

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre 2 - Aras Attracta
Centre ID:	OSV-0004910
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Lead inspector:	Thelma O'Neill
Support inspector(s):	Christopher Regan-Rushe; Stevan Orme
Type of inspection	Unannounced
Number of residents on the date of inspection:	15
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 inform a registration decision. 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:
08 January 2018 10:20	08 January 2018 18:41
09 January 2018 09:00	09 January 2018 17:20

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

In May 2016, following the conclusion of a two-year regulatory programme, an inspection was completed to inform a registration decision. During that inspection, inspectors found significant non-compliance with the regulations leading to a poor quality of life for residents. In addition, inspectors found that the provider's governance and management arrangements were inadequate and were failing to ensure that the service being provided was of sufficient quality and was keeping residents safe. Due to the significant failings found during the May 2017 inspection, the provider was issued with a notice of proposal to cancel the registration of the centre in September 2017

In November 2017, the provider submitted written representations to the Office of the Chief Inspector, setting out the actions they had taken to address the failings identified in the May 2017 inspection. HIQA published details of the inspection reports from the two-year regulatory programme in November 2017 and summarised these in an overview report. These reports are available at www.hiqa.ie.

Following the publication of the overview report and the receipt of the provider's representation to the notice of proposal to cancel the registration of the centre, the Office of the Chief Inspector notified the Health Service Executive (HSE) that a final decision on the registration of the centre would be made by February 2018.

This inspection was completed to verify the implementation and impact of the actions the provider stated they had taken. Inspectors considered whether there had been any progress to improve the quality and safety of the service, as described in the provider's representation response dated 27 November 2017 and the actions arising from the May 2017 inspection. The findings from this inspection will be used to inform a registration decision.

How we gathered our evidence:

During the inspection, the inspectors met with all 15 residents at the centre. Inspectors also spoke with eight staff members about the service provided. Staff gave very positive feedback on the quality of service now being delivered to residents. Inspectors also reviewed documentation relating to residents' needs and the operational management of the centre; such as, personal plans, health records, risk assessments, policies and procedures and staff files.

Some residents were able to tell inspectors about the service they received. Residents were complimentary and said that they were happy; however, some residents were still looking forward to the transition to the community.

Where residents were unable to tell the inspectors about the quality of support they received, inspectors spent time observing residents' interactions with staff. Inspectors found that residents appeared relaxed when supported by staff. At the last inspection, inspectors found that although staff were caring, staff knowledge of residents' needs was inconsistent and not all staff had received up-to-date training. There was also a reliance on temporary workers at the centre. On this occasion, inspectors found that there was a stable core team of staff in each bungalow, and all staff were familiar with the residents' needs and had completed mandatory staff training.

Inspectors interviewed the new provider representative and person in charge as part of the inspection and found that they were suitably qualified and knowledgeable of residents' needs and their regulatory requirements.

Description of the service:

The provider had produced a document called the statement of purpose, as required by the regulations. Inspectors found that the service was accurately described in that document in relation to services and facilities provided to meet residents' needs. The

designated centre is part of a large campus operated by the Health Service Executive (HSE) in Mayo. The centre provides full-time, seven day residential and respite services to 17 adults with a disability. The centre comprised of six bungalows which were configured into either single or multi-occupancy bungalows, and was close to a nearby town with easy access to all local amenities and shops.

Overall judgment of findings:

During this inspection, inspectors reviewed the 47 actions from the last inspection and found that significant improvements had occurred in the governance and management of the centre. In addition, the provider had strengthened the operational management systems to ensure more effective oversight of the service. Inspectors found that an improved quality of service was now being provided to meet residents' assessed needs.

The previous inspection found non-compliances in 16 of the 18 outcomes inspected against, and in response the provider submitted an action plan to HIQA containing 47 specific actions. Inspectors reviewed these actions on this inspection and found that 38 actions had been completed, two actions were partially completed and seven actions not completed.

On this occasion, inspectors found considerable improvement in the quality of service provided. Residents' rights, dignity and consultation had improved for residents and their families, complaints management had improved and there were no active complaints at the time of the inspection. In addition, residents' healthcare needs were being met and a schedule of maintenance works had been completed to ensure safe and suitable premises for residents. Furthermore, the overall governance of centre had been strengthened following the complete change in the management team since the last inspection. Inspectors found this had a positive impact on service delivery.

Of the 16 outcomes inspected, 13 outcomes were found to be compliant or substantially compliant; however, further improvements were required in the other three outcomes. For example, inspectors found one major non-compliance under workforce as the provider did not have a complete record of schedule two documents in the staff files. Moderate non-compliance was found in two areas; social care needs, and health and safety and risk management.

