HCI to complete onsite training for Register Provider Nominee and Person in Charge on the 22nd January 2018. This training will be provided in line with the HIQA National Standards & Regulations & Registration. Currently the following will be in attendance at this training:-

- Provider Nominee
- Person in Charge
- All PPIM's in the designated centres
- HR Manager

An invitation will also be extended to Board Members.

Proposed Timescale: 31/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of staff files demonstrated that there were gaps in employment history and inadequate references on file, contrary to schedule 2 of the regulations.

10. 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:
All personal files of staff will be reviewed in relation to gaps in employment history and reference. The HR Manager will ensure that the information and documents as specified in Schedule 2 Under Regulation 15 (5) are held on file and adequate.

The HR Manager will request from each staff member where required employment history which will identify any gaps in employment and document rationale for same.

Proposed Timescale: 30/06/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Information including garda vetting, evidence of training and adequate references were not available for external staff employed by the provider.

11. 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:
The provider will ensure that documentation will be provided by agencies to evidence that their staff are garda vetted, trained and have adequate references.

Proposed Timescale: 31/01/2018

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Rostering arrangements during the weekdays impacted on residents with changing needs who may wish to remain at home on occasions .

There was no evidence that external staff had the training to deliver the care required by the residents.

12. 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:
· In the event that a resident requests to stay at home on occasion or is unwell to attend their day services resources will be allocated from their day service to support and care for them in their home.

· The staff allocated to provide care and support to the resident in their home will be relocated from the residents day service and will be familiar with the needs of this individual and will have the necessary care skills and qualifications to deliver the care required.

· The provider will ensure that documentation will be provided by agencies and held on file to evidence and verify that their staff have the training and qualifications to deliver

the care required by the residents.

Proposed Timescale: 31/01/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A review of staff training records indicated that an insufficient number of staff are trained in infection control in relation to the preparation and handling of food.

13. 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:
All residential staff will receive HACCP training from an in-service HACCP Instructor

Proposed Timescale: 30/06/2018