

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre B1
Centre ID:	OSV-0005389
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Lead inspector:	Helen Thompson
Support inspector(s):	Marie Byrne
Type of inspection	Unannounced
Number of residents on the date of inspection:	21
Number of vacancies on the date of inspection:	1

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 1 day(s).

The inspection took place over the following dates and times

From: 06 December 2017 09:10 To: 06 December 2017 21:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
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 this centre. It was the third inspection of this designated centre in a standalone capacity.

The inspection was conducted by two inspectors over one day. The required actions from the centre's previous registration inspection in July 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, health care assistants, household staff, the person in charge, a meaningful activities manager and maintenance supervisor.

The inspectors met with ten residents over the course of the inspection and garnered opinions on the care and supports provided from three of them. Overall, residents were observed to be contented, and they reported that they were happy living in the

centre. Of note, five residents were due to return to their recently refurbished bungalow on the evening of the inspection.

Additionally, in assessing the quality of care and support provided to residents, the inspectors spent some time observing staff engagement and interactions with residents. As part of the inspection process the inspectors spoke with the aforementioned staff and reviewed various sources of documentation which included the statement of purpose, some residents' files, centre data sets and a number of the centre's policy documents. The inspectors also completed a walk through of all the centre's premises, including the most recently refurbished bungalow which was in the final preparations for the residents' return that evening.

Description of the service

The service provider had produced a statement of purpose which outlined the service provided within this centre. The centre was situated within a large campus site which had a number of facilities, including a canteen and a day service facility.

The statement of purpose stated that the centre provided care and support to residents with a range of needs which included their intellectual disability, mental health and psychological issues, physical and sensory challenges and varying medical complications.

There was capacity for 22 residents but it was now home to 21 residents whose ages ranged from early sixties onwards. This included ten ladies and eleven gentlemen.

Overall judgment of our findings

Eleven outcomes were inspected against and overall the inspectors found that, though there was some improvement in the level of compliance with the regulations, progress was still required to ensure that each individual resident's optimal quality of life was comprehensively supported and achieved. Improvements were still required with some residents' social care, safeguarding and healthcare needs. Additionally, the standard of maintenance of the resident's personal documentation required attention.

Overall, the centre's governance and management systems required improvement, including their process for the performance management of their workforce and effective usage of their information sets.

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):

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

Findings:

In general, inspectors observed progress with regard to the ensuring of each resident's rights and dignity in this centre, however, further improvements were required with regard to some practices.

Inspectors observed that the resident's personal information was on display in some areas, this included being available on publicly displayed fire evacuation plans and on personalised placemats which were not appropriately stored between mealtimes.

Inspectors noted that since the previous inspection, the historic practice of a staff office being located within the resident's home was being incrementally addressed and alternative systems introduced in each location to accommodate the resident's file, medications and safeguarding of their finances.

Inspectors reviewed a sample of intimate care plans. The majority of intimate care plans reviewed outlined the resident's care and support needs.

During the inspection, staff were observed to engage with residents in a positive and respectful manner.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Overall, the inspectors observed that though there had been some progress made with the provision of the resident's social care needs, further improvements were required to ensure that the resident's wellbeing and welfare was maintained by a high standard of evidence-based care and support. Areas for improvement included the assessment process to underpin the resident's social care needs, the quality of goal planning, review and evaluation of the resident's plans, accessibility of the resident's plan and the provision of meaningful activities for some residents.

Members of the multidisciplinary team were noted to be involved in the resident's assessment and review process. Residents were found to be supported at times of change and transition.

From a review of some residents' files, the inspectors observed that a number of different assessment tools were completed to inform the development of each resident's plans. However, it was noted that further improvement was required with the quality of some resident's social care needs assessment process. The review and evaluation of some residents' plans required improvement to ensure that this process was regularly completed and brought about positive changes for the resident. Also, improvement was required in relation to the systematic review of a resident's healthcare plan.

The inspectors did acknowledge that some work had commenced in this area of need since the previous inspection and were informed at the opening meeting that it was on-going. This included auditing and individual support work with staff to develop their care planning skills. However, the quality of some observed plans still required improvement to ensure that they informed and guided staff member's care and support delivery to the resident.

Inspectors also noted that improvement was required with the provision of their plan in an accessible format to each resident.

With regard to the provision of meaningful activities for residents, inspectors observed

that the provider had undertaken some actions to address the previously identified deficits. This included the recent employing of a meaningful activities manager for the service, to assess and oversee the provision of a meaningful day for each resident, and in tandem to organise the required transport resources to facilitate the resident in accessing the community. At the opening meeting inspectors were informed that an activities co-ordinator was now also working three days a week within the centre and also a new driver post had recently been secured for the service.

Inspectors also noted that staff had recently been facilitated with education with regard to meaningful day provision with residents.

During the walk around of the centre, inspectors observed that a number of residents were out and about, either availing of their day service options, going for coffee/walks within the campus or gone out to do their personal shopping with staff. From a review of files it was noted that some residents had an interest checklist completed, and a hobbies and interest questionnaire in place which outlined activities they enjoyed. However, on reviewing their recorded meaningful activities they were not in line with the checklist or questionnaire. Additionally, it was noted that the quality of some residents' activities required improvement as there were limited and sometimes functional in nature. For example, over the course of a month, one resident had four community based activities, three walks on grounds and remaining activities were home based. Another resident had six walks on grounds, four community based activities, and the remaining activities were home based. The assessment process was still to be conducted for some residents.

Inspectors observed that residents were supported at times of change and transition, particularly when moving between areas within the centre. For example, review of a resident's file showed that their transition had involved multidisciplinary team meetings and incremental visits to their new home.

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, the inspectors found that the design and layout of the centre was suitable for its stated purpose, and met the individual and collective needs of the number of residents present on the day of inspection. However, some improvements were required with the maintenance and upkeep of some areas of the premises.

Inspectors completed a walk through of all the premises including the most recently refurbished bungalow which was in the final preparations for the residents' return that evening. Since the previous inspection in July 2017, three of the bungalows that comprised this centre had been incrementally renovated to ensure that they more effectively addressed each resident's individual and collective needs. Inspectors observed that these areas were homely and comfortable, with residents having been involved in the redecoration and personalisation of their bedrooms. Some further decoration and finishing touches were planned, for example, curtains to be hung in some rooms, storage issues to be finalised and new furniture to be purchased for a number of rooms.

In one bungalow, a small bedroom, in line with the provider's previous action plan response, had been decommissioned and the provider noted in feedback that no further admissions were planned for the centre.

However, some other areas of the centre were noted to require care and attention to ensure that the resident's environment was comfortable, for example:

- painting required in a number of areas
- cracked tile in a bathroom and
- some skirting boards and doors were scuffed.

Inspectors observed evidence of systems in situ to ensure that equipment utilised by the resident was reviewed and checked.

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 health and safety of residents, visitors and staff was promoted and protected. There were policies and procedures in place for risk management and emergency planning.

There was a comprehensive risk register in place in the centre which detailed risks

identified in the centre. It outlined the management of identified risks, and measures in place to control these risks. It included an action plan and additional control measures section which was completed when existing control measures were found to be insufficient to manage the risk. There was evidence of ongoing review of the risk register. These reviews were carried out by relevant members of the multidisciplinary team including, the person in charge, clinical nurse manager, household staff, maintenance staff, health and safety representative, staff nurses, clinical nurse specialist, and quality manager. Residents had individual risk assessments in place for identified risks such as choking, manual handling, fire evacuation, and slips trips and falls.

Inspectors reviewed documentation in relation to vehicles in the centre. There was adequate insurance in place, evidence of servicing of vehicles, NCT certificates, and Log books. Comprehensive fortnightly driver walkabouts were completed and records of these maintained in the centre.

There was a system in place for recording incidents. The inspectors reviewed a number of incident reports in the centre. The incidents correlated to risks identified on the risk register. However, there was a lack of clear and consistent follow up and learning for some incidents. For example, only two of 11 incidents reviewed were clearly documented as being appropriately closed off. During the opening meeting the provider had noted that this was an identified area for improvement.

There were satisfactory procedures in place for the prevention and control of infection. Cleaning schedules were in place, and overall the centre was found to be clean.

Works had just been completed in the centre in relation to fire containment. There was suitable fire equipment provided. Fire doors were fitted throughout the centre. There were adequate means of escape, and emergency lighting throughout the centre. There was a fire safety register in each house and apartment in the centre. It contained emergency contact information, and records of quarterly fire alarm servicing, and annual servicing records of fire safety equipment.

Staff had completed fire safety training and taken part in fire drills. Fire drills were completed in the centre at least six monthly by the health and safety coordinator. There were four drills completed in the centre over the last 12 months. The fire drill records detailed how the drill went, how long it took, instructions given to residents and staff, and recommendations for future evacuations. The centre completed checks on fire safety equipment and maintained records. There was evidence of follow up if faults were identified.

Residents had personal evacuation plans in place. These plans were individualised and adequately accounted for residents' mobility and cognitive understanding. They contained step by step procedures on how to support residents to safely evacuate in the event of a fire.

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:

Overall, the centre had measures in place to protect residents from being harmed or from suffering abuse with appropriate action taken in response to allegations, disclosures or suspected abuse. Residents' emotional and behavioural needs were recognised with a positive approach observed. However, improvements were required to ensure that staff were provided with all information and training to facilitate the optimal supporting of residents' positive behaviour support needs. Additionally, improvement was needed to ensure that residents' safeguarding needs were promoted and protected when a restrictive practice was utilised in response to their behaviour that challenged.

Since the previous inspection, the provider had undertaken a number of measures to address/support residents' safeguarding needs. These included a review of a resident's placement to achieve a more appropriate fit in keeping with their needs, an increase in staff available to support residents, and facilitation of safeguarding training for staff. Inspectors did note though, that some safeguarding plans had not been reviewed and updated to reflect all developments.

From observations, interviews with staff, and file reviews the inspectors observed that residents' emotional and behavioural needs were recognised and supported. Residents were supported by a number of clinicians which included their general practitioner, a clinical nurse specialist in behaviour, psychiatrist and input on a sessional basis from a psychologist.

However, inspectors observed that some residents' files and plans contained insufficient detail to inform and guide staff responses and practices when supporting their behavioural support requirements. This was particularly noted as a gap with some residents that had more complex needs.

Additionally, staff had not been facilitated with all required education and training to allow them to comprehensively support residents, for example, training in a positive behaviour support model, behavioural management, mental health conditions and restrictive practices. Inspectors noted that this was contrary to a related risk assessment

which identified staff knowledge and training as a control measure.

Inspectors observed that restrictive practices were utilised as a response to some residents' behaviour that challenged. This primarily included chemical restraint and an environmental restriction. However, there was a lack of due process mechanisms to safeguard residents' rights in this matter, for example:

- no protocol to systematically guide staff
- lack of a clear review process for the usage of the restriction, though a review requirement post usage of chemical restraint is cited on the resident's support plan
- no evidence of consent from the resident/their representative

The policies as required by regulation were available in the centre.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

In general, the inspectors found that the resident's day to day healthcare needs were met. However, improvement was required to ensure that all possible healthcare related needs were comprehensively assessed, supported and reviewed.

Residents had access to allied health professionals in line with their identified care needs as outlined in the statement of purpose in the centre. Residents had access to a medical practitioner of their choice who visited the campus three days a week.

An assessment of need had been completed for residents, and from this care plans were developed. However, there were deficiencies in documentation identified when reviewing personal plans and care plans. Review dates and evidence of implementation of care plans was not consistently documented. A comprehensive range of assessments were completed in line with residents' identified healthcare needs. However, these assessments were not consistently reviewed and updated in line with the statement of purpose of the centre.

There was evidence that where a resident refused treatment, that their choice was documented and brought to the attention of, and reviewed in recent months by their

medical practitioner. However, at the time of inspection, there was no single overarching protocol to clearly guide staff responses when the resident refused treatment. Refusal of treatment was not routinely documented in the resident's personal plan. There was no clear plan in place in relation to how often the resident's personal plan would be reviewed in relation to refusal of treatment and possible healthcare implications, or evidence of tracking/analysis of how often refusal occurred. Inspectors reviewed the resident's medicine administration records and over a one month period the resident refused to take their prescribed medicines on 20 days in that month.

Food in the centre was found by inspectors to be nutritious, appetizing, varied and available in sufficient quantities. Food was prepared in a central kitchen, and delivered to the centre. There were also cooking facilities in the centre if residents choose to cook or bake, or eat meals outside of the times that food was delivered. There was a supply of snacks and drinks available in the centre throughout the day.

