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A designated centre for people with disabilities operated by Health Service Executive, Tipperary

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002442
Centre county:	Tipperary
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Carol Moore
Lead inspector:	Noelene Dowling
Support inspector(s):	Caroline Connelly;
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 September 2015 10:00	08 September 2015 20:00
09 September 2015 08:00	09 September 2015 15:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 06: Safe and suitable premises
Outcome 10. General Welfare and Development
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This follow up inspection was undertaken to ascertain the progress the provider had made in order to address the actions identified at the registration inspection which took place on 28 April 2015.

Inspectors observed practices and reviewed the documentation such as personal plans, medical records, accident logs, policies and procedures and staff files.

The provider had responded to that action plan in a timely and comprehensive manner. An update on the plan had been requested by the inspector and this was also provided in a timely manner in 27 July 2015.

Inspectors were satisfied that the provider had demonstrated a commitment to address the substantive issues and had made significant progress in doing so. At the registration inspection, 35 actions were identified with six areas of major non compliance found. At this inspection there were no major non compliances found . Twenty two of the required actions were satisfactorily resolved with 11 actions partially resolved. The actions not resolved were staff training and recruitment processes and further recruitment was also required to ensure staffing levels were

adequate.

The provider had made significant progress in safeguarding systems, the protection of residents from abuse by peers, access to psychological interventions assessment and interventions, the management of behaviour and restrictive practices, promotion of residents rights, social care needs and multidisciplinary reviews of residents personal care plans.

Good practice was evident in residents access to health care services and medication management. Governance structures had been revised and there was adequate overview of the delivery of care. Some of these changes were interim measures while a recruitment process was undertaken. The provider was in the process of recruiting an assistant director of nursing who would act in the absence of the person in charge.

The location, numbers of staff and management support for the most outlying house had been addressed in the interim with additional staff and management availability. Alternative accommodation nearer to the main premises had been sought but found unsuitable. Further plans for this house were to be addressed following a full review of the residents care needs by the contracted psychology service. Inspectors were satisfied with the current arrangements and the risks identified had been satisfactorily addressed in the interim.

Some areas of improvement were still required in:

- risk management strategies
- recruitment procedures
- staff training in safeguarding and manual handling
- system to consistently monitor the quality and safety of care
- provision of an annual report
- adequate day care services
- development of policies

The actions required to achieve compliance with the Health Act (Care and Support of Residents in Designated Centres (Children and Adults) With Disabilities Regulations 2013 are outlined at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors were satisfied that systems to promote resident rights had been implemented since the previous inspection. There were five specific actions required in this outcome and the provider had made significant progress in addressing the issues satisfactorily. On an individual basis staff supported residents with as much choice and control as possible by facilitating residents individual preferences for example in relation to their daily routine, meals and recreation..

Advocacy services had been sourced for a number of residents and social work support was also made available.

Residents meetings continued in each of the houses and again these were documented in written and pictorial format. On this inspection there was evidence that the views of residents were heard and acted upon by staff following these meetings.

Where residents were unable to verbalise their own views there was evidence that staff acted as advocates on their behalf. For example, staff reside issues in relation to any deficits in the premises which impacted on the residents mobility or access.

Systems for the management of complaints had also been resolved and the availability of manager in each of the houses ensured that concerns will be acted upon. Inspectors were informed that no complaints had been made.

There was evidence that residents and their relatives were now involved in their personal planning and review meetings and again the content of the plans clearly demonstrated that staff had a very good knowledge of the resident's needs and

preferences. The plans had been developed in a format which could be understood by the residents and "social stories" which were person centred had commenced for a number of residents.

There was evidence that staff maintained resident's dignity and privacy when carrying out personal care with doors closed and there was no sharing of shower or bathroom facilities. As required, suitable locking mechanisms had been placed on the bathroom doors to ensure residents privacy and dignity since the previous inspection.

In the centre where a female resident was accommodated with three males issues of privacy and dignity were now addressed in her personal and safeguarding plans as required by the previous inspection. This entire unit and the suitability of residents to be accommodated together is currently under review by psychology services. Gender issues were respected in the provision of such care.

