

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Centre A1
<b>Centre ID:</b>	OSV-0005386
<b>Centre county:</b>	Co. Dublin
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Peamount Healthcare
<b>Lead inspector:</b>	Helen Thompson
<b>Support inspector(s):</b>	Anna Doyle
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	20
<b>Number of vacancies on the date of inspection:</b>	3

## **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 unannounced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 11 October 2017 09:45 To: 11 October 2017 20:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

Background to the inspection

This was an unannounced inspection to assess the centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. It was conducted as part of the provider's application to register the centre. It was HIQA's fourth inspection of the centre.

This inspection was completed by two inspectors over one day. The required actions from the centre's previous inspections, primarily in January 2017 and subsequently May 2017, were also followed up as part of this inspection.

How we gathered our evidence

The inspectors met with a number of the staff team which included nursing staff, healthcare assistants, the person in charge and the service's meaningful activities coordinator. The inspectors also met with residents that were present during the inspection process and had direct conversations with three of them.

Additionally, in assessing the quality of care and support provided to residents, the

inspectors spent time observing staff engagement and interactions with residents. As part of the inspection process, the inspectors also spoke with the aforementioned staff and reviewed various sources of documentation which included the statement of purpose, centre data sets, residents' files, centre self-monitoring documentation and some of the centre's policy documents.

The inspectors also completed a walk through all six locations that comprised the centre's premises.

Overall, residents were observed to be contented within their home and this was endorsed in discussions with residents.

#### Description of the service

The service provider had produced a statement of purpose (SOP) which outlined the service provided within this centre. It was located on a large campus based setting with a number of facilities, including a day service on the site.

The SOP stated that the aim of the service was to deliver individual best outcomes and to provide a range of high quality health and social care services to residents, whereby the residents are cared for, valued and supported to embrace an independent lifestyle and maintain the best possible health.

Residents' support requirements included their intellectual disability medical conditions, mental health conditions, autism and behaviour that challenged.

There was capacity for 23 residents, but on the day of inspection the centre was home to 20 residents over 18 years of age.

#### Overall judgment of our findings

Eleven outcomes were inspected against and overall, the inspectors found that there was a good level of improvement in the centre's compliance with the regulations. It was evident that the provider had systematically addressed a number of the previously identified regulatory breaches which had positively impacted on the day to day experience for residents of this centre. The centre's governance and management systems had stabilised, post recent changes and developments, which was observed to positively impact on service provision and delivery.

However, continued improvement was required with regard to some outcomes, including the optimal provision of residents' social care and safeguarding needs. Whilst the inspectors acknowledged the progress made in these areas, and the provider's commitment to bringing about change on this campus setting, they concurrently highlighted the resident's entitlement to a quality, rights based model of service provision. Also, the centre's workforce required further improvement with regard to the number and familiarity of staff supporting residents.

In addition, two locations within the centre's premises required attention to ensure that the residents' home optimally supported their needs.

The inspector found that overall residents' healthcare needs were supported. These findings along with others are further detailed in the body of the report and 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 since the last inspection, the practice of residents paying for the use of personal assistants in order to meet some of their social care needs had ceased. No other aspects of this outcome were inspected.

**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 services and between childhood and adulthood.*

**Theme:**

Effective Services

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

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

implemented.

**Findings:**

In general, since the previous inspection, the inspectors found that there had been good progress made with regard to the provision and facilitation of residents' social care needs. Multidisciplinary team members and residents/their representatives were involved in the assessment process. However, progress needed to be maintained/further developed, and some improvements were still required, especially with regard to social goal identification and the care planning review process.

Improvements were observed by inspectors in the facilitation of residents' social care needs and in their level of community participation. A recently appointed activities coordinator was met by inspectors and discussed their role. They had completed training with staff - 76 on the campus to date, and had started meeting with staff in each unit to review the residents' activities. They acknowledged that there is still some work to be done in this area, and that there were plans in place to address more meaningful activities for residents relevant to their wishes and age profile.

Also, since the previous inspection, a meaningful activity assessment had been completed by an occupational therapist and included the resident's wishes and interests. External service providers had also been employed in the day services to provide more options to residents, for example, a yoga instructor. The person in charge was also promoting the development of meaningful unit based activities. For example, cooking and baking. One resident was observed enjoying this activity on the day of the inspection.

Residents were observed to be engaged in activities on the day of inspection. Activities boards were in place in each unit and there was information displayed in units about an upcoming social event that was planned for October 2017.

The quality of the assessment process had improved since the previous inspection and care plans audits had been completed. Some residents' goals were observed to be resulting in positive outcomes for residents. For example, some residents had been away on holidays and had gone on chosen day excursions.

However, some other goals were not meaningful and tended to be more functional in nature. For example, health care needs, such as weight management being met.

Some residents' plans required improvement in the review, evaluation and implementation process to ensure that it was conducted in a comprehensive outcome focused manner which brought about change.

The inspectors noted that residents were supported during periods of transition and service provision moves.

**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):**

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

**Findings:**

Overall across the locations, the inspectors found improvements with regard to the centre's premises. However, further work and attention was required in two locations to ensure that the resident's environment supported their needs in a homelike manner.

The inspectors completed a walk around of the six locations and observed that one of the actions from the previous inspection had been achieved by the provider. This involved the completion of the planned structural work which had positively impacted on the premises occupied by some residents.

The units had been redecorated to a good standard and bedrooms were personalised. In one unit a vacant bedroom in the centre had been reconfigured into an additional recreation room for residents. This was finished to a high standard.

However, in two of the locations it was observed that some areas required improvement in their furnishing and decorating. Inspectors noted a bare and unkempt environment which failed to optimally support residents' well being.

Issues identified included:

- a lack of and broken blinds on windows
- a lack of furnishing and decoration
- soft furnishings in one unit were worn and torn in some areas
- the kitchen area in one unit was sparsely decorated.

All units in in the centre were observed to be clean.

**Judgment:**

Substantially 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):**

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

**Findings:**

Overall, the inspectors found that the provider had systems in place to promote the safety of residents, staff and visitors in the centre. However, some improvement was required with the centre's risk management system.

Since the last inspection the provider had commissioned a review of the risk management process for all residents in the centre who were left unsupervised. Inspectors were informed that additional staffing had been introduced after this review and residents due to their support needs, were no longer left unsupervised in the centre.

The person in charge also informed the inspectors that learning from any incidents occurring in the centre was discussed regularly at team meetings. For example, one resident had been referred for discussion at a multi-disciplinary meeting to discuss their behaviours of concern.

The person in charge also met with the risk management officer in the centre on a monthly basis to discuss incidents in the centre and review the risk register to ensure that risks were being monitored and reviewed. Monthly health and safety checklists were also completed in each unit by designated personnel. Inspectors followed up on one incident that had been notified to HIQA and found that some actions had been taken to address this matter. However, the review of this incident was not comprehensive and the incident was not considered serious by the reviewing committee, despite the resident requiring hospitalisation. Inspectors found that not all control measures had been considered, as the procedure for ensuring that the correct medication was dispensed had not been reviewed to mitigate possible future risks.

There were appropriate fire systems in place in the centre. Since the last inspection fire doors had been installed in four of the units to address fire containment measures and all staff had completed fire safety training in the centre.

A sample of fire drill records viewed demonstrated that residents could be safely evacuated from the centre. This included a night time drill. Residents' personal emergency evacuation plans outlined the supports required to ensure a safe evacuation of the centre.

Satisfactory procedures were in place for the prevention and control of infections. For example, hand washing facilities were available throughout the centre, along with personal protective equipment. Infection control audits were completed and the findings from this had been discussed at a recent staff meeting in the centre. A service infection prevention and control committee also met regularly in the wider organisation.

**Judgment:**

Substantially Compliant



**Outcome 08: Safeguarding and Safety**

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

**Theme:**

Safe Services

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

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

**Findings:**

In general, inspectors observed that there were measures in place to protect residents from being harmed or suffering abuse with appropriate actions taken in response to allegations and suspected abuse. Residents' therapeutic needs were recognised and there was a positive approach to behaviour that challenged.

However, improvements were required with regard to the identification, implementation and due process for the usage of restrictive practices. In summary, the regulatory breaches found on this inspection related to the further facilitation of staff educational needs and a lack of a systematic, rights based approach around the usage of restrictive practices.