Findings from the inspection are explained in the body of the report and actions required are found in the action plan at the end.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that residents were involved in decisions about the running of the centre and supported in-line with their assessed needs. Furthermore, inspectors found that complaints were now being investigated in-line with the provider's policies.

Following the last inspection, inspectors found that residents were now involved in weekly 'voices and choices' meetings in each bungalow. Meeting minutes and discussions with staff showed that residents were supported to make decisions in areas such as the weekly menus, planned social activities and the décor of bungalows. Where residents were unable to tell staff what they wanted at the meeting, staff told inspectors that they advocated on their behalf based on their knowledge of the person's likes and dislikes. Furthermore, communication aids such as photographs were used to help residents make decisions on the choices offered.

In addition to 'voices and choices' meetings, residents and their representatives were involved in discussions on the future of both the centre and the whole campus through regular residents and family forums. Furthermore, residents had access to advocacy services with contact information displayed throughout the centre. Records examined also showed that advocacy services were invited to and attended residents' review meetings.

Inspectors found that following the last inspection, the person in charge now maintained an up-to-date complaints log. Inspectors found that complaints were recorded from both residents and their families and showed that investigations had been conducted in-line with the provider's policies. In addition, the complaints log showed that the complainant

was informed of the outcome of the investigation, and their satisfaction with the outcome was recorded.

Inspectors observed that the contact details for the centre's complaints officer were displayed throughout the centre, and that following the last inspection, the provider had developed an accessible complaints policy and reporting form for residents. Inspectors found evidence that the accessible reporting form was being used by residents. Records also showed that staff had advocated for residents and made complaints on their behalf using the new complaints form. In addition, inspectors found that staff knowledge reflected the provider's complaints policy.

Judgment:

Compliant

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that while residents' communication needs were being met by staff, they had not received an assistive technology assessment by a suitably qualified professional.

Inspectors found that following the last inspection, the provider had ensured that staff received communication training and this was further reflected in discussions with staff. The inspectors found that each resident now had a communication passport in place, which clearly described how they communicated and how staff should support them. Inspectors spoke with staff about residents' communication needs and found that their knowledge reflected the communication passports reviewed. Furthermore, inspectors found that residents' communication passports were regularly updated by their key worker and audited by the person in charge.

Throughout the inspection, inspectors observed residents being supported by staff to express their needs and wishes in a manner of their choice. Inspectors observed staff and residents using communication methods such as sign language, hand gestures, photographs and objects of reference, which reflected communication passports reviewed.

Although residents' communication needs were met by staff at the centre, inspectors

found that following the last inspection, assistive technology assessments had not been completed. However, the person in charge provided assurances to inspectors that assessments were scheduled to be completed by the campus' occupational therapist and speech and language therapist.

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that residents had up-to-date written agreements in place.

The previous inspection had found that residents' written agreements did not contain information on total fees charged at the centre.

Following the last inspection, inspectors found that the provider had reviewed residents' written agreements and these now provided information on the total fees charged to both residents and their representatives. In addition, written agreements included information on any additional charges to be met by the resident while at the centre, such as the cost of social activities and holidays.

Inspectors found that written agreements had been signed by both the provider and residents or their representatives.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that residents' assessed needs were being met in-line with their personal plan, although plans were not available in an accessible version.

Following the last inspection, the provider had ensured that all residents' personal plans had been subject to an annual review. The inspectors reviewed meeting minutes and found that all aspects of the residents' plans had been discussed, and this had involved an assessment of the plan's effectiveness in meeting the residents' needs. Records showed that review meetings had also discussed residents' personal goals, and the residents' current goals were now linked to their assessed needs and wishes. However, inspectors found that goal-related records did not consistently include named staff supports and expected time frames for the achievement of goals.

Inspectors examined review meeting minutes and found that following the last inspection, residents and their representatives had participated in the personal plan review along with the person in charge, centre staff and multidisciplinary professionals such as dietitians and behavioural specialists.

Inspectors found that residents' personal plans had been updated following their annual review meetings and reflected both observed practices and staff knowledge. Inspectors further found that residents' key workers had developed accessible versions of personal plans for residents which included information on their likes and dislikes, family support networks, and goals. Although inspectors found that accessible plans were not available to all residents at the time of inspection, evidence provided showed that these were in the process of being developed by staff and the campus' speech and language therapist.