From a review of the policy and the CCTV system in use inspectors remained satisfied that the current arrangements were satisfactory, necessary and the least intrusive on the residents privacy. From a review of the management of resident monies inspectors were satisfied that the systems were transparent and monitoring systems were undertaken to safeguard this.

There were detailed records of all residents personal possessions compiled.

There was evidence that more regular access to meaningful activities and day care had improved. This was primarily due to the additional one to one supports made available for a number of residents which ensured that normal routines for other residents were not consistently disrupted or deferred. However, access to day services is discussed further under outcome 19 General Welfare and Development.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

Inspectors viewed the new contracts and found them to be in compliance with the Regulations. Nine of the residents had signed contracts in place at this inspection. The

remainder had been issued and were awaiting return by their representatives. No new admissions had taken place for some years. There were documentary systems in place to ensure that if residents required admission or transfer to other services detailed information was available.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

On the previous inspection the premises had been deemed fit for purpose with improvements required in timely and responsive maintenance, the provision of suitable assistive rails in corridors and bathrooms and general decor in one of the houses.

Inspectors saw that all of the actions required from the previous inspection with one exception, had been addressed promptly. The grab rails had been installed in the resident's toilets, door handles replaced and although the grab rails in the corridors have not been installed the physiotherapy review had taken place and the rails had been ordered.

In addition, the environment in one of the houses had been improved by the addition of secure pictures and resident's photographs in the hallways. A mural was planned for one of the bedrooms to improve the environment for the resident. It was planned to do this in conjunction and consultation with the resident.

Staff and management advised inspectors that there were better arrangements in place to address maintenance requests. Staff carried out regular checks of the premises and logged all maintenance requests in a log. These were then submitted to the technical services department.

Cleaning staff had been available over the summer period and schedules drawn up. They were not available at the time of the inspection but inspectors were informed that a panel would be created with the local HSE services and household staff for the individual houses would be available once this was established. Inspectors observed that the premises were very clean and overall well maintained on this inspection.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

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

Findings:

There was one action identified following the previous inspection in relation to this outcome. Access to meaningful activities and occupation for residents had been severely impacted upon by staffing levels, behaviours and changes made in recent years to the day service. Improvements were found at this inspection but some were still required to ensure appropriate services were available to all residents. The changes were influenced by the provision of one-to-one staff for some residents and behaviour support plans being implemented.

Individual activities took place in house or externally and these included baking, board games, horse riding and life skill training and residents went shopping and to local amenities. One resident worked in a local store part time and another in the campus laundry. A number attended specific day care workshops external to the service and received payment for this. One resident took responsibility for cleaning areas of the unit and others went for the weekly shopping which they told inspectors they enjoyed doing. Life skill development was evident including support with personal care and road safety.

The internal day service staff had been reduced to one person in recent years. This resulted in a drop in the number of days and type of activities available to the residents. Staff from the houses still accompanied residents and remained in the day service with residents who attended.

On this inspection there was no direct evidence that this staffing arrangement impacted negatively on the remaining residents. However the ability to provide meaningful and varied activities was limited due to the restrictions of the day service staffing and this required significant day to day organisation of staffing in the houses.

Inspectors were informed that a system of assessment which will include the psychology service, audits of current activation, staffing levels and skill mix necessary will be used

to plan ongoing day services and access staffing for this purpose. The arrangements were found to be more structured however and with less disruption evident.

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):

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

Findings:

There were five specific actions required from the previous inspection to ensure that residents needs were identified, assessed and being attended to appropriately. From a review of nine residents medical records and personal plans, inspectors found that the provider had taken significant steps to address the issues and meet the needs of the residents. There was good access to allied health services including speech and language, dieticians, physiotherapy, dentistry and optician services were evident. There was also on this occasion good and effective access to clinical psychological support for the residents. The interventions were documented in the resident's plans.

There were evidenced based assessment tools used for falls, pressure areas and nutrition and communication. The assessment tools were regularly updated by staff. Residents personal goals, social preferences, communication needs were also documented in the care plans. The personal plans seen were very detailed and covered a range of health care, social care and behavioural needs.

The documentation however was duplicated and cumbersome and not suitable as working tools for staff.

The provider and person in charge were aware of this and stated that they were in the process of reviewing the documents to make them more easily accessible

There was evidence from records and confirmed by residents and staff that the social care needs of residents were acknowledged in planning and being met to a significant degree on this occasion. There was also a more robust system for assessing the

outcomes of the personal plans evident.

This was due primarily to the provision of additional staff support for some residents and therefore increased access to social activities for other residents was made possible. Residents had holidays away and overnight stays in hotels, attended music events and had planned and individualised activities during the day. These were based on the content of their personal plans.

On this inspection the resident's personal plans showed evidence of assessment and interventions for residents psychological well being and care by clinical behaviour psychology specialist. The process initiated by the provider was comprehensive and multifaceted. It included direct training and guidance for staff in understanding the underlying issues for the individual residents and specific intervention planning.

The impact of this could be seen on the incremental decrease in incidents and restrictive practices and access for some of these residents to increased activities and the external environment. Inspectors found that staff were very motivated to support this change process in the residents best interested.

This process was ongoing for a number of residents and the provider informed inspectors that this would continue .The provider had also initiated a specific recruitment process to procure this service internally in order to ensure this support was readily available. The process was also examining the suitability of placements, the care model and the suitability of residents to reside together.

There had been 11 out of twelve multidisciplinary reviews of resident's personal plans undertaken since the previous inspection. The records of these demonstrated that the residents or representative was involved, the current health, social and mental health needs of the residents was reviewed and the interventions of the allied professionals were included in the reviews. Ongoing plans were made following these reviews.

As result of these changes inspectors were satisfied that the provider was making sufficient arrangements to ensure that the needs of the residents could be met.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

There were five actions identified by the previous inspection in relation to the management of risk and fire safety. Three of these actions had been satisfactorily resolved with two partially resolved. Records demonstrated that all staff had updated fire safety training since the inspection. The inspectors found that fire doors were not wedged open as on the previous inspection and there were signs in all areas to remind staff of this.

Staff did however point out and inspectors observed that in one house it was very difficult for the residents to access the kitchen themselves due to the weight of the fire door. Staff themselves had suggested the mag-locks be placed on these doors.

Good practice continued in the servicing of fire safety equipment, regular fire drills which residents participated in and detailed pertinent personal evacuation places for each resident. A fire safety review of the premises had been undertaken 2104 by the HSE and a draft report was available. This was primarily concerned with improvements as opposed to necessary fire safety systems.

The unsuitable chair had been removed from the bathroom and inspectors found that general infection control practices were good and adhered to by staff. Where a specific health care infection risk was identified inspectors saw that advice and guidance was sought promptly and the appropriate actions were taken

The combined risk management and health and safety documentation seen by the inspectors contained details of all of the issues required by the regulations. The risk register contained pertinent organisational risks including the deficits in staff and the lack of on-going psychology support for the residents. There were actions taken and further strategies planned to address these deficits.

From a review of the accident and incident records and the monthly audit of incidents undertaken inspectors were satisfied that systems were being developed in a more cohesive manner to identify risks, put control systems in place and to learn from events which occurred. All incidents were reviewed by the local management team which included the clinical nurse specialist.

There had been a significant reduction in the number of incidents which had taken place. Remedial actions were identified including changes to resident's routines and the development of pictorial schedules for the residents to avoid unnecessary incidents. However, some incidents were not reviewed promptly due to the lack of information in the incident reports and the availability of staff that were present at the time of the incident.

This process required review as it resulted in unnecessary delays in reviewing incidents, taking remedial actions as well as learning from accidents and incidents. It was also noted that some environmental issue identified following incidents not been actioned. This included the need for a quick closing system for one door. There were no medication errors found on this inspection and where peer to peer incidents took place these were now found to be promptly investigated.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

There were six actions required following the previous inspection. The provider had made significant progress in addressing the actions with the exception of the provision of training for staff in the revised policy on the protection of vulnerable adults. The person in charge was the designated officer. However, training had not been provided to her on the implementation of this policy and her function as the designated officer. Inspectors were informed that this was scheduled for May 2015. However this had not taken place at the follow up inspection .