Meal times in the centre were observed to be positive and social events. Residents were observed by inspectors to be supported to eat and drink in a sensitive and appropriate manner in line with the advice of dietitians and speech and language therapist.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Overall, inspectors found that residents were protected by the policies and procedures for medication management in the centre. There were written policies relating to ordering, prescribing, storing and administration of medicines to residents. Overall individual medication plans were reviewed and put in place as part of the residents' personal plans.

There were appropriate procedures in place for the handling and disposal of unused and out of date medicines. However, a facility was not in place to segregate out of date or medicines for return to the pharmacy, from other medicinal products.

There was a medication management folder in place in the centre which contained guidelines for nurses on medication management. Audits were completed in the centre

on oxygen cylinders, fridge temperatures for medicine fridges, and stock control of loose medicines. The inspector reviewed audits completed by the pharmacist in the centre. The audit examined ordering, prescriptions, storage and labeling of medicines, errors and near misses, and staff training in the centre. There were no issues identified by the pharmacist in the audits, and no errors or near misses were identified.

Judgment:

Substantially 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):

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

Findings:

The centre had a written statement of purpose in place. The statement of purpose outlined the aims, objectives and ethos of the centre. It also outlined the facilities and services provided for residents in the centre.

The statement of purpose was reviewed in line with the requirement of regulations. It contained the information required by Schedule 1 of the regulations.

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):

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

Findings:

Overall, the inspectors found that though there had been some improvements regarding the oversight and monitoring of the safety and quality of care provided to residents, further improvements were required to ensure that each resident was optimally supported. These included further developments of the centre's overarching managements' systems and the performance management of each staff member to ensure that they are accountable for their responsibility in the delivery of a safe and quality service.

Inspectors acknowledged that the provider had, since the previous inspection, taken some steps to address the identified regulatory non-compliances which included a bolstering of the centre's management structure, with the person in charge now working completely in a supernumerary capacity, and the recent commencement of an assistant director of quality for the service who was now providing additional support to the person in charge. The provider had also put other service wide meeting structures in situ to promote learning opportunities for the centre's management team. However, local centre management processes for the delivery of care and support to each resident required improvement.

There was evidence of self-monitoring systems being utilised through the six monthly provider visit (July 2017), a recently completed annual review and audits conducted on intimate care plans, resident's privacy and choice and medication management. Additionally, the person in charge completed daily environmental walkabouts which looked at a number of issues including rosters, staff training, premises, hygiene standards, personal plans, meaningful activities, food and nutrition and residents issues. Residents meetings were also facilitated in each area.

However, inspectors observed that there was a lack of utilisation of information garnered from these systems being analysed and effectively utilised to bring about improved outcomes in all aspects of the resident's daily life, as evidenced in the continued non-compliances found on this inspection.

Additionally, the inspectors noted that improvement was required with the supervision and performance management of staff to ensure that each member of the workforce was accountable for the care and support that they provided. A staff supervision system and template had recently been introduced but was not yet observed to be clearly underpinning staff member's daily work role and responsibilities. Also, the inspectors observed that staff meetings had not occurred in the centre in recent months, the last documented staff meeting took place on 31 August 2017. This was especially noted given the number of new staff that had recently joined the centre's workforce.

Inspectors noted that the person in charge had worked in the centre for a number of years, demonstrated good knowledge of the residents and was clearly identifiable to them. The person in charge was aware of their responsibilities and was continuing to maintain their professional development.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Overall, the inspectors found that there had been progress made with regard to the stabilisation of the centre's workforce which included the number of staff available in the centre, and additional skill mix with the introduction of a meaningful activities co-ordinator post. However, improvements were still required with regard to the provision of training that would facilitate staff to optimally support the resident's comprehensive needs. This was noted to be particularly relevant given the number of new staff that had recently joined the centre's workforce.

From reviewing staff training records it was evident that staff had completed the mandatory training courses. However, a number of staff required refresher training in fire equipment training, fire on line training, manual handling, behavioural management and hand hygiene. Also, not all staff in the centre had completed training in line with the assessed needs of the resident such as training in personal outcome measures (POMS), and risk assessment training.

The inspectors found staff to be aware of the policies and procedures related to the welfare and protection of residents. Staff described how to safely evacuate the centre in the event of an emergency, and described the procedures in place for safeguarding residents. Staff members were observed to interact with residents in a positive and respectful manner.