There were established systems with regard to the resident' safeguarding needs with evidence of incidents being reported, investigated and appropriately followed up. Safeguarding plans were available to guide staff in their support to residents. Inspectors noted that at the time of inspection there had been no reported safeguarding incidents for residents in recent months.

Staff member's safeguarding knowledge was found to be good and positive respectful interactions with residents were observed.

Inspectors observed that since the previous inspection work had been completed regarding the residents' intimate care plans with the quality of same improved to inform and guide staff practices.

Residents' emotional, therapeutic and behavioural needs were recognised and supported. Residents had access to support from a psychiatrist, a clinical nurse specialist in behaviour and an occupational therapist. It was also noted that in line with residents' support requirements, external consultations were sought. There was evidence of review of the resident's medication requirements. It was also noted that since the last inspection, there was improvement in the quality of the behaviour support plans available to inform staff supports to residents.

However, the inspectors found that significant improvements were required with regard to the identification, implementation and review of restrictive practices. It was noted

that there was no clear rationale in place for the use of some environmental restrictions. For example, residents' televisions being locked in cabinets. Some staff were unaware of this practice. Inspectors were informed that the trialling of opening the cabinets was occurring, but there was a lack of clarity/systems around these processes.

The inspectors observed that PRN medication had recently been used in response to a resident's behaviour that challenged. However, there was no documented protocol or procedure available to inform and guide staff practice in response to the resident's needs. Also, no records to demonstrate that the least restrictive practice had been explored before the utilisation of this restrictive practice. Staff could verbally outline the process but there was no documentation to underpin the practice and to safeguard the resident. Additionally, inspectors did not observe consent from the resident or their representative for the usage of their restrictive practice.

Since the previous inspection, some improvements were noted, for example, doors being locked in one unit. A reduction plan was in place and was being reviewed. Also, two presses were no longer locked in another unit.

Since the previous inspection there had been some improvements and progress made with the facilitation of staff training to meet residents' specialist needs. Staff had attended training in positive behaviour support, autism and in behavioural management. However, staff had not been facilitated with any education regarding residents' rights and restrictive practices and a small number still required behavioural management training.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

The inspectors found that a record of incidents was maintained in the centre and as required notified to the chief inspector.

**Judgment:**

Compliant

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

Overall, the inspectors found that residents were supported on an individual basis to achieve and enjoy the best possible health.

Residents' healthcare needs were observed to be identified, promptly responded to and assessed. Plans were subsequently developed to inform and guide staff supports, with the inspectors noting that these were reviewed and evaluated.

Residents were supported by a general practitioner of their choice who visited the centre, with provision also made for their out of hours support requirements. Residents as required, had access to a multidisciplinary team (MDT) and allied health professionals which included occupational therapy, physiotherapy, psychiatry and nurse specialists in dementia and challenging behaviour. Residents' neurology, chiropody, ophthalmology and diabetic needs were observed to be supported. Staff were also facilitated with training in correlation with residents' support requirements.

Inspectors observed that residents' food and nutrition needs, and preferences were assessed and supported. MDT personnel such as a speech and language therapist and dietician were involved as required. A healthy lifestyle was promoted and supported with residents with inspectors noting their involvement in food preparation. On the day of inspection some residents were observed to participate in, and enjoy a baking activity and new cookery books were recently purchased.

**Judgment:**

Compliant

**Outcome 13: Statement of Purpose**

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

**Theme:**

Leadership, Governance and Management

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

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

**Findings:**

Inspectors reviewed the centre's statement of purpose (dated September 2017) and observed that a number of improvements were required to ensure that this document accurately reflected the centre's layout, current service provision for residents and met all regulatory requirements.

Improvements included:

- some residents' personally identifiable and sensitive information was still contained in the statement of purpose (SOP), particularly in the description of the single apartments; this had been highlighted on the previous inspection.
- arrangements for the review of the resident's individual personal plan were not outlined in the SOP.
- the information regarding admission criteria required clarification, respite care is referenced on one section.
- the floor plan details of two locations did not correlate with the actual room usage, and five rather than six locations in the centre is referenced in places.