On the previous inspection training records demonstrated that only 11 staff had undergone training in the protection of vulnerable adults since 2012. Training for all staff in the new policy was required; the provider said it was very difficult to access places for this training currently due to the significant demand. The inspectors informed her that safeguarding training was required as a matter of urgency for all staff. This is actioned under Outcome 17 Workforce.

The systems in place to protect residents from physical abuse by their peers had been significantly improved. Staff demonstrated a heightened awareness of peer to peer abuse and systems had been implemented to protect residents.

The number of incidents had significantly reduced and comprehensive, effective safeguarding plans were seen in resident's personal plans. These were specific in some instances. For example, close supervision was detailed as "within arms length in one plan" and staff understood this and adhered to it. There was also evidence that families were informed of any such incidents and this was detailed in safeguarding plans. On this inspection it was also noted that the person in charge had adhered to her responsibility

to notify the Authority of any incidents and had also forwarded historical notifications of such events since 3013.

As required from the previous inspection the policy on the management of behaviours that challenge had been devised and implemented. The policy was in accordance with national policy and defined the need to examine the meaning behind such behaviours and intervene in the least restrictive but most supportive manner.

Practices in the management of behaviours that challenging and restrictive practices had been altered and this was supported by clinical assessment, planned interventions and clear rationales for restrictive practices. The provision of one-to-one staff support for a number of residents had also impacted positively on this outcome.

There was evidence of multidisciplinary review and ongoing clinical support both for the residents and for staff in supporting the residents.

Since the last inspection a psychologist had been contracted to provide psychological assessments and detailed behaviour management plans which were seen to be in place. Staff reported that the psychologist was available to provide support and advice to staff and they were implementing the behavioural plans as prescribed.

Staff demonstrated competence, calmness, knowledge of the presenting behaviours and the meaning behind them for the residents.

From a review of the use of PRN medication for the management of behaviours inspectors were satisfied that this was not a feature of the behavioural supports being used.

While the restrictive practices remained in place there was evidence that these were reducing in length, and the resident was being supported to recognise triggers and manage their own behaviours in a more constructive way. This was seen to result in a better quality of life for the residents. For example, trips to the swimming pool and other constructive outings had recommenced for a resident who had not had access to these for some time. One-to-one support had reduces the numbers of incidents.

A protocol for the use of all restrictive practices had been introduced and was being monitored by the senior managers and behaviour specialist nurse.

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):

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

Findings:

The two actions required from the previous inspection in relation to this outcome were satisfactorily resolved. The end of life policy had been developed and implemented. Staff informed inspectors that it was their hope in the event of a resident requiring such care that they would be able to facilitate this in the resident's home and nursing care was available in this event. The policy was satisfactory.

There was evidence of discussion with clinicians and relatives in relation to resuscitation and recording of the decisions regarding this.

Records of the evening meal were also maintained as required to ensure there was variety for the residents.

Inspectors were satisfied that resident's diverse healthcare needs were met but there were areas for improvement required in the documentation and records in relation to this. There was very good access to general practitioners (GP) services both in the centre and in the GPs surgery. However the records in relation to this were not available in a discreet format. For example, some were documented in progress notes. This did not support ease of access, retrieval or accuracy of current information.

Inspectors were satisfied however, from a review of a range of other documentation and speaking with staff that the health care needs of the residents were assessed and met promptly. Staff also completed a comprehensive document entitled "OK health check" but this was not consistently signed by the GP as evidence of review.

These deficits are actioned under outcome 18 Records and Documentation.

A range of allied health services were available including occupational therapy, speech and language therapy and dentistry and opticians and on this occasion psychology and psychiatric services. The interventions identified by the clinicians were detailed in the care plans and staff was seen to be knowledgeable in relation to them. The inspectors noted that the daily records maintained by staff were very detailed and indicated that staff were observant and responded quickly to any changes in resident's health.