The provider had reviewed the centre's staffing arrangements and assigned core staff teams to each bungalow since the last inspection. The provider's review of staffing arrangements had ensured that opportunities for residents to access a range of activities in-line with their interests and assessed needs had increased. Activity records showed that residents were supported to enjoy activities within their bungalow such as artwork, massage and sensory relaxation, as well as community activities including visits to places of interests, shops and cafes.

In addition to providing core staff teams to each bungalow, the provider had also ensured that additional community resources were available to residents through the establishment of the 'community connectors' team. This team will further support residents to access community activities of their choice.

The previous inspection had found that where residents were in the process of moving out of the centre, transitional plans did not include information on the new accommodation and time frames for the move to be achieved. During this inspection, inspectors reviewed residents' transitional plans and found they had improved and were now detailed in nature. Plans included information both on the new accommodation as well as the expected date for the transition to be achieved. Plans were regularly updated and indicated progress made as well as evidencing ongoing consultation with both the resident and their representatives.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors reviewed the three actions required from the last inspection relating to general maintenance, repairs and equipment and found that the three actions had been completed.

On the previous two inspections, inspectors found that improvements were required to the internal and external maintenance of the centre, such as; access to suitable bathroom facilities and the completion of planned renovation work to kitchens. During this inspection, inspectors found that all of these actions had been completed.

Inspectors were shown evidence of internal and external renovation works completed, such as external pathways being installed, bathroom refurbishments, new kitchen installations, new emergency lighting, new ceiling tiles, and floor coverings that had been replaced. In addition, a revised programme of maintenance work was now operational in the centre and a record of each maintenance request was maintained in each house. Inspectors saw evidence that previous repairs had been completed in each house.

On the previous inspection, inspectors found that an internal divide in one bungalow had limited residents' access to both a bath and a shower; however, access to both facilities has now been re-established, and this had increased residents' choice in relation to their personal care options.

On the previous inspection, some residents did not have access to kitchen facilities in their bungalow and in another bungalow the kitchen needed to be replaced. These issues are now resolved and residents living in these bungalows have full access to a kitchen. Furthermore, inspectors found that residents were now being supported to utilise their kitchens. This had reduced the centre's reliance on the centralised kitchen on the campus to provide the meals for the residents. Inspectors were told by staff that residents were now cooking their own meals up to four times a week in some bungalows and this was having a positive impact on their quality of life and preparation for transitioning to live in the community.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors reviewed the provider's response to risk management in the centre since the last inspection and found that the management of accidents, incidents, fire safety management, and infection control had significantly improved. This had resulted in improved health and safety for residents, visitors and staff. Inspectors found that the six actions arising from the previous inspection had been addressed and the fire safety concerns previously identified, which had resulted in two immediate actions, had also been completed.

At the last inspection, inspectors found that the provider did not have adequate arrangements in place to ensure the safe evacuation of residents in the event of a fire. Furthermore, risks associated with choking and falls management had not been adequately assessed or managed. During this inspection, inspectors found significant improvement in all of these areas, although some further improvements were required.

Inspectors found that the overall level of risk in the centre had reduced and this could be attributed to increased operational oversight by the provider, additional human resources and expertise being made available to the centre and a new quality and safety committee to oversee the operational risks in the centre.

During this inspection, inspectors noted that:

- emergency lighting had been fixed
- all emergency escape routes from the centre were clear and residents could be effectively evacuated from the centre in the event of an emergency
- fire drills were now being regularly carried out and all residents were able to evacuate the bungalows in a timely manner
- fire evacuation plans were now up to date and staff members were familiar with the centre's evacuation plans
- all staff had now received fire safety training, as required by the provider's policy
- a system was now in place to regularly review the panic alarm system
- the quality and safety committee now had oversight of any fire safety concerns in the centre.

Inspectors were provided with a fire consultant risk assessment for this centre and this report identified that some of the current internal doors needed to be upgraded; this work is due to be completed by end of March 2018.

In general, inspectors found considerable improvement in risk management since the last inspection. However, inspectors found that the local risk register required updating to accurately reflect all of the current risks in the centre, namely falls risks. The person in charge told inspectors that she had arrangements in place for the HSE's national risk manager to review and update the risk register in the coming week.

The provider had implemented a range of measures to ensure that accidents or incidents had reduced and the oversight of risks in the centre had improved. Each house now had a health and safety folder which included a revised safety statement. In addition, minutes of the monthly quality and patient safety committee meetings showed evidence of discussion of the current incidents or patterns of risk in the centre between the management team, multidisciplinary team and team leaders.

A new 'safety pulse' folder was being used to inform each staff member at the start of each shift of specific issues relating to risk; such as, residents at risk of choking, absconding, safeguarding concerns, and the number of positive behaviour support plans active in the bungalow. Staff had to sign that they had read this folder at the start of each shift. In addition, due to the number of agency staff working in the centre, the person in charge had introduced an induction folder to support new and existing staff to stay informed of the new standard operating procedures being introduced in the centre as they were developed.

Inspectors found that the provider had implemented a new falls prevention and management policy to support and guide staff in the management of falls. While this had improved the management of falls in the centre, there were gaps in learning and actions taken in order to reduce or prevent the risk of further falls for some residents. For example, inspectors found that residents' fall care plans had not been updated following a fall and referrals had not been sent to the multidisciplinary team for further review.

Inspectors saw evidence that all residents now had a choking risk assessment completed and residents at risk of choking were regularly reviewed by the speech and language therapist. In addition, inspectors found staff knew which residents were at increased risk

of choking and the measures required to manage these risks. All staff working with residents at risk of choking had now completed training in feeding, eating and drinking disorders.

Infection control risks in the centre had been reassessed since the last inspection. Inspectors found that while adequate infection control measures were now being taken by the provider, to prevent or reduce the risk of residents acquiring a healthcare-associated infection, not all staff had completed hand hygiene training.

At the last inspection, inspectors found that the overall management of risks relating to the maintenance of the centre required significant improvement. During this inspection, inspectors found that there was now a system in place to identify, monitor and review the actions taken to address the risks in the centre. Maintenance audits had been completed, a planned programme of repairs had been undertaken by the maintenance department and general refurbishment had occurred in some of the bungalows. Uneven surfaces had been repaired and broken ceiling tiles and floor covering had been replaced.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors reviewed the five actions from the previous inspection relating to safeguarding and safety, behaviour management, staff training, and management of restrictive practices and found all had been completed. Inspectors found that there were appropriate measures in place to protect residents from being harmed or suffering abuse. Appropriate action had been taken in response to allegations, disclosures or suspected abuse since the last inspection.

The provider was now ensuring that the national safeguarding policy was being implemented in the centre and that staff were using this policy to inform their practice on a daily basis. Inspectors found that the general manager and the national

safeguarding office had taken responsibility for overseeing the management of local safeguarding concerns, and monthly reviews were occurring of the centre's progress in this regard. In addition, inspectors found that significant improvements had been made to positive behaviour management and restrictive practices. Since the last inspection, the provider had implemented new policies and procedures, conducted reviews of all of the current safeguarding risks in the centre and was monitoring these on a very frequent basis, both from an operational management level and from a senior provider level in the organisation.

Inspectors found that monthly safeguarding meetings between the designated officer and the national safeguarding officer were taking place. A safeguarding oversight committee had been established and meetings were being held monthly, chaired by the provider's representative, who reviewed all active safeguarding concerns in the centre. In addition, all staff safeguarding training had been complete. A safeguarding register was now in place and the number of historical safeguarding plans had been reviewed, actioned and closed, where appropriate. In addition, audits of staff safeguarding knowledge had been completed and actioned by the designated officer, as required, with follow-up audits being completed to ensure that staff knowledge in relation to safeguarding had improved. This was confirmed by inspectors during discussions with staff.

In line with the provider's representation response, the provider had appointed an additional designated officer to this centre to review all safeguarding concerns and update all existing safeguarding plans; this was in progress at the time of inspection. However, inspectors found that although the safeguarding concerns were regularly investigated and reviewed by the designated officer, the recommendations from these reviews were not clearly documented in the safeguarding plan for staff to follow. Inspectors also found that even though safeguarding plans were in place, the quality and the content of these plans required review. This issue had been identified by the person in charge prior to the inspection and inspectors were assured that this was commencing shortly in the centre.

While some safeguarding concerns remained in the centre, inspectors found that the provider was aware of these concerns and had taken measures to prevent, minimise and manage these risks. In addition, staff had received training in how to accurately report concerns and allegations of abuse. For example, on the last inspection, there was a significant number of incidents of unexplained bruising being reported that had not been investigated. However, on this occasion staff told inspectors that while they now document bruising, a new system has been implemented to support staff in reviewing residents' daily notes to identify the cause of bruising. This meant that on many occasions staff and the residents have been able to explain the cause of bruising and put measures in place to prevent the incident re-occurring. The person in charge also informed inspectors that the provider was implementing a protocol in relation to the management of bruising and how to effectively treat and report such incidents.