Planned and actual rosters were in place for the centre. On reviewing a number of rosters, overall there were sufficient numbers of staff on duty, however, there were a number of occasions when only one nurse was on duty in the centre. This situation was noted to be identified on the centre's risk register as if it occurred one nurse would be responsible for the administration of 21 residents medicines' needs. At the opening meeting, the provider also noted that ensuring nursing cover at times of sick leave was

a challenge.

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):

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

Findings:

Overall, the inspectors found that complete records were not consistently maintained in the centre. Not all records were kept up-to-date including daily narrative notes, personal plans, and care plans. Additionally, a resident's safeguarding plan lacked a date of creation and was not updated to reflect the current situation. Some assessment documents were also missing staff signatures and dates of creation.

In summary, across a number of outcomes, the inspectors observed that the quality of residents' documentation did not comprehensively underpin the delivery of their support needs, particularly during a period when a number of new staff had joined the centre's workforce

Records in the centre were kept secure and were easily retrievable. Records relating to inspections by other authorities such as fire and health and safety were maintained.

The centre has all the written operational policies as required by Schedule 5 of the Regulations. The safeguarding policy, and the medication policy had been reviewed since the last inspection.

The centre was adequately insured against accidents or injury to residents, staff and visitors.

Judgment:

Non Compliant - Moderate

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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:

Helen Thompson
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Peamount Healthcare
Centre ID:	OSV-0005389
Date of Inspection:	06 December 2017
Date of response:	29 January 2018

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

As outlined in the body of the report, some improvement was still required with regard to the ensuring of privacy around the resident's personal information.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

1. Residents personal information is no longer on display in public areas
2. Personalised placemats are stored away following each mealtime.

Proposed Timescale: 1. Complete, 2. Complete & Ongoing.

Proposed Timescale: 29/01/2018

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:

As outlined in the body of the report, improvement was required to ensure that some residents' assessment of need process was comprehensive, particularly with regard to their social care needs.

2. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

1. PIC will ensure that the Key Worker and Named Nurse will review and complete the assessment of Residents Social care needs and develop goals with the Resident.
2. The Meaningful Activities Manager and Activities staff will continue to support meeting the social care needs of the residents.

Proposed Timescale: 20/02/2018

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, further improvement was required with the provision of meaningful activities and implementation of personal goals for each resident.

3. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

1. PIC will ensure that the Key Worker and Named Nurse will review and complete the assessment of Residents Social care needs and develop goals with the Resident.
2. The goals will be linked from the assessment of need and regular interaction with residents to take account of their wishes.
3. The Meaningful Activities Manager and Activities staff will continue to support meeting the social care needs of the residents.

Proposed Timescale: 28/02/2018

Theme: Effective Services

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

Some resident's personal plans were not available to them in an accessible format.

4. 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:

1. The PIC will ensure that each resident's personal plan will be made available to them in an accessible format.

Proposed Timescale: 28/02/2018

Theme: Effective Services

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

The review and evaluation of the resident's personal plan was not conducted in a systematic manner that demonstrated improved outcomes for the resident.

5. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan 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. The PIC will ensure that there is a system put in place to review and evaluate the resident's personal plans. Any changes or new developments will be recorded.

Proposed Timescale: 28/02/2018

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, some areas of the premises required care and attention to ensure that the resident's environment was homely and comfortable.

6. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

1. The recently refurbished bungalows will be completed to ensure they are homely and comfortable.
2. New Seating has been ordered for some of the units that were identified on inspection.
3. Further upgrade works are being costed and funding will be sought from HSE.

Proposed Timescale: 1. February 28th 2018 and ongoing.

Proposed Timescale: 28/02/2018

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:

The centre's risk management system did not have a clear process in operation to ensure that there was learning and follow up from incidents that occurred.

7. 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. All risks on units are submitted by Risk Management Occurance Form to the Risk Manager where they are thoroughly reviewed and followed up on. Any follow up that takes place with the PIC is communicated back to all staff.
2. Risk Management issue a monthly report to each centre with summary information that is centre specific, trends identified and learning from incidents is communicated to staff at handover and at staff meetings.

Proposed Timescale: 1,2 Ongoing

Proposed Timescale: 26/01/2018

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:

Staff were not facilitated with comprehensive information and knowledge to optimally support and respond to some resident's behaviour support needs.

