Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Adults Services Palmerstown Designated Centre 6
Centre ID:	OSV-0003903
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Limited
Provider Nominee:	Brendan O'Connor
Lead inspector:	Caroline Vahey
Support inspector(s):	Thomas Hogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	2

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
01 June 2017 08:50	01 June 2017 21:30
02 June 2017 09:30	02 June 2017 19:10

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection
Background to the inspection
This was the second inspection of the designated centre, the purpose of which was to monitor ongoing regulatory compliance. The centre was previously inspected in October 2014. Significant concerns were identified during this inspection and the scope of the inspection focused on residents' safety and wellbeing. Therefore six outcomes were inspected against on this inspection.

Description of the service
The centre comprised of four units, located on a campus based setting. The centre provided residential services for up to 32 residents and there were 30 residents living in the centre on the day of inspection.

How the inspectors gathered evidence.
The inspectors met with the person in charge and with two clinical nurse managers. The inspectors spoke to approximately twelve staff over the course of the two days of inspection and discussed areas such safeguarding knowledge, residents' needs and the practices in the centre pertaining to areas such as healthcare, restrictive practices, behaviour support and the provision of food and nutrition. The inspectors also spoke to two residents on the morning of the first day of inspection and observed practice such as a meal being provided, the provision of healthcare, staff interactions with residents and the use of some restrictive practices. Significant

concerns identified on both days of inspection resulted in two meetings with the provider and four immediate actions being issued. The inspectors also met with the designated liaison officer and the risk manager specifically to discuss safeguarding concerns and risk management. Documentation such as personal plans, daily monitoring records, incident records, staff personnel files, rosters, staff training records and rosters were also reviewed.

Overall judgment of findings
The inspectors found the service provided was not safe and had failed to ensure residents were protected from abuse, and to ensure residents' healthcare needs were met. There was an overall lack of accountability across all levels of service provision to respond to risks and safeguarding concerns in the centre and the inspectors identified a lack of urgency in the response to an issue identified as immediate risk on the day of inspection. There was evidence of institutional practices, and residents' right to a safe and appropriate service which also upheld their basic human rights was not evident on the day of inspection. Serious concerns were identified in safeguarding and safety and in the provision of safe and appropriate healthcare and three immediate actions were issued to the provider. A further immediate action was required to be issued on the second day of inspection, as inspectors deemed information was being withheld with regards to incidents in the centre. Inspectors were required to provide instruction three times; such was the level of risk found in fire safety and the provision of adequate nutrition. Underpinning these failing was a lack of effective governance and management, to oversee the service provided in the centre, and the methodology used by the provider to assure them as to the quality of care and support was found to be significantly deficient.

All six outcomes inspected against were found to be in major non-compliance with the Regulations. These findings are discussed in the following report and the regulations that are not being met in action plan at the end of the report.

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

Outcome 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):

Findings:
The inspectors found residents' dignity and privacy was not upheld due to practices in the centre and in the layout of one unit. There was evidence of institutional type practices in the centre.

The inspectors observed a meal being served to residents in one unit and found this did not ensure residents' dignity was respected. The environment was found to be noisy and the meal experience rushed. One resident's meal experience lasted a total of 2 minutes and 20 seconds. Residents who required assistance were not given this and inspectors observed a resident with a visual impairment was left unsupervised. It was evident from observations and from the assistive equipment used that this resident required assistance however, the lack of supervision resulted in a significant portion of the resident's meal falling on the floor and the resident eating some of their meal without cutlery. The inspectors noted the resident's food was on the floor for a number of minutes, before a staff attended.

Staff were not observed to sit with most residents at this mealtime and the tables were not set with condiments and tableware prior to the meal being served. One resident was observed to be offered appropriate assistance with their meal.

In another unit, it was identified there were no toilet facilities in the main bathroom and toilets were located at the far end of the unit corridor. The inspectors were not assured therefore that residents' right to privacy could be upheld.

Judgment:
Non Compliant - Major

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
The inspectors found the health and safety of residents, visitors and staff was not maintained in the centre. Significant concerns were identified in the identification and management of risk and in fire safety, and immediate actions were issued in relation to these failings. Improvement was also required in infection control measures.