**Judgment:**

Substantially 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):**

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

**Findings:**

Overall, the inspectors found that the management systems in place in the centre ensured the delivery of safe and quality services. There was a clearly defined management structure with identified lines of authority and accountability. The centre was managed by a suitably qualified person. The quality of care provided and the experience of residents was monitored. However, some improvements were required with regard to the centre's self-monitoring process.

The centre had self-monitoring processes in situ which included an annual review, the six monthly registered provider visits and the utilisation of the audit methodology. Audits completed in the centre included a medication audit completed by the pharmacist, mealtime audits, finance and infection control audits.

The annual review process was completed recently (September 2017) and in general it's findings correlated with a number of those found on this inspection. It included an action plan for identified areas of improvement.

Though the review referenced a residents' satisfaction survey that was completed earlier in 2017, it did not comprehensively outline information regarding this process. It summarised that the results were very positive in relation to a number of areas.

A second six monthly provider visit for the year was completed in August 2017. However, as on the previous inspection some improvement was required with regard to clearly documenting exactly which units had been visited.

Inspectors observed that there was a defined management structure in place for the centre with clear lines of authority and accountability. The person in charge (PIC) had taken up the role in recent months and was directly supported by a person participating in management who held a senior organisational role. The PIC also received support and guidance from the provider nominee.

The inspectors observed that there were established communication and meeting processes in operation around these management structures. The PIC was clearly engaged in the governance, operational management and administration of the centre. She had previously worked in this centre and outlined the manner in which she had, since taking up this post, refamiliarised herself with the residents' needs and wishes and with the general status of the centre. She was additionally the PIC for another designated centre on the campus.

On interview and during the inspection process the PIC demonstrated good knowledge of the legislation and her statutory responsibilities. She was also clearly committed to her own professional development. Residents could promptly identify and were observed to engage with the PIC. There were clear arrangements for the absence of the person in charge.

Also, the inspector observed that there were arrangements in place for staff to exercise their responsibilities and express any concerns regarding the quality and safety of the services provided. Regular staff meetings were being held in the centre. From the records viewed a wide range of topics pertinent to the quality of services being provided were reviewed. This included a review of incidents, findings from audits and residents' support requirements.

**Judgment:**

Substantially Compliant

**Outcome 17: Workforce**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff*

*have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

**Theme:**

Responsive Workforce

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

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

**Findings:**

Overall, improvements had been made to the staffing levels in the centre to ensure that residents' needs were met in a safe and consistent manner. However, the inspectors observed that further improvements were still required with this area of need.

The inspectors found that the provider had taken responsive action to address failings identified to ensure that safeguarding measures could be implemented in the centre. This had resulted in the provider submitting an application to vary the centre to include another unit in May 2017 to address this matter.

The provider had also employed additional staffing to ensure that residents' social care needs were being met in the centre. This included employing an activities coordinator to oversee all of the centres on the campus, additional staffing had been redeployed two days a week to support residents with social care activities, a floater staff had been employed everyday to assist with some activities and one staff had been redeployed on a supernumerary basis to assist the person in charge (PIC) with oversight of the centre.

The provider had also commissioned a staffing review in July 2017 to assess whether residents' needs were being met in the centre. The findings from this demonstrated that some residents' social care needs were still not being met in the centre. The PIC informed inspectors that a meeting was scheduled with the provider on 17th October 2017 to review this. At the feedback meeting it was acknowledged by the provider that this remained an issue and inspectors were satisfied that the provider intended to address this.

A planned and actual rota was maintained in the centre. However, there was an over reliance on relief staff in some units in the centre. The PIC informed inspectors that 15 whole time equivalent posts currently being filled across the service with relief staff, had been sanctioned to be converted to permanent posts. A recruitment drive was currently underway in the service to address this, and two staff had already been recruited for one unit to promote consistency.

The inspectors found that while this needed to be addressed, there were systems in place to promote consistency of care for residents. For example, an induction folder was in place in each unit for all relief staff to read and sign. The records viewed demonstrated that this was completed. There were also specific relief staff assigned to the centre that were always employed to fill vacant shifts.