Positive behavioural support plans were in place for a number of residents and inspectors found that these plans had been formally reviewed by the positive support team since the last inspection. In addition, all staff had now received training in positive behaviour support and this was found to have had a positive impact on staff ability to

manage ongoing behaviour management risks. Furthermore, staff seminars and staff knowledge audits and 'on the spot coaching' are occurring to support staff in managing behaviours of concern. Inspectors also found that the reduction in the number of residents living in multi-occupancy bungalows, as well as the introduction of a stable staff team and team leaders in each house, had significantly reduced the level of behaviour incidents occurring in the centre.

Some therapeutic interventions, such as environmental and chemical restraint, were in use in the centre. Inspectors found that consent had been sought from the resident and their representatives for the use of these interventions. There were also some chemical interventions in use in the designated centre which were supported by 'as required' medication protocols and associated positive behavioural support plans. Both of these documents were used in conjunction with each other and gave clear guidance as to when a chemical intervention should be used and the criteria for its review.

Judgment:

Substantially Compliant

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

A record of all incidents occurring in the designated centre was maintained and notifiable incidents were submitted within the required time frame to the Chief Inspector.

Judgment:

Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

Findings:

Inspectors found that each resident’s personal choice of social activities was promoted in the centre and the activities residents were participating in reflected their interests and personal goals. Inspectors reviewed the two actions from the last inspection and found that one action was completed, but one action had not been addressed. Although residents accessed social activities in the local community, no assessments had been completed to support residents to participate in education, training or employment opportunities.

Inspectors reviewed residents’ activity records and found that since the previous inspection residents now had increased opportunities for social activities in the local community. A community connector was employed for 30 hours per week to facilitate these activities and staff told inspectors that they found the support useful in supporting the residents’ personal choices.

On the last inspection, inspectors were told by staff that residents’ access to activities in the local community was at times affected by the availability of suitably qualified staff and accessible vehicles. On this inspection, inspectors found that each house had a core staff team and access to suitable wheelchair accessible vehicles. This had greatly benefitted residents and their quality of life had improved.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that residents’ healthcare and nutritional needs were being met and significant improvement had occurred in this area since the last inspection. Residents’ healthcare needs were being met through timely access to GP services and appropriate treatment and therapies. In addition, inspectors found that residents’ healthcare needs had been appropriately assessed and were being met by the care provided in the centre. Inspectors reviewed the three actions from the last inspection and found they had all

been adequately addressed.

Residents had access to allied healthcare services, which reflect their diverse care needs. Inspectors saw evidence of residents accessing the services of the multidisciplinary team; such as, behaviour support specialists, physiotherapists, occupational therapists, dietitians and speech and language therapists. However, in some cases there was a waiting list for some services such as speech and language therapist.

On the last inspection, inspectors found there was no general practitioner (GP) services available every fourth week in the centre, which the provider had identified as putting residents' health at risk. The absence of a GP service was impacting on residents who required medical treatment and on occasions had led to residents being transferred to the local general hospital or waiting until the out-of-hours GP service was available for medical treatment. The person in charge confirmed to the inspector that this issue has recently been resolved and that a new GP had agreed to provide a service every fourth week to the campus.

Inspectors reviewed residents' healthcare plans and found that each resident's healthcare needs were now being appropriately assessed and care was being delivered as required, regularly reviewed and evaluated. Inspectors sampled healthcare records and found that following incidents of concern, referrals and follow-up appointments had been made to the appropriate multidisciplinary team member; for example, the GP, medical or surgical consultant, psychologist, dentist, speech and language therapist or dietitian. Inspectors reviewed residents' access to medical treatment and found that all required medical procedures had been attended by residents, who were supported by staff, as required. Inspectors also reviewed the protocols in place around the use of therapeutic medical equipment. Inspectors found that the person in charge had ensured that protocols were in place for the correct use of nebulisers, oxygen and catheters.

On the last inspection, inspectors found that residents' meals were being provided by a centralised kitchen on the campus, which had resulted in a limited choice for residents. In addition, residents had limited access to a choice of snacks and alternative meals as they wished. During this inspection, while it was noted that the centralised practices continue in some houses, inspectors found that residents had more access to their own kitchens and were more involved in cooking their meals at home, rather than ordering the meal from the main kitchen on campus. Food choices had also improved and residents now had more access and choice around their snacks and cooking alternative meals.

Judgment:

Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

<p>Theme: Health and Development</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: The previous inspection found that the centre's practices did not ensure that residents received medication in a timely manner and as prescribed. During this inspection, the provider's policies and centre's practices were now ensuring that residents received medication as prescribed.</p> <p>Inspectors found that the provider had reviewed the staffing complement in all of the centre's bungalows and medication-trained staff were now in place to ensure that residents received their medication as prescribed. In addition, the provider had ensured that additional suitably qualified staff were available at all times to residents and, through the commencement of 'safe administration of medication' training, had increased the number of non-nursing staff qualified to administer residents' medication.</p> <p>Furthermore, the provider had appointed a new 'night supervisor', which increased the complement of suitably trained staff during the night. The provider had also introduced a new medication administering system at the centre which further assisted staff in the safe administration of medication and ensured that residents received their medication as prescribed.</p>
<p>Judgment: Compliant</p>

<p>Outcome 13: Statement of Purpose <i>There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.</i></p>
<p>Theme: Leadership, Governance and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: The centre's statement of purpose now reflected the service and facilities provided and met the requirements of Schedule 1 of the regulations.</p> <p>Inspectors found there was a written statement of purpose that accurately described the service provided in the centre. The services and facilities outlined in the statement of</p>

purpose, and the manner in which care was being provided, reflected the diverse needs of residents.

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):

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

Findings:

Inspectors reviewed the quality of care and experience of the residents in this centre and found that significant improvements had occurred since the last inspection. The provider had completely revised the management team in the centre and had implemented enhanced governance arrangements and systems to monitor the delivery, quality and safety of service. The provider had also completed the two actions required in this area from the last inspection.

In September 2017, HIQA issued the provider with a notice of proposal to cancel the registration of this centre. In response, the provider appointed a new provider representative, director of services, person in charge and three team leaders to the centre. As part of the inspection, inspectors conducted fitness interviews with the new provider representative, the person in charge and the director of services and all appointments were found to meet the requirements of the regulations including the qualifications and experience required to hold the posts.

Inspectors found that the new provider representative had an active presence in the centre two days a week, and was supported in his role by the director of services who manages the service on a full-time basis. In addition, the person in charge was appointed to her full-time role in November 2017. She had an active presence in each of the bungalows in the centre and regularly met with residents and staff. She promoted leadership on the ongoing quality improvement works being implemented by the provider and demonstrated to inspectors her involvement in this process. She was supported by one clinical nurse manager and three team leaders who liaised with the staff team to ensure the oversight of care delivery in the centre.

In addition to the new internal management structure, inspectors saw that monthly service improvement steering group meetings was held regularly and chaired by the Chief Officer. These meetings ensured that external oversight of the governance and management of the centre was maintained. In addition, quality and safety committees were established to support the review of the centre's quality improvement plan and its risk management systems. The provider had arrangements in place so that where overdue actions were identified, these were escalated to the head of social care and, where necessary, linked to the risk register. Further arrangements were now also in place to allow a separate conference call to be held with the head of social care when a serious incident occurred, although there had been no serious incidents in the service since the last inspection.

The annual review of the service was recently completed and a copy was now available to residents in an accessible format. In addition, the six-monthly unannounced audit had been completed in November 2017 by the provider's representative and the actions identified during the audit had all been addressed. For example, the provider's representative recommended that a number of historical safeguarding plans be reviewed and closed if they were no longer a concern and inspectors found that there were now only nine active safeguarding plans in place, where previously there were 22.

At the last inspection, inspectors found that the provider's governance of safeguarding procedures at the centre had not ensured that concerns were consistently investigated to make sure that residents felt safe and that they were protected from the risk of abuse. On this inspection, inspectors saw that there was now a safeguarding oversight committee in place, where safeguarding incidents report were discussed and decisions to manage the concern were made. Any significant concerns identified during this meeting were escalated to the quality patient safety committee to be discussed by the senior management team and ensure that no safeguarding risks were left unmanaged.

Inspectors found that current systems in place were effective and appeared to be appropriate in managing the risks in this centre. In addition, the provider was able to demonstrate how the newly established meeting structure ensured that operational front-line staff were now involved and participated in the local and campus-wide leadership of the centre. These committees also enabled open and clear accountability for the actions required to bring the centre into compliance. Inspectors reviewed meeting minutes and agendas for meetings which demonstrated a high level of senior staff attendance, that actions were being appropriately closed upon completion and escalated to senior managers, and that minutes were being shared with all staff in the service.

Judgment:
Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

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

Findings:

There was one action issued in this area on the last inspection and this had been addressed. Since the last inspection, the provider had reviewed the staffing, transport and social care arrangements to ensure suitable resources were available to all residents living in this centre.