The inspectors requested complete records of all incidents in the centre since the previous inspection on the first morning of inspection and this was requested a further three times up to the afternoon of the second day of inspection. Some records were presented to inspectors in relation to one unit, however, information remained outstanding. An immediate action was then issued specifying Section 77 (b) of the Health Act 2007, to the provider nominee at 2pm on the second day of inspection, requiring the provider to present the requested incident records to the inspectors within a one hour timeframe. These records were subsequently presented within the timeframe specified in the immediate action.

The inspectors reviewed these incident records and serious concerns were identified in the management of risk resulting in poor outcomes for residents and exposing them to ongoing risk of harm. The inspectors found there was a clear and substantial absence of arrangements for the identification, investigation of, and learning from serious incidents involving residents. While incidents had been reported to the person in charge, peer to peer assaults had not been identified and reported at this point as safeguarding concerns and as such appropriate measures were not put in place to ensure residents were safe from injury as per the providers legislative requirements. Incidents were reviewed on a quarterly basis by the risk manager, however, the risk manager told the inspectors they did not provide any oversight with regard to reporting and responding pathways once incidents occur and specified this included safeguarding concerns.

Significant failings were found throughout the centre with regards to fire safety. Staff were not knowledgeable on the evacuation procedures in a unit and of the specific support requirements, to assist residents in the event of a fire. The inspectors spoke to staff members and found they were not clear on the support requirements to evacuate residents, reflective of their assessed needs. The inspectors also reviewed the overall evacuation plan and the personal evacuation emergency plans (PEEP's) for residents in

one unit. The night time evacuation plan did not clearly outline the procedure to evacuate residents and PEEP's had not been reviewed to reflect changes in residents' needs. Given the lack of staff knowledge and the level of staffing available at night-time the inspectors were not assured residents were safe. The inspectors requested the evacuation plan at night be reviewed to reflect residents' needs and the available support, and this was completed by the night sister and available for review the following morning.

Staff identified that some residents in this unit required the assistance of a wheelchair to evacuate and staff showed the inspectors the location of wheelchairs at night time. This room was cluttered, wheelchairs were not easily accessible and the inspectors identified that there was a potential for the main evacuation route of the hallway to become obstructed, during an evacuation. Therefore the inspectors were required to instruct staff to tidy this room to make all wheelchairs accessible and to place a wheelchair in a resident's bedroom, easily accessible in the event of a fire.

In one unit the fire panel was located in an external shed and access to the shed was through three locked doors or gates. A staff member did not know the location of this fire panel. Fire doors throughout the centre were not closing correctly. The use of over-door clothes hangers on a number of fire doors and paint on a smoke seal of one door negated the function of those doors in the event of a fire.

The inspectors reviewed records of fire drills. In one unit the last available record of a fire drill was from October 2015. In another unit an issue identified during a fire drill had not been followed up in order to mitigate risks. Records were not maintained in a unit of regular checks of the fire panel, emergency lighting and of emergency exits being clear of obstruction. Emergency exit signs were not in place in some units as well as emergency lighting in one unit not provided for one exit.

One staff member had not been provided with training in fire safety.

Suitable arrangements were not in place for infection prevention and control. Mould was observed on the ceiling of a kitchen as well as a build up of grime and food debris in the food preparation area. One bathroom door was stained with hair dye.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

Findings:
The inspectors found residents had not been safeguarded against abuse. There was a lack of knowledge and recognition of what constitutes abuse, as well as a lack of response across all levels of service provision to ongoing safeguarding concerns. Safeguarding measures had not been implemented at the time of incidents or as ongoing supportive and protective interventions to minimise the impact and likelihood of injury to residents. There was inappropriate use of restrictive practices in the centre impacting on residents' quality of life, their right to privacy and their right to freely access their own home. Residents had not been provided with appropriate support to support them with their behavioural and emotional needs.

There was a policy on the prevention, detection and response to abuse however, given the significant failings identified during the inspection, the inspectors were not assured the policy guided practice. On the first day of inspection, safeguarding concerns were identified by inspectors and there had been a number of peer to peer physical assaults reported through incident management reporting systems. The inspectors spoke to staff and managers, however, none of these considered these incidents as abuse and therefore had not progressed these issues as safeguarding concerns. The person in charge was not able to confirm if the national policy and procedures on the protection of Vulnerable Persons at Risk of Abuse had been implemented. Staff were not knowledgeable on what constitutes abuse and the required responses, and some staff could not identify the designated liaison officer.

The inspectors also met with the designated liaison officer, who confirmed no safeguarding reports had been made pertaining to residents in this centre since the last inspection. As a result of these overall failings, no safeguarding plans had been developed for residents experiencing repeated physical assaults, to minimise the likelihood or impact of injury. Due to the delay in receiving incidents records for the centre, the remaining incidents were not reviewed by the inspectors until the second day of inspection. This review identified a total of 58 peer to peer incidents since the last inspection.

The inspectors met with the provider on the first day of inspection and issued an immediate action. Assurances were sought regarding the safeguarding practices in the centre. A written response was provided by the second day of inspection outlining the measures the provider was initiating to review incidents and practices in the centre.

The inspectors identified that due to a lack of identifying safeguarding concerns, the Health Service Executive (HSE) and the Health Information and Quality Authority (HIQA) had not been notified of these safeguarding concerns in line with national policy and legislative requirements.

One safeguarding concern had been notified to HIQA since the last inspection and following investigation, a number of actions were outlined by the provider in response to findings. The inspectors found these actions had not been implemented and the inspectors were not assured, given the circumstances of the concerns that residents were safe. An immediate action was issued on the second day of inspection requiring the provider to give assurances regarding this concern. The provider in response subsequently outlined the measures being taken to assure the provider residents would be protected in this regard.

The inspectors reviewed records of staff training and identified one staff had not received training in safeguarding. Five staff had not received refresher training in line with the timeframe specified by the service provider.

Restrictive practices were in use throughout the centre including environmental, physical and chemical restraints, some of which had not been reported to HIQA as required. The inspectors observed inappropriate issue of some of these practices including chemical and environmental practices. From review of documentation and discussions with staff, it was evident that in some cases, the criteria for use of these practices was not adhered to. For example, a staff member had outlined the criteria for use of a locked door and this criteria presentation was currently not an issue for the resident. However, the inspectors observed the door was locked on the day of inspection. In addition, a resident had been administered a chemical restraint on the morning of inspection however, staff stated the resident was in good form all morning and had been brought out for a walk, which inspectors identified was within one hour of this administration. In one circumstance where locked wardrobes were in place, the staff outlined the reason for their use however, the inspectors observed that a resident was actively encouraged to access peers' wardrobes as part of participation in household duties. Staff confirmed consent had not been given by residents for their peer to access their wardrobes and the inspectors found the use of this practice was not proportionate to the risk given that peers were encouraged to access wardrobes at times of the day. In addition, the inspectors found the lack of consent was not upholding individual resident's' rights to privacy. Complete records were not maintained in the event restrictive practices were used.

The inspectors reviewed an environmental restrictive practice implemented 24 hours a day and discussed the rationale for use with staff. Staff were clear on why this environmental restriction was in place however, there was no evidence to confirm that this was the least restrictive measure for the shortest duration. The inspectors discussed with staff if there was a plan in place to reduce this practice however, staff outlined this would require works, which would take a number of months to attend to.

Most restrictive practices were reviewed on a quarterly basis by a service committee and the inspectors reviewed a sample of minutes for six meetings held in 2017. The inspectors were not assured that this review was a robust process, for example, some decisions to continue restrictive practices were not apparently informed by trials or plans to reduce a practice, and had not considered if these practices were the least restrictive for the shortest duration.

The inspectors found sufficient efforts were not made to alleviate the underlying causes

of behaviour. Some residents with emotional and behavioural needs did not have a behaviour support plan developed. Some staff were unable to identify residents who did have a behaviour support plan. The inspectors spoke to a staff member with regards to a residents' behaviour support plan, however, the staff was not able to comprehensively outline the reactive strategy to respond to presenting behaviours of concern. A referral had been made for a resident requiring psychology input in July 2016 however a review had not been completed up to the day of inspection.

Judgment:
Non Compliant - Major

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

Findings:
The inspectors found residents' healthcare needs were not appropriately or safely met and a healthcare risk identified on the day of inspection, resulted in an immediate action, as well as direct instruction being given by inspectors. The inspectors found there was an overall lack of accountability and acceptance of responsibility in relation to the provision of safe healthcare, in particular in relation to one vulnerable resident.