Inspectors' also found that where residents health care needs had deteriorated and become more complex there were additional and pertinent care plans and interventions implemented. Fluids and food intake was monitored and all specialised equipment necessary was made available. Effective strategies for pressure area prevention were implemented. There were specific protocols' for the management of emergency medication and epilepsy which the staff were familiar with.

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:

There were six actions required from the previous inspection in relation to this outcome. The provider had made satisfactory progress on all actions to ensure the safe delivery and monitoring of care with some improvements required in the completion of the annual report and auditing of practices.

While an annual report had not as yet been compiled a six monthly report on the safety of care was available. An external consultant had scheduled a date to undertake the second evaluation on behalf of the provider. The service was also audited by the HSE as part of the initiative to support care improvements. The provider had undertaken an unannounced visit to the centre and met with residents. A template had been devised for these visits to ensure they were as effective as possible.

The person in charge was on statutory extended leave at the time of this inspection. The clinical nurse manager 11 was acting in the absence of the person in charge as an interim arrangement and was suitably qualified and experienced to do. He demonstrated good knowledge of his regulatory responsibilities. Inspectors were informed that a full time assistant director of nursing was due to take up post on the 23 September. This person would then be the nominated person in charge for the duration of the leave.

The arrangement by which the person in charge was responsible as the person in charge for two other centres had ceased as the findings of the previous inspection had demonstrated that this was not a sustainable or suitable arrangement.

Arrangements for communication and reporting had as required been improved with regular formal meetings taking place between the provider and the person in charge. The systems were seen to be effective with detailed action plans made and monitored to address all of the issues identified in the previous report along with current issues.

The most significant change was the allocation of a CNM 11 to each of the individual units with responsibilities and revised hours of work for the CNMs so that there was direct out of hours support to the units and support over the week.

This ensured that each unit had a manager with responsibility for direct overseeing and direction of care. It also ensured that the outlying unit had the regular presence of a senior manager to oversee care practice and support staff. Staff informed inspectors that this had made a significant difference to their support and access to management. While the CNM 11 was not always available at weekends a CNM 1 on duty in one house was designated as the nurse in charge. Inspectors did not find that this had a negative impact but did request that the provider keep this under review in the context of this high support service

The staff supervision system had commenced and a detailed format had been devised. Training had been provided for some of the managers in implementing this. There was evidence that the presence of these senior staff nurses was in itself an additional supervisory tool. There was also evidence that where the need arose such as staff not adhering to residents specific safety plans this was dealt with effectively by the senior managers.

Some improvements were required in the development of an auditing system such as medication and the sourcing the views of resident and relatives to inform the annual review of care practice.

Resourcing of the service in terms of staffing remains an issue with a considerable number of agency staff being used over the summer months as between 150 and 250 agency hours were utilised. Rosters also showed that the CNM11 had to undertake regular duty hours in the absence of staff. This is actioned under outcome 17 Workforce.

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:

There were three actions required following the previous inspection. Inspectors reviewed a sample of staff files and found again that they were not in full compliance with Schedule 2 of the Regulations. For example, some files did not contain up-to-date relevant current registration with a professional body; one file had an incomplete employment history; one file had no vetting disclosure despite being employed for a considerable number of years.

Where agency staff were used there was an arrangement between the person in charge and the agency to ensure all of the required documents were available. A core group of agency staff had been nominated to support better continuity of care.

The previous inspection found that there was a failure to ensure staff had access to appropriate training, including refresher training, as part of a continuous professional development program. Inspectors found that this had not been adequately addressed with the exception of fire safety training.

Training in the management of aggression and violence was scheduled to take place for newly appointed staff.

Mandatory training for staff in manual handling remained out of date for 14 of the staff. Ten staff were identified on the training matrix on this inspection as not having completed training in the detection and prevention of abuse. However, the training rating records were poorly managed and not conducive to either auditing or monitoring by the person in charge.

Training in the management of aggression and violence was scheduled to take place for newly appointed staff. Mandatory training for staff in manual handling remained out of date for 14 of the staff. Other training provided to staff included the management of sharps, CPR, hand hygiene and chemicals. Specific training was being provided to staff in relation to the management of individual resident's psychosocial well-being and behavioural support and this was seen to have a beneficial impact.