The provider had taken measures to ensure that residents who used wheelchairs had sufficient access to transport. Where wheelchair users could not access the centre's own transport, the provider had made alternative arrangements to ensure the residents could access the community, when required, by renting suitable alternative transport services. In addition, the provider had ensured that there was now a stable staff team in each of the bungalows.

On the last inspection, inspectors found that mobility equipment was not available to residents as required. During this inspection, inspectors found that a motorised wheelchair had been provided to a resident to improve their independence. Inspectors saw the resident using their new motorised wheelchair. The resident told inspectors how happy they were with their new chair and how the chair had enhanced their quality of life on a daily basis. Staff told inspectors that the resident was now accessing the local community independently and the resident was so happy with their new chair.

Since the last inspection, the provider had introduced core staff teams in each house and appointed specific community connectors on 30 hour contracts to support residents with community integration. In addition, inspectors found that residents had access to 24 hour nurse cover in the centre, where required, to meet their emergency healthcare needs.

Judgment:

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):

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

Findings:

Inspectors found that the provider's revised staff arrangements ensured that residents' assessed needs were met. However, not all staff had received training in-line with residents' needs and staff records did not contain all documents required under the regulations.

The previous inspection found that staffing arrangements in the centre did not ensure residents' assessed needs were met in relation to night-time nursing support and continuity of care. Inspectors found that following the last inspection, the provider had reviewed staffing in each bungalow and ensured that suitably qualified 'core' staff teams were in place, including the provision of nursing staff, where required. Inspectors reviewed staffing rosters and found that staffing levels reflected residents' assessed needs as described in personal plans, safeguarding plans, behaviour support plans and risk assessments. Furthermore, activity records showed that staffing arrangements in each bungalow ensured that residents were supported to engage in activities of their choice both at the centre and in the local community, including activities such as trips to places of interest, personal shopping and meals out. Inspectors found that although core staff teams were assigned to each bungalow, the provider continued to use temporary workers to meet residents' needs alongside permanent employees due to staffing vacancies. However, records and discussions with staff showed that a consistent team of temporary workers was being used in each bungalow to ensure that residents received continuity of care and support. Records also showed that temporary workers had been inducted on residents' assessed needs and were suitably qualified.

In addition to core staff teams in each bungalow, the provider was now ensuring that nursing cover was available at all times to residents through the availability of a suitably qualified night-time supervisor. Furthermore, the provider had appointed three team leaders with management responsibility for specific bungalows within the centre. Records and discussions with staff showed that each team leader supported the person in charge by ensuring that staffing arrangements were in place to meet residents' needs, as described in their personal plans. Inspectors spoke with the team leaders during the inspection and found them to be both suitably qualified and knowledgeable of residents' assessed needs.

The previous inspection highlighted that staff had not accessed training in-line with residents' assessed needs. Inspectors examined training records and spoke with staff and found that following the last inspection a range of training had been provided to staff within the centre. Records showed that staff had received training in both mandatory areas such as fire safety, as well as to meet residents' needs in areas such as communication. Inspectors found that although the provider had a training schedule in place to address staff training needs, at the time of the inspection not all staff had received training in the administration of emergency epilepsy medication and supporting residents with feeding, eating, drinking and swallowing difficulties (FEDS). However, inspectors were assured that staff knowledge on supports provided to residents with

FEDS difficulties reflected both personal plans reviewed and the recommendations of multidisciplinary professionals such as dietitians. In addition, inspectors received further assurances from the provider that staff employed in bungalows with a high risk of residents' choking had received training following this inspection.

The previous inspection found that the provider had not maintained all staff records as required by Schedule 2 of the regulations. Inspectors reviewed a sample of staff personnel files and found that all records were available at the centre apart from copies of Garda Síochána (police) vetting disclosures. However, inspectors were assured by the centre's director of services that requests had been made to acquire copies of the disclosures, but these had not been received at the time of the inspection.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Inspectors found that the provider had now ensured records and documentation maintained at the centre were in accordance with regulatory requirements.

Inspectors reviewed records and documentation required under Schedule 3 and 4 of the regulations and found that all records were now in place and being maintained. For example, following the last inspection, an up-to-date restrictive practice log was being maintained and complaint management records showed investigations in-line with the provider's policy. Furthermore, residents' written agreements had been revised by the provider to include information on total fees charged and any additional costs to be met while at the centre.