On the first day of inspection, inspectors identified a resident with specific hydration requirements was not being cared for appropriately and was presenting with symptoms of dehydration. Staff were not consistent with who was assigned to care for this resident. One staff stated the student nurse was assigned to ensure this resident's needs were being met and the other two staff stated that all staff on duty were responsible. The inspectors reviewed fluid intake chart for this resident however, minimal fluids were recorded as been given up to the time of review at 2pm.

Some staff were able to state the symptoms of dehydration and one staff member subsequently checked the resident for these signs, confirming the resident was presenting with these symptoms, however, at this point no intervention was attempted by staff to deal with this issue. Other staff members were not able to comprehensively describe these signs and symptoms and the assessment of potential differential causes, and told inspectors this would be determined by monitoring the level of fluid intake at the end of the day. The inspectors instructed the staff nurse on duty at this point to provide fluids to the resident. There was no written plan of care in place regarding this resident's hydration needs and overall the inspectors found a lack of urgency to deal with the risk presented.

The inspectors met the chief executive officer (provider nominee) and members of the management team on the afternoon of the inspection and issued an immediate action in relation to the provision of safe and appropriate healthcare to this resident. A plan of care was developed by the end of the first day of inspection and the inspectors were assured that at this point the resident had received sufficient hydration.

The inspectors reviewed the healthcare needs of a resident in another unit who had a specific risk and corresponding emergency medical treatment prescribed. The inspectors spoke to staff regarding this risk and prescribed treatment, however, the staff were not able to identify this risk or the corresponding emergency treatment. Given the nature and seriousness of the risk, and the staffing arrangement at night-time in this unit, the inspectors issued an instruction to a member of the management team, requiring them to provide instructions to staff on this risk and associated emergency treatment plan. In addition, the plan in place to support a resident with self injury and maintaining skin integrity was basic and did not guide practice.

The inspectors were not assured that the choice of meals was wholesome and nutritious and that residents were provided with adequate choice at mealtimes. Observations at a lunchtime meal, identified that the two choices of meals provided, were in fact the same meal. The food provided for the main meal in the evening did not have sufficient portions available for all residents in the unit, and the staff described alternative offered to residents was a canned fish with salad option.

The inspectors spoke to staff members in this unit regarding the provision of food and nutrition. Staff identified that some residents can pour their own drinks, however, inspectors identified this was not supported, and residents were not provided with an opportunity at mealtime to promote this skill.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and 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:
The inspectors found the provider had failed to provide a safe and reliable service in which residents' needs were appropriately met and residents were protected from abuse.

Significant concerns were identified during the inspection with regards to safeguarding and the provision of healthcare, and immediate actions were issued for two safeguarding issues and one healthcare issue. A further three instructions were also issued by inspectors with regard to fire safety and healthcare. The immediate actions and further instructions were required, due to the level of concern inspectors had in relation to the residents' well-being and safety. In addition, appropriate practices were not in place and appropriate support provided in a range of areas such as behaviour support, the use of restrictive practices, maintaining residents' privacy and dignity, fire safety and infection control. The provider had failed to ensure sufficient and skilled staff were in place to comprehensively meet residents' needs and staff were not appropriately supervised in order to assure the provider this was an effective service in line with their regulatory obligations.

The systems the provider had in place to monitor the services provided were inadequate and had failed to audit some areas of concern and identify significant risks. Serious concerns were identified with the management and auditing of adverse incidents involving residents and as previously identified, there was a systematic failure to identify, report and respond to incidents of abuse in the centre across all levels of service provision. The inspectors reviewed the unannounced visits completed by senior management on behalf of the provider since the last inspection. One unit had not had an unannounced visit since October 2015 however, the inspectors identified there were significant concerns regarding safeguarding in this unit. More recent visits in two units did not review the incidents, despite incidents being part of the template used by the provider for these reviews. The provider had implemented a weekly audit completed by the person in charge. However, safeguarding did not form part of this audit and the methodology for this audit was reliant on documentary evidence. The provider acknowledged at a meeting during this inspection that this audit required improvement and was currently under review.