The deficit identified at the previous inspection in relation to the staffing levels with particular reference to the outlying house had been much improved by the allocation of one to support for a resident. However some deficits still remained with agency staff being used regularly, senior managers having to undertake nursing duties on the rosters and the availability of nursing staff to the outlying house on some occasions. This meant that on occasion a nurse had to travel the 12-14 miles to this house to administer the medication. The provider was aware of this and informed inspectors that staffing levels would be formalised on completion of the clinical psychologists assessments in relation to the unit and the mix of residents within it.

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:

The inspector found that records in relation to residents required some improvements in order to ensure completeness, ease of retrieval and access. This included discrete documentation of GP visits and outcomes.

IRecords pertaining to staff were also not complete.

Judgment:

Non Compliant - Moderate

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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Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002442
Date of Inspection:	08 and 09 September 2015
Date of response:	08 October 2015

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 10. General Welfare and Development

Theme: Health and Development

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

The ability to provide meaningful and varied activities consistently was limited due to the restrictions of the day service staffing.

1. Action Required:

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

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

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

Currently the Clinical Nurse Specialist (behaviour support) is working actively with residents, key workers, the psychologist and the day service manager to thoroughly review people's lives which will include day service activities. Three individuals have had full reviews. Plans are in place to commence this process in a second residence (4 individuals) in November This process is planned to continue until all residents have been reviewed.

Proposed Timescale: 08/10/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The process for reviewing and responding to and learning from untoward events required review as there were unnecessary delays in reviewing incidents and therefore taking remedial actions.

2. Action Required:

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

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

The current, incident processing procedure, has been reviewed.

As incidences occur staff will contact the nurse-on-call to carry out investigation of the incident immediately. This procedure has been implemented from 08/10/15.

Incidents will be reviewed monthly at manager's team meetings and learning will be shared with front line staff at house team meetings.

The new procedure minimise unnecessary delays in the review and learning from incidents.

Proposed Timescale: 08/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

Some improvements were required in the development of an auditing system such as

medication and the sourcing the views of resident and relatives to inform the annual review of care practice.

3. Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

1. A Medication Systems Audit tool has been designed and is being implemented currently throughout the designated centre.

2. The gathering of views of residents and their families into the planning of service provision has already commenced and their views will be included in the annual report. The annual report is scheduled to be completed on the 15th October and will be available to all stakeholders approximately two weeks later.

Proposed Timescale: 29/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The numbers and skill mix of staff were not consistently satisfactory to ensure the safe delivery of care and residents access to consistent and suitable day care services.

4. 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. The replacement of permanent employees by agency staff on a like for like basis continues to be a priority for management when necessary to use agency staff. The agency staff provider is aware of this priority.

2. Recruitment to fill vacancies is ongoing as panel's have been set up.

3. As above - Currently the Clinical Nurse Specialist (behaviour support) is working actively with residents, key worker's, the psychologist and the day service manager to thoroughly review people's lives which will include day service activities. Three individuals have had full reviews. Plans are in place to commence this process in a second residence (4 individuals) in November This process is planned to continue until all resident's have been reviewed. Skill mix of staff will be reviewed in line with the outcome of reviews.

Proposed Timescale: 08/10/2015

Theme: Responsive Workforce

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

Staff did have access to mandatory training including manual handling and the protection of vulnerable adults.

5. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

All staff in the designated centre (except those who are currently on long term sick leave or maternity leave) will have;

1. Trust in Care completed by 13/10/15.
2. Manual Handling training will be completed by 22/10/15.

Proposed Timescale: 22/10/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

The records required in relation staff were not available.

6. Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:

All records are been complied in compliance with Schedule 2 and will be available in the actual designated centre. Any omissions in staff records relating to schedule 2 to be rectified.

Proposed Timescale: 31/10/2015

Theme: Use of Information

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

The records in relation to residents access to health care were not complete and easily retrievable.

7. 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:

A new template is to be designed as a discrete and separate record, which will be held in the Residents file. This will be completed by G.P's and any other Health Care Professionals involved in the persons health care support.

Proposed Timescale: 30/11/2015