Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Damien House Services
Name of provider:	Health Service Executive
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	28 November 2018 and 04 December 2018
Centre ID:	OSV-0002442
Fieldwork ID:	MON-0021698

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Damien House provides full-time long term care to twelve residents, male and female over 18 years old. Care is provided to residents who have a primary diagnosis of intellectual disability. The centre comprises three houses and an apartment. One of the houses is a community based residence, and the other two houses and the apartment are campus based.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
28 November 2018	09:30hrs to 18:30hrs	Julie Pryce	Lead
04 December 2018	09:00hrs to 17:30hrs	Julie Pryce	Lead
28 November 2018	09:30hrs to 18:30hrs	Tanya Brady	Support
04 December 2018	09:00hrs to 17:30hrs	Tanya Brady	Support

Views of people who use the service

The inspectors met six residents, and spent time with some and respected the preferences of others to maintain their private space. Residents who spoke to the inspectors were keen to express their dissatisfaction with the lack of transport to facilitate preferred activities.

Residents were observed to be welcomed home from day activities by staff, and were familiar with their surroundings. However many of them were not involved in daily evening activities such as meal preparation. Some residents were observe to be watching television, and some were unoccupied. There was no other information available relating to the views of residents, other than staff views on residents' preferences or opinions.

Capacity and capability

This service was not well governed and managed and there was a negative impact on the quality and safety of care delivered to the residents as a result. There was insufficient evidence of clear oversight of the service, or of monitoring of the quality and safety of care and support provided to residents of the centre. This resulted in non-compliances remaining unresolved, in the quality of life for residents deteriorating over time and a lack of any quality improvement.

Arrangements for oversight of the service by management were not adequate. The designated centre comprised one house in the community and two houses and one apartment in a campus setting. There was a clinical nurse manager in each of the houses. The person in charge was one of these clinical nurse managers, and while they were a regular presence in the one house they had responsibility for, there was little evidence of oversight of the other houses. For example a record of visits to the house in the community showed that visits were irregular, and at the most once a fortnight. The purpose of these visits was usually to get an update from staff. Staff incorrectly identified the clinical nurse manager of the house they worked in as being in charge, not the Person in Charge of the centre,

The provider's system for assuring a management presence in the centre was not effective. It was reported to inspectors that the two Clinical Nurse Managers worked opposite each other so that one of them was on duty each week day. However there was no manager rostered on in that capacity on the first day of the inspection, and nursing cover in the houses was provided by agency nurses. A review of the rosters

indicated that there had been one day each week of the previous month where both managers were off duty together rather than covering each day. The Clinical Nurse Manager 1 covered alternate weekends. Therefore there were three days one week and one day the alternate week where there was no management presence in the centre.

There was not an adequate system for review of the quality and safety of care and support offered to residents. There was no evidence of monitoring of services in the form of audits. An audit of medication management presented to the inspectors was a stock count, and an audit of incidents was a frequency count. Neither process involved a review of practices or processes, an analysis of data, or the development of any action plan. There were no other audits, so the provider was not demonstrating the capacity to self identify and address issues..

There were occasional 'walk arounds' conducted by the person in charge, There was little structure to the documents resulting from these occasions, no consistency in areas of focus and documented actions were vague, for example 'to be reported to line manager'. There were no defined actions or identified person responsible for actions.

The requirement of the regulations for a six monthly unannounced visit on behalf of the provider had not been implemented appropriately. The registered provider representative had conducted a visit to the centre in May 2018, called a 'walk around' although it was not clear that this visit was unannounced. Documents presented as the required six monthly unannounced visits had been conducted by one of the clinical nurse managers of the centre, and so did not demonstrate oversight on behalf of the provider.

An Annual Review of the service was available. The document was not dated but inspectors were informed that it had been completed in December 2017. Not all the information in the document was accurate, for example it stated that there were accessible versions of personal plans, however this was not the case. It was also stated that residents' files and information were stored securely, but in one of the houses records were seen on open shelves in the hallway, and in another in open boxes in an unlocked office. While the document identified required actions, several of those reviewed by the inspector had not been completed during the intervening year. For example, required procedures had not been developed, and a recommended group in relation to documentation had not been set up. A review of day service opportunities was to have been undertaken by March 2018, but this had not taken place, and a complaints log, while it had been developed, was not in use.

There was insufficient evidence of oversight of any required actions or tasks. Required tasks were entered into the diary of the house but there was no evidence of any follow up to ensure completion. Staff reported requests were made for some of the maintenance issues, but there was no evidence that these were followed up. Clinical nurse managers reported that they had little input into the completion of any required maintenance jobs, other than submitting these maintenance requests. There was no evidence of any monitoring of these requests. As a result the premises

were poorly maintained, and basic upkeeping tasks were not completed.

Inspectors were concerned about the apparent lack of oversight in these areas, and also in the management of risk. Suggested control measures in some of the risk assessments reviewed by the inspectors had not been implemented, and there was no monitoring of these actions, and therefore no response to the lack of implementation. Additionally there was lack of oversight of restrictive interventions, as there was no log kept of all the interventions. This did not demonstrate that the provider was ensuring the least restrictive interventions were in use for the shortest time required to mitigate any associated risk.

Inspectors were informed that there was a series of meetings at various levels. However minutes or records of meetings were not available to staff on either day of the inspection. Staff engaged by the inspectors were unable to locate the minutes of staff meetings, and were unaware of any required actions following meetings. Some staff said they had not been involved in a staff meeting for a significant time.

Minutes of meetings were submitted by email following the inspection, including house team meetings. The last meeting for one of the houses was April 2018. Some of the issues raised had been reviewed by inspectors, and had still not been addressed, including maintenance issues and residents' request for television services. Only one meeting had been held in another house, in September 2018, and again a series of issues had not been addressed. Quarterly meetings had been held in the third house, but again issues raised as far back as March 2018 had not been addressed.

Minutes for Local Managers meetings for June and July 2018 were submitted. Again, actions had not been implemented. For example it was agreed in June that future meetings would begin with a review of any incidents. This was not implemented or discussed again at the July meeting. There was no evidence of any further meeting this year.

The provider had not ensured that staffing arrangements were adequate and effective. There were adequate numbers and skill mix of staff available to meet the needs of residents for the most part. An actual and a planned roster were maintained, although staff surnames were not included. Rosters were only disseminated on the Friday of the week prior to the duty schedule, and staff could not tell the inspectors which staff would be on duty in a few days time. The skill mix included nurses of three disciplines and care staff, and the numbers were usually adequate, including where one-to-one or two-to-one staffing levels were required to support residents.

However, staff were not always deployed appropriately. For example one of the residents required a two-to-one staffing ratio, and while two staff were rostered for this responsibility, the inspectors noticