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:	Grand Priory
Centre ID:	OSV-0002569
Centre county:	Meath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Maureen Burns Rees
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From:	To:
09 January 2018 09:30	09 January 2018 17:30

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was a seven outcome inspection carried out to monitor compliance with the regulations and standards. The previous inspection to inform a registration decision was undertaken on the 2 of August 2016. The centre was registered in October 2016.

How we gathered our evidence:

The inspector interviewed the person in charge, assistant director of nursing, a staff nurse and two social care workers. The inspector reviewed care practices and documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

As part of the inspection, the inspector met with each of the five residents living in the centre. Each of the residents told the inspector about how they loved living in the centre, about the many activities that they were involved in within the community and about how kind and supportive staff were to them. The inspector observed really warm interactions between the residents and staff caring for them and all of the residents were in good spirits. One of the residents had an upcoming birthday and each of the residents told the inspector that they were looking forward to the party which was planned.

Description of the service:

The service provided was described in the providers' statement of purpose. The centre provided residential care for five residents with an intellectual disability and low support requirements. There were no vacancies in the centre at the time of inspection.

The centre was located on the outskirts of a medium sized town in county Meath. The centre comprised of a detached, five bedroomed, two story house situated in a well maintained housing estate. It had a nice sized back garden and there was a large communal green area to the front of the property.

Overall Judgment of our findings:

The inspector found that arrangements were in place for residents to be well cared for and that the provider had arrangements in place to promote their rights and safety. The inspector was satisfied that the provider had adequate systems in place to ensure that the majority of regulations were being met. The person in charge demonstrated extensive knowledge and competence during the inspection and the inspector was satisfied that he remained a fit person to participate in the management of the centre. The inspector reviewed a number of written complements sent to staff by relatives which outlined their satisfaction with the level of care provided to their loved ones. Of the seven outcomes inspected on this inspection, four outcomes were compliant and three outcomes were in substantial compliance as outlined below.

Good practice was identified in areas such as:

- Each resident's well-being and welfare was maintained by a good standard of evidence-based care and support. (Outcome 5)
- There were appropriate measures in place to keep residents safe and to protect them from abuse. (Outcome 8)
- Resident's healthcare needs were met in line with their personal plans and assessments. (Outcome 11)
- There were systems in place to ensure the safe management and administration of medications. (Outcome 12)

Areas for improvement were identified in areas such as:

- The risk management policy in place did not meet all of the requirements of Regulation 26(1) and some improvements were required in relation to maintenance arrangements. (Outcome 7)
- Some improvements were required to ensure that the monitoring arrangements in place met all of the requirements of the regulations. (Outcome 14)
- Some improvements were required in relation to the information in staff files, as required by schedule 2 of the regulations. (Outcome 17)

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:
Each resident's well-being and welfare was maintained by a good standard of evidence based care and support.

Each resident's health, personal and social care needs were assessed. A personal plan was in place for each resident which detailed their assessed needs, capacities and interests. There was a detailed activities of living plan of care. Personal goals were detailed in 'important goals for me and my action plan'. There was evidence that a review meeting was undertaken on a monthly basis by each residents key worker to review goals set and progress in achieving same. Residents were involved in a wide range of activities. Examples included, swimming, horse riding, self defence, cinema, bowling, shopping and eating out. Two of the residents were enrolled in the special Olympics for their expertise in table tennis and golf. Each of the residents attended day service and one of the residents had a part-time job in the local community.

There were processes in place to formally review resident's personal support plans with the involvement of the providers multidisciplinary team on at least an annual basis. There was documentary evidence to show that resident's family representatives were invited to review meetings and generally attended. Overall, the inspector found that residents personal plans had been implemented to meet the support needs of the residents.

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):
No actions were required from the previous inspection.

Findings:
The health and safety of residents, visitors and staff were promoted and protected. However, the risk management policy in place did not meet all of the requirements of Regulation 26(1) and some improvements were required in relation to maintenance arrangements.

There was a risk and incident management policy, dated June 2016. However, it did not meet all of the requirements of regulation 26. For example, it did not include the measures and actions in place to control a number of risks specified in the regulations. There was a formal risk escalation pathway in place. The centre had an up to date risk register in place. The inspector reviewed individual risk assessments for residents which contained a good level of detail, were specific to the resident and had appropriate measures in place to control and manage the risks identified.

There was a safety statement dated May 2017, with written risk assessments pertaining to the environment and work practices. The decking area in the back garden had been identified as a specific risk and was in the process of being replaced. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address any issues identified.

Hazards and repairs were reported to the provider's maintenance department. However, records showed that requests were not always attended to promptly. For example, there were a number of requests outstanding for a prolonged period.

There were arrangements in place for investigating and learning from serious incidents and adverse events involving residents. This promoted opportunities for learning to improve services and prevent incidences. The inspector reviewed a sample of incidents and accidents reported which also recorded actions taken. All incidents were risk reviewed and signed off by the person in charge and also reviewed by the assistant director of nursing. There was evidence that incidents were reviewed and discussed at staff team meetings with learning agreed in the centre. In addition, specific trends of incidents were discussed at quality and safety management meetings which were held on a monthly basis. This promoted learning across the wider service. Overall, there were a low number of incidents reported.

There were procedures in place for the prevention and control of infection. The interior of the centre had been repainted in the previous 12 months period, with new flooring

provided in a number of areas. The inspector observed that all areas were clean and in a good state of repair. Colour coded cleaning equipment was used and appropriately stored. The inspector observed that there were sufficient facilities for hand hygiene available with paper hand towels in use and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. A cleaning schedule was in place and records were maintained of tasks undertaken.

Suitable precautions were in place against the risk of fire. There was a fire safety policy, dated August 2016. There was documentary evidence that the fire equipment, fire alarms and emergency lighting were serviced and checked at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified in the front garden of the house. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each resident had a personal emergency evacuation plan in place which adequately accounted for the mobility and cognitive understanding of the resident. Staff who spoke with the inspector were familiar with the fire evacuation procedures. All staff had received appropriate training. Fire drills involving residents had been undertaken at regular intervals and one had been completed since the recent admission of a resident.

There was a major emergency plan in place, dated February 2016 to guide staff in the event of such emergencies as power outages or flooding.

Judgment:
Substantially Compliant

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):
No actions were required from the previous inspection.

Findings:
There were appropriate measures in place to keep residents safe and to protect them from abuse.

The provider had a safeguarding vulnerable persons at risk of abuse policy, dated March 2016. There was also an easy to read version, titled 'what is abuse and what can you do

to stop it'. Staff who met with the inspector were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. There had been no incidents or suspicion of abuse in the previous 12 month period. All staff had attended appropriate safeguarding training.

There was an intimate and personal care policy in place. Residents required minimal support in meeting their intimate care needs. The inspector reviewed individual intimate care plans on residents files. These contained a good level of detail to guide staff in supporting residents.

Residents were provided with emotional and behavioural support. The inspector observed residents seek advice from staff on various matters, with staff providing appropriate support and advice. There was a policy regarding the management of behaviour that challenges, dated November 2016 and a policy on the use of restrictive procedures, dated July 2017. However, residents in the centre did not present with any behaviours that challenge. There were no restrictive practices in use at the time of inspection.

Judgment:
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:
Resident's healthcare needs were met in line with their personal plans and assessments.

The inspector reviewed a sample of resident's files and found that their health needs were appropriately assessed and met by the care provided in the centre. Each of the residents had their own general practitioner (GP) located in the local town. An out of hours GP service was also available. Residents accessed a number of allied health professionals, including physiotherapists and dieticians. Records were maintained of all contacts with such professionals. Care plans were being implemented which reflected multidisciplinary team recommendations.

The person in charge and one of the staff team was a registered nurse. Although a staff nurse was not rostered on duty at all times, the centre had access to nursing support on a 24 hour basis through an on-call system and nursing support in a nearby centre. This ensured that residents, who had medical conditions that required monitoring, had access

to nursing care as required.

The centre had a fully equipped kitchen come dining area. This was observed to be an adequate space to make meal times a social occasion. The service had 'guidelines on monitoring nutritional intake', dated July 2017. There was a weekly menu planner in place which was agreed at residents meetings on a weekly basis. A range of nutritious, appetising and varied foods were provided for residents. Recommendations from the dietician for individual residents were being adhered. This had resulted in one of the resident loosing a considerable amount of body weight and generally improving their health and well being.

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:
There were systems in place to ensure the safe management and administration of medications.

The processes in place for the handling of medicines was safe and in accordance with current guidelines and legislation. A medication management policy was in place, dated July 2017. There was a secure cupboard for the storage of all medicines. The inspector reviewed a sample of prescription and administration sheets and found that they had been appropriately completed and medications were administered as prescribed. Staff interviewed had a good knowledge of appropriate medication management practices. All members of the staff team had received appropriate training in the safe administration of medications. The person in charge reported that he was due to complete a train the trainer course in the safe administration of medications so that he would provide this training to staff across the service.

Staff had assessed the ability of individual residents to self manage medication and found it was not appropriate for any of the residents to be responsible for their own medications. Easy to read information on individual medications were maintained.

There were systems in place to review and monitor safe medication management practices. Medication management audits were undertaken on a regular basis and where issues were identified appropriate actions had been taken. The inspector observed that

all medications in use could be accounted for at all times.

There were procedures for the handling and disposal of unused and out of date drugs. A record was maintained of all unused and out of date drugs medication returned to pharmacy. There was a separate secure area for the storage of out of date medications.