Gaps included:

- insufficient information in the resident's file to inform and guide staff responses
- further education in line with the resident's needs, for example, in positive behaviour support, mental health conditions, behavioural management and rights and restrictive practice.

8. Action Required:

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

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

1. All behaviour support plans are being comprehensively reviewed and updated with input from the MDT to ensure they guide practice.
2. Staff will be kept informed and involved in updating of Behaviour Support plans.
3. Positive Behaviour Support Plans will be agreed by the resident and or their representative.
4. All staff will complete PMAV training which is ongoing on the campus.
5. Staff will be provided with Training on Mental Health conditions.
6. Protocols are now in place for Chemical restraint to guide staff on when to administer PRN medication.
7. Individual PRN usage records are now in place to monitor the ongoing administration of Chemical restraint.
8. The usage of PRN Medications will now be reviewed monthly by the attending GP.
9. All safeguarding plans in the centre will to be reviewed and updated at the MDT for each resident.

Proposed Timescale: 1. 2. 3 28th February 2018 4. 16th February 2018. 5. March 31st 2018. 6. Complete 6. 7. Complete, 8. Ongoing, 9. February 28th 2018.

Proposed Timescale: 31/03/2018

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, improvements were required to ensure that the least restrictive practice was consistently implemented in response to a resident's behaviour that challenged.

9. 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. In order to ensure that the least restrictive practice is being used the behaviour support plans are being updated in conjunction with the key workers/MDT to ensure alternatives are considered.
2. Restrictive Practice will only be used as a last resort.
3. Rights and Restrictive Practice committee has been established to review all restrictive practices in the centre.

Proposed Timescale: 28/02/2018

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There were gap in supporting documentation in relation to the assessment, implementation and evaluation of some resident's healthcare needs.

10. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

1. The PIC will review the care plans to ensure there is a comprehensive assessment implementation and evaluation of the residents healthcare needs.
2. PIC will discuss the personal plan with individual key worker/nurse and at weekly staff meetings.
3. The refusal of Medication Protocol for one Resident has been completed and does now include how often the recording chart is to be reviewed by the GP. The Protocol has been discussed with the resident in order to gain his consent.

Proposed Timescale: 1. 28th February, 2. Ongoing 3. Completed.

Proposed Timescale: 28/02/2018

Outcome 12. Medication Management

Theme: Health and Development

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

There was no facility in place to segregate out of date or medicines for return to pharmacy, from other medicinal products in the centre.

11. Action Required:

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

1. A system will be put in place to segregate out of date medicines and medicines for return to pharmacy.

Proposed Timescale: 31/01/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

As cited in the body of the report, further improvement was required with the centre's management systems to ensure that each resident was in receipt of a safe and quality service.

12. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

1. The PIC will ensure that information gathered from current systems in place will be utilised to bring about improved outcomes for residents.
2. The PIC will hold Staff meetings monthly in the centre.

Proposed Timescale: 1.2., Ongoing

Proposed Timescale: 26/01/2018

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, improvement was required with the supervision and performance management of staff.

13. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

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

1. Through the process of Supervision by the PIC all staff will be made aware of their responsibilities and a Personal Development Plan will be developed where necessary.
2. The PIC will attend regular supervision sessions with his line manager.

Proposed Timescale: 1.2., Ongoing

Proposed Timescale: 26/01/2018

Outcome 17: Workforce

Theme: Responsive Workforce

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

A number of staff required refresher training in mandatory training courses, and some staff required access to education and training to meet the assessed needs of residents as outlined in the body of the report.

14. 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:

1. All staff are 100% compliant for Mandatory Training and this will be monitored by the PIC and discussed at staff meetings.
2. All staff will have completed their Risk Assessment Training by 20th February.

Proposed Timescale: 1. Completed and Ongoing, 2. February 20th 2018.

Proposed Timescale: 20/02/2018

Outcome 18: Records and documentation

Theme: Use of Information

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

As outlined in the body of the report, information in some residents' personal documentation was not consistently maintained in a comprehensive and accurate manner.

15. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

1. The PIC will ensure through the regular monitoring of the centre that all care plan documentation is consistently maintained.
2. This will be covered at all staff meetings and in supervision meetings where required.
3. The Quality Manager will do regular audit of care plans and report non compliances to the PIC and Provider.

Proposed Timescale: 1. 2. 3., Ongoing

Proposed Timescale: 26/01/2018