In addition, following the last inspection, the provider had ensured that all organisational policies as required under Schedule 5 of the regulations were available at the centre. Available policies included the provider's recruitment and selection policy which had not

been available at the time of the last inspection. In addition, the provider had ensured further compliance with the requirements of Schedule 5 and clarity for staff through the development of a separate restrictive practices policy, which was provided to inspectors following the close of the inspection. The previous restrictive practices policy had been incorporated into the provider's behaviour support policy.

Judgment:

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004910
Date of Inspection:	08 & 09 January 2018
Date of response:	28 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 02: Communication

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that assistive technology assessments had not been completed for residents.

1. Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all

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

times to communicate in accordance with the residents' needs and wishes.

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

The Speech and Language Therapist completed assistive technology screening assessments on each Resident in Centre 2 and this was completed on 05/02/2018.

Proposed Timescale: 05/02/2018

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that not all residents had an accessible personal plan available to them.

2. Action Required:

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

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

All residents personal plans will be made available in accessible format to the resident and where appropriate their representatives to be completed by March 31st 2018. There are currently 4 residents plans in progress due to be completed by March 10th 2018

Proposed Timescale: 31/03/2018

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that residents' personal goals did not include named staff supports and agreed timeframes.

3. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Residents personal goals will be identified through the accessible format documentation with named staff support and agreed timeframes to be completed by 31st March 2018. Currently there are six due to be completed by March 10th 2018 .

Proposed Timescale: 31/03/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that risk management arrangements had not ensured that :

- Up-to-date risk assessments were reflected in the centre's risk register.
- Residents' falls management plans identified all risks.

4. Action Required:

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

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

A risk log is in place in each bungalow which will inform the provision of a risk register.

A risk register will be compiled for Centre 2 by the PIC, using HSE standard process, which will be managed locally in conjunction with the Social Care Quality and Risk Advisor.

Resident's falls management plan has been reviewed and now identifies all risk. Post falls assessment tool has been implemented and Team Leader in house has attended training on falls management and review since inspection. Post fall reviews are being assessed by MDT including Senior Physiotherapist and advice given.

Proposed Timescale: 30/03/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that not all staff had received infection control training, such as, hand hygiene.

5. 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 staff in Centre 2 have now completed Hand Hygiene training by 28th February 2018.

Proposed Timescale: 28/02/2018

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Fire doors had not been installed in all areas of the centre as identified in a fire risk report.

6. 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:

Fire works review has been completed today 28.02.2018. The fire risk assessment is being updated and it will be issued by 02.03.2018 in line with this. The letter of acceptance to the contractor will issue tomorrow 01.03.2018 and the contractor will issue his works programme on 02.03.2018. The works programme to complete Bungalows 9 and 13 will also issue from the contactors on 02.03.2018. The intent is that works will be completed on Bungalows 9 and 13 by 15.03.2018. The remainder of the fire works for all bungalows is scheduled to be completed by 30.06.2018.

Proposed Timescale: 30/06/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that residents' safeguarding plans did not include documented evidence of when they had been reviewed following further incidents of a similar nature.

7. Action Required:

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

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

Residents safeguarding plans have been reviewed since inspection and documented evidence is now noted from similar incidents in the plans.

External advice has been sought in relation to the format of the safeguarding plans in order to review the quality and content of the plans to meet best practice guidelines.

Safeguarding trends will be monitored through the safeguarding oversight committee on a monthly basis.

Proposed Timescale: 30/03/2018

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Inspectors found that the residents' educational, training and employment needs had not been assessed.

8. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Since the inspection each resident has been assessed using the national tool to determine the ability of the resident to engage in education, training and employment. Links are being established with voluntary and community groups to assist in meeting the individual requirements of the resident.

Proposed Timescale: 31/05/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The inspectors found that staff personnel files did not contain all information required under Schedule 2 of the regulations.

9. 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:

Staff files contain all Schedule 2 documentation with the exception of Garda Vetting disclosures, which is securely stored elsewhere for data protection reasons. Staff files have been reviewed and all staff who works in Centre 2 and external contractors who provide a service in Centre 2 have been checked and have Gardai vetting. The HSE process is that the disclosures are kept by a HSE Data Controller and submitted to HIQA within 72 hours of inspection as required under legislation. They are posted by registered post to Registration Office, Cork if request by HIQA Inspector.

Proposed Timescale: 10/01/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The inspectors found that staff had not received training in-line with residents' assessed needs.

10. 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:

Training will be provided on the administration of emergency epilepsy medications, with priority given to staff working with residents with epilepsy.

Since inspection 61 staff has been trained on assisted feeding and risk of choking, with 26 staff from Centre 2 and additional training planned for February 2018.

Proposed Timescale: 31/05/2018