The inspectors were not assured the person in charge had the appropriate knowledge and skills in order to ensure the effective delivery of care and support. The person in charge had been appointed to this centre in April 2017 and had previously been a person participating in management in this centre from May 2015 to December 2015. In the interim, the person in charge had been appointed as a person in charge for two other designated centres in the Stewarts Care services. The inspectors found the person in charge was not knowledgeable on peer to peer abuse and the requirement to report these issues as safeguarding concerns. In addition, the inspectors found the scope of the person in charge to manage two designated centres comprising eight units did not ensure the effective governance, operational management and administration of the centre given their legislative requirements and the failing identified during this inspection The person in charge identified it was difficult to manage the centre given their scope of responsibility. The provider acknowledged the failings with regard to the person in charge.

The inspectors were not assured that some managers employed within the centre demonstrated sufficient knowledge of residents' needs, issues of risk in the centre and safeguarding concerns, and there was a lack of insight into quality of life indicators for residents in the centre, in order to inform evidence based practice.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
The inspectors found there were insufficient staffing levels at times in accordance with the assessed needs of residents and the stated required levels. Staff were not sufficiently knowledgeable or skilled on residents' needs and of their support requirements. Continuity of care was observed not to be maintained. Appropriate supervision of staff was not in place.

The inspectors spoke to approximately twelve staff over the course of the inspection however, significant deficiencies were identified in some staff's knowledge of residents' needs, and of the care and support requirements to safely and appropriately meet these needs including healthcare needs, behaviour support needs and fire safety supports. Significant knowledge deficits were also found in the identification and reporting of safeguarding concerns across all levels of service provision. On the day of inspection, the staffing arrangement at staff lunchtime did not ensure continuity of care. Inspectors observed that the staff with the most experience working with residents in one unit, was a supernumerary student nurse who had worked in this unit for a total of three weeks.

The inspectors reviewed rosters and found that staffing levels were not consistently maintained in accordance with the assessed needs of residents and identified risk control measures. For example, in one unit where four staff are required daily, three staff were on duty, for three of a seven day period reviewed. In another unit, where a resident had an assessed need for 2:1 staffing for external activities, two staff were provided for three residents for a total of 24 of a 28 day period reviewed.

The inspectors reviewed training records for staff and most staff had been provided with mandatory training. However, some staff had not been provided with refresher training in fire safety and in safeguarding in accordance with the timeframes set out by the provider.

The inspectors found adequate supervision was not in place and the arrangements which were in place were ineffective to ensure a safe and reliable service. There were two clinical nurse managers who worked directly with staff in two units of the centre and the responsibility for the day to day supervision of care in two units was delegated to clinical nurse managers and staff nurses. In the remaining two units these clinical nurse managers were assigned to provide governance and oversight, however, these managers were not in attendance in these units on a regular basis. Staff nurses only in these remaining two units were responsible for the day to day supervision of care and support. However, the findings on the day of inspection of practices in the centre, did not assure the inspectors that this supervision was appropriate. Formal supervision arrangements were in place however, the timeframes as specified by the provider were not consistently adhered to. In addition, the inspectors found supervision meetings did not adequately address practice issues in the centre.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Vahey
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 Stewarts Care Limited
Centre ID:	OSV-0003903
Date of Inspection:	01 & 02 June 2017
Date of response:	24 September 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation
Theme: Individualised Supports and Care **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There were no toilet facilities in a bathroom and the location and location of toilet facilities in this unit could not ensure the privacy and dignity of residents. Dignity of residents was not upheld during a mealtime.

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

1. Action Required:
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:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a clear and substantial absence of arrangements for the identification, investigation and learning from serious incidents resulting in poor outcomes for residents and exposing residents to ongoing serious risk of injury and harm.

Incidents were not reported appropriately to the relevant personnel in order to initiate actions to reduce the risk of harm to residents.

The personnel identified by the provider as responsible for the identification and management of adverse incidents and risk had failed to fulfil these responsibilities.

2. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Mould was evident in the kitchen of one unit and the area of the kitchen, on which food was prepared had visible collection of grime and food debris.
One bathroom door was stained with hair dye.

3. Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
All areas have now been checked for mould.
Areas requiring redecoration have been addressed.
The issue of condensation in kitchens and bathrooms has also been addressed by the Technical Services Department. Additional ventilation will be installed as required.

Proposed Timescale: 01/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire panel for one unit was located in an external shed, and access to this location was through three locked gates or doors. A staff member was not aware of the location of this fire panel.