Staff had completed mandatory training and additional in service training had been provided to staff on dementia care, stoma care, epilepsy and social care activities. The PIC informed inspectors that they intended to continue this practice in the centre.

Supervision meetings held with staff were facilitated by the PIC or the clinical nurse manager 1. A sample viewed by inspectors confirmed this and found that a schedule of supervision was in place. For example, five staff had received supervision in September 2017. Staff spoken to felt supported in their role.

One personnel file was viewed by inspectors and was found to contain the requirements under the regulations. This had been an action from a previously completed inspection.

**Judgment:**

Non Compliant - Moderate

**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:**

The inspectors found that the policy on medication management practices in the centre had been finalised in July 2017 and was specific to the practices in the centre.

A record was also maintained in the centre of when a resident was discharged, transferred or was not residing in the centre. These had been actions from the last inspection. No other aspects of this outcome were inspected.

**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 report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Peamount Healthcare
<b>Centre ID:</b>	OSV-0005386
<b>Date of Inspection:</b>	11 October 2017
<b>Date of response:</b>	11 January 2018

### Requirements

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

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

#### Outcome 05: Social Care Needs

**Theme:** Effective Services

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

The review of some residents' plans were not conducted in a systematic manner which incorporated meaningful reflection on their effectiveness.

**1. Action Required:**

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan

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

reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1. PIC has reviewed all care plans to ensure they now only include social care needs. (Closed).
2. PIC will continue to sample and monitor resident's care plans to be assured that they are comprehensive and outcome focused and result in improved outcomes for residents.

Proposed Timescale: 1. Closed 2. 31st March 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:**

As outlined in the body of the report, improvements were still required with the implementation and follow up of recommendations from the review of some residents' personal plans.

**2. 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:**

1. PIC will monitor to ensure that recommendations and proposed changes at Personal Plan Reviews are recorded.
2. PIC will continue to sample and monitor resident's care plans to be assured that they are comprehensive and outcome focused and result in improved outcomes for residents.

**Proposed Timescale:** 31/03/2018

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

As outlined in the body of the report, two locations in the centre required attention to ensure that they were decorated and furnished in a homely manner for the residents.

**3. Action Required:**

Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

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

1. The PIC and Registered Provider will address the issues identified in the report across both specified locations and will source durable furniture that is homily and suitable for the two locations .

**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:**

As outlined in the body of the report, improvement was required with the centre's review of, and response to risk.

**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:**

1.Regarding the incident referred to in the report, The Registered Provider will escalate the feedback from this Inspection to the Drugs and Therapeutics Committee Chair for review and consideration. In addition, the Registered Provider will follow up to ensure that the actions agreed at the Meeting held on 29.09.2017 are closed out and fully implemented to mitigate possible future risks.

**Proposed Timescale:** 31/03/2018

**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:**

As outlined in the body of the report, staff training needs required further attention and improvement to ensure that staff could comprehensively support the resident's needs..

**5. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

1.The Registered Provider will review and as indicated revise the Restraint/Restrictive Procedures Policy to:

- support effective practice where the use of restrictive practice is identified and regularly monitored to be assured that due process is undertaken for each individual service user/resident
- ensure that consent from the resident or their representative for the use of restrictive practice is discussed with the relevant party and provision of informed consent is documented
- ensure that the least restrictive practice is employed as a response to behaviour that challenges
- ensure there is clear rationale for the use of environmental restrictions
- relevant staff will receive training on this revised policy and related practice will be monitored.

2.The PIC will identify and monitor to ensure that staff who have not received behavioural management training are supported to undertake this training.

Proposed Timescale: Meeting on 19th January 2018

Close out of related issues by 31st January 2018

**Proposed Timescale:** 31/01/2018

**Theme:** Safe Services

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

Consent from the resident or their representative for the usage of their restrictive practice was not present.

**6. Action Required:**

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

1.In light of new information of concern regarding organisational risk, the service provider has instructed that the Rights and Restraint Committee meet urgently on Friday 19 January 2018 to immediately address the issues raised in this Action Plan and those arising from new information.

2.The Registered Provider will review and as indicated revise the Restraint/Restrictive Procedures Policy to ensure that consent from the resident or their representative for the use of restrictive practice is consistently discussed with the relevant party and provision of consent is documented and that relevant staff receive training on this revised policy and related practice is monitored.

Proposed Timescale: Meeting on 19th January 2018

Close out of related issues by 31st January 2018

**Proposed Timescale:** 31/01/2018

**Theme:** Safe Services

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

The provider had not ensured that there was a clear, systematic, rights based due process mechanism underpinning the usage of restrictive practices with residents.

**7. 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:**

1. In light of new information of concern regarding organisational risk, the service provider has instructed that the Rights and Restraint Committee meet urgently on Friday 19 January 2018 to immediately address the issues raised in this Action Plan and those arising from new information.

2. The Registered Provider will review and as indicated revise the Restraint/Restrictive Procedures Policy to:

- support effective practice where the use of restrictive practice is identified and regularly monitored to be assured that due process is undertaken for each individual service user/resident
- ensure that consent from the resident or their representative for the use of restrictive practice is discussed with the relevant party and provision of informed consent is documented
- ensure that the least restrictive practice is employed as a response to behaviour that challenges
- ensure there is clear rationale for the use of environmental restrictions
- relevant staff will receive training on this revised policy and related practice will be monitored.

1. The Registered Provider has already identified a requirement for further oversight and stewardship of the identification, promotion and upholding of service user and resident rights including restrictive practices. The Rights and Restraint Committee will be convened on 19th January 2018 and the Terms of Reference of this Committee will reflect this vision.

2. The PIC will identify and monitor to ensure that staff who have not received behavioural management training are supported to undertake this training.

3. The Registered Provider will ensure that the current PRN Protocol is reviewed and revised to address the issues raised during this inspection.

**Proposed Timescale:** Meeting on 19th January 2018

**Close out of related issues by 31st January 2018**

**Proposed Timescale:** 31/01/2018

**Theme:** Safe Services

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

It was not evident or documented that the least restrictive practice was employed as a response to the resident's behaviour that challenged.

**8. Action Required:**

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

1. PIC will :

- support and implement revised Restraint/Restrictive Procedures Policy
- monitor to ensure that every effort is made to identify and alleviate the cause of resident's behaviour so as to ensure all alternative measures are considered before restrictive procedure is used.

Proposed Timescale: Meeting on 19th January 2018

Close out of related issues by 31st January 2018

**Proposed Timescale:** 31/01/2018

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

As outlined in the body of the report, improvements were required to ensure that the centre's statement of purpose met all the regulatory requirements

**9. Action Required:**

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. Registered Provider and PIC will review the Statement of purpose to ensure that it meets all the regulatory requirements.

Proposed Timescale: Will be completed as soon as new Statement of Purpose Template is available. (20th December 2017)

**Proposed Timescale:** 20/12/2017

#### **Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The provider's unannounced visit report did not clearly outline the areas visited and additional details.

**10. Action Required:**

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

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

1. Going forward, the Registered Provider or nominee will ensure that all unannounced visits to the designated centre will clearly outline the houses visited and action required in the report

**Proposed Timescale:** 31/03/2018

#### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Some residents social care needs were not being met due to insufficient staffing levels in the centre.

**11. 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:**

1. Activity manager will continue to review the needs of the residents around social care needs and will provide the Registered Provider with an update on the results of the review to ensure that there is measurable and consistent improvement towards meeting

all residents' social needs.

2. In addition the PIC has oversight of the residents needs being met and provides a weekly report to management of social activity.

3. Any further requirement for an increase in staffing for social care needs will be addressed by the PIC in the Staffing Review with the Management Team.

**Proposed Timescale:** 31/03/2018

**Theme:** Responsive Workforce

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

Some whole time equivalent posts in the centre were currently been filled with relief staff.

**12. 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 ongoing monitoring of the centre is completed by the PIC at local level and staffing issues are reported to the Provider. Regular staffing reviews ensure the appropriate staffing levels for the centre. Relief staff are being reduced through regular recruitment for the campus. A review of the centres 3 weeks rotas from January 1st 2018 demonstrate that Peamount relief staff are only being used for leave cover with one external agency shift in place. Any relief or agency staff member working in the centre receives the appropriate training, induction and oversight to care for the residents needs.

**Proposed Timescale:** 31/03/2018