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:
There were management systems in place to ensure that the service provided was safe, consistent and appropriate to resident's needs. However, some improvements were required to ensure that the monitoring arrangements in place met all of the requirements of the regulations.

The centre was managed by a suitably qualified, skilled and experienced person. The person in charge had been in the position for the past two years but had more than nine years management experience prior to that working with a different provider. He is a registered nurse in intellectual disabilities and held a degree in nursing. He had recently completed a certificate in leadership and quality initiatives. Staff interviewed told the inspector that the person in charge was a good leader, approachable, person centred and dedicated to meeting the needs of the residents. The inspector found that the person in charge was knowledgeable about the requirements of the regulations and standards. He also had a clear insight into the health needs and support requirements for each of the residents. Residents were observed to interact warmly with him and to seek his opinion and advice on various matters important to them.

The person in charge was in a full time post and held responsibility for another designated centre located a relatively short distance away. There was evidence that he was based in the centre on a regular and consistent basis. On-call arrangements were in place and staff were aware of these and the contact details.

There was a clearly defined management structure that identified lines of accountability and responsibility. Staff who spoke with the inspector had a clear understanding of their role and responsibility. The person in charge reported to the assistant director of nursing who in turn reported to director of nursing. The person in charge reported that he felt supported in his role and had regular formal and informal contact with his manager.

An annual review of the quality and safety of care and support for 2017 had been undertaken and made available to families. There was evidence that the assistant director of nursing visited the centre on a regular basis. An unannounced visit to review the safety and quality of care had been undertaken by the provider in November 2017. An improvement action plan to address issues identified had been put in place, with an appropriate assignment of responsibility and timelines. The previous unannounced visit, with the production of a written report, had not been completed within a minimum of a six month period, as per the requirements of the regulations. It had been completed in February 2017.

The person in charge undertook a suite of audits on a regular basis. Matters audited included, residents finances, health and safety, medications, fire safety, residents care plans and 'my important to me' goals. There was evidence that appropriate actions were taken to address any issues identified. Quality and safety meetings were held on a regular basis. These were attended by members of the senior management team and persons in charge of centres in the area. There was evidence that results of audits and trends of incidents were reviewed at these meetings with shared learning agreed across the service.

Judgment:
Substantially Compliant

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:
There was a consistent team of staff working with residents who had received up-to-date mandatory training. However, some improvements were required in relation to the information in staff files, as required by schedule 2 of the regulations.

The staffing levels and experience were sufficient to meet the needs of the residents in the centre. There was an actual and planned staff rota in place. The majority of staff had worked in the centre for a number of years. A small number of agency staff were used on occasion but had each been working with the residents for an extended period. This meant that residents had continuity in their care givers. Residents had access to nursing support at all times. There were on-call arrangements on display.

A training programme was in place for staff which was coordinated by the providers training department. Training records showed that staff were up-to-date with mandatory training requirements. Staff interviewed were knowledgeable about policies and procedures in place. The inspector observed that a copy of the standards and regulations was available in the centre.

There was a recruitment and selection procedure in place. The inspector reviewed a sample of four staff files. Overall, the information as required by schedule 2 of the regulations was in place. However, in one of the four files reviewed, the inspector found that the evidence of the persons identity, including a recent photograph was not sufficient to meet the requirements of the regulations.

Staff were being supervised in line with the frequency specified in the providers policy. Supervision records reviewed showed that supervision undertaken was of a good quality.

There were no volunteers working in the centre at the time of inspection.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Maureen Burns Rees
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-0002569
Date of Inspection:	09 January 2018
Date of response:	05 February 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 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:
The risk and incident management policy in place did not meet all of the requirements of regulation 26(1).

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 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
The risk policy has now been reviewed and updated to reflect the recommended changes and is compliant with Part 7, section 26 (1) of the regulations (Health Act 2007)

Proposed Timescale: 02/02/2018

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:
An unannounced visit had been undertaken in November 2017. However, the previous unannounced visit, with the production of a written report, had not been completed, within a minimum of a six month period, as per the requirements of the regulations.

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

Please state the actions you have taken or are planning to take:
The Provider Nominee and Director of Nursing have agreed a schedule of unannounced reviews for 2018 which are within timeframes of 6 months as set out by the regulations. A report will be written following the unannounced visit and available in the designated centre. Action plans and timeframes will be attached to the report and reviewed as set out with PIC.

Proposed Timescale: 02/02/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
In one of the four staff files reviewed, the evidence of the persons identity, including a recent photograph, was not sufficient to meet the requirements of the regulations.

3. 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 staff photo ID has been recopied and validated and the PIC has reviewed all staff photo ID to ensure clear photo ID available on staff files

Proposed Timescale: 02/02/2018