4. Action Required:
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
The fire panel will be relocated.
Staff induction has now changed so that staff who are moved to unfamiliar areas or new areas will receive induction that includes the location of the fire panel.
Technical services are reviewing the location of all fire panels and will reposition as required.

Proposed Timescale: 01/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of fire doors throughout the centre were observed not to be closing. Metal over door hangers on some doors and paint observed on a fire seal, negated the function of these doors in the event of a fire.

5. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Technical Services have assessed the fire doors throughout the centre. Any that are not of the required standard will be replaced or the fire seal will be replaced if required.

Proposed Timescale: 01/10/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not aware of the evacuation plan and of the support residents required in order to assist them in evacuating the centre in the event of a fire. Plans outlining support residents required to evacuate the centre were not up-to-date reflecting current needs of residents. The night-time fire evacuation plan was not clear and did not guide practice.

Documentary evidence was not available to confirm regular fire drills were completed in one unit.

Remedial action had not been taken following an issue which arose during a fire drill.

6. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
All staff have receive fire training.
Any staff new to the area will receive an induction which includes the fire procedure.
Individual fire plans have been updated and communicated to staff.
The completion of fire drills is reported to the Director of Care who ensures any actions required are fully implemented.

Proposed Timescale: 01/08/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Checks of emergency lighting, clear evacuation routes and the fire panel did not form part of routine fire checks.

7. Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Checks of emergency lighting, clear evacuation routes and the fire panel now form part of routine fire checks.

Proposed Timescale: 21/07/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Wheelchairs used to assist residents in the evacuation of a unit were not readily accessible and posed a risk in the event the unit required to be evacuated.

Emergency exits were not clearly marked throughout the centre.

One exit used in the event of evacuation had no emergency lighting and no signage.

8. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One staff had not received training in fire safety.

9. 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:
All staff have now received fire safety training.

The Person in Charge monitors the training matrix to ensure that staff receive refresher training.

Proposed Timescale: 01/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A significant number of residents did not have plan in place to support them with behaviour that challenges.

Staff were not aware of the reactive strategy in place for a resident to support them with their behavioural needs.

Staff were unable to identify those residents who had behaviour support plans in place.

A psychology review had not been facilitated following referral for a resident in July 2016

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

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A chemical restraint was administered to a resident on the day of inspection however, staff identified there were no clinical indicators for it's use on this occasion.

A number of restrictive practices in the centre were not reported to HIQA as required.

The inspectors observed inappropriate use of environmental restraint however, the criteria for use of these practices was not met at the time of observation. In addition, staff described the criteria for a use of locked wardrobes in one unit however, some practices contradicted the rationale for use of this restrictive practice. An implementation of an environmental restrictive practice, was not informed by best practice. There was no plan in place to reduce this practice and no evidence to confirm this was the least restrictive measure for the shortest duration.

The review of restrictive practices in the centre was not a robust process.

11. 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:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A staff member had not received training in safeguarding.

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

Please state the actions you have taken or are planning to take:
All staff are now trained in safeguarding and the person in charge monitors the training matrix to ensure that staff receive refresher training as and when required.

Proposed Timescale: 03/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents of peer to peer abuse were not investigated.

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

Please state the actions you have taken or are planning to take:
Incidents of peer to peer abuse are now investigated and immediate safety plans are put in place to safeguard residents at all times.
Staff have been advised as to what constitutes abuse and the actions that they should take to ensure safety.

Proposed Timescale: 01/08/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Incidents of peer to peer abuse were not identified as safeguarding concerns and as such were not reported in line with the national safeguarding policy and these incidents of peer to peer abuse had not been reported to the appointed designated officer. As a result adequate measures were not in place to ensure residents were safeguarded.

The actions arising following investigation of a safeguarding concern were not implemented.

The management team in this designated centre were not aware if the national policy and procedures on Safeguarding Vulnerable Person at Risk of Abuse had been implemented in full in this centre.

Staff were not aware of the policy and procedures regarding safeguarding of residents. Staff were not knowledgeable on the types of abuse.

14. 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 response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with appropriate healthcare and the lack of care put residents wellbeing at risk. There was no plan in place to address a resident's identified healthcare need. Staff were not clear on who was responsible to ensure this resident's needs were met and on the actions being taken in response to the presenting deterioration.

Staff were not aware of a resident's known healthcare risk and the associated emergency interventions.

A plan in place to support a resident with self injury and maintaining skin integrity was basic and did not guide practice.

15. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each

resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not given adequate choice at mealtimes.

16. Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
A full audit of mealtimes has been undertaken. This has included whether adequate choice is offered at mealtimes.

The Head of Catering and a member of the local Service Improvement team are now implementing a remedial action plan.

A follow up audit will be conducted in September to monitor progress and to ensure actions have been taken.

Proposed Timescale: 01/10/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors were not assured that the choice of meals was wholesome and nutritious.

17. Action Required:
Under Regulation 18 (2) (b) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not supported to assist in preparing their own drinks.

18. Action Required:
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

Please state the actions you have taken or are planning to take:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors were not assured the person in charge had the appropriate knowledge and skills to ensure the effective governance and management of the centre.

19. 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:
An experienced and qualified Person in Charge has been put in place.

The areas and breadth of responsibility for each Person in Charge has been reviewed and a new structure will be put in place. Each Person in Charge will have reduced areas of responsibility. (in terms of the number residents and staff).

A new programme of competency based induction is being carried out by the Programme Manager. The Person in Charge will meet regularly with the Programme Manager to ensure that the skills and knowledge are in place.

Proposed Timescale: 04/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The scope of the person in charge to manage two designated comprising eight units did not ensure the effective governance, operational management and administration of the centre given their legislative requirements and the failing identified during this inspection

20. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The Structure of the designated centre will change and the areas of responsibility will be reduced.

A local Service Improvement team has been put in place to ensure the effective governance, operational management and administration of the centre .

A programme of external audits has been undertaken to provide the Persons in Charge with detailed remedial action plans. These plans are monitored through the Daily Care Planning meeting.

Proposed Timescale: 29/09/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place had not ensured the service provided was safe in particular in relation to safeguarding, risk management, meeting residents' healthcare needs and fire safety.

The management systems in place had not ensured the service provided was appropriate to residents' needs in particular in relation to the use of restrictive practices, appropriate supports in relation to behaviour management and the provision of food and nutrition.

The inspectors were not assured that some managers had sufficient knowledge and insight into issues in the centre in order to inform practice.

The services provided and systems in place were not appropriately monitored. Issues of concern were not identified and acted upon. There was a lack of accountability throughout the service to identify and act upon issues of concern. The inspectors found on the day of inspection a lack of urgency to deal with the issues presented. The current auditing systems in place either failed to audit issues, or to act on presenting

trends particularly in relation to incident management and risk to residents' safety.

21. 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 response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The numbers of staff on duty at times was not in accordance with the required levels and of the assessed needs of residents.

The inspectors were not assured, given the knowledge deficit identified, that sufficiently skilled staff were in place to provide support to residents.

22. 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:
The response submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Continuity of care was not maintained and the inspectors identified that those staff supporting residents during staff breaks were not sufficiently knowledgeable on residents' needs and supports.

23. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than

full-time basis.

Please state the actions you have taken or are planning to take:
The Person in Charge has reviewed the roster and the structure of the day. Changes will be made to ensure that the correct levels of support are in place to meet service user need. Break times have been rescheduled to ensure that the correct staff are in place at key times.

Any member of staff who is new or unfamiliar with an area will receive area specific induction and ongoing support from a designated individual. Daily induction sessions are carried out .

Personal Support plans are being rewritten by keyworkers to ensure that the plan clearly guides practice.

A recruitment campaign has been successful in recruiting frontline staff (both nurses and care staff) this has led to reduction in the use of agency staff and an increase in the continuity of care.

Proposed Timescale: 31/10/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff had not been provided with refresher training in safeguarding and in fire safety.

24. 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 staff are now trained . The Person in charge monitors the training dates on the training matrix to ensure that refresher training occurs as required.

Proposed Timescale: 21/07/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised either directly or through formal supervision processes.

25. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
A new Person in charge is now in place and is supported by two additional managers and the local Service Improvement Team. Both formal recorded supervision and a visible management presence within the units is now in place.

The role of the mangers within the units has been clarified and additional support is being given to ensure the correct supporting structures are in place. These take the form of the local service improvement team , the daily planning meeting and the introduction of the specified induction staff.

Proposed Timescale: 21/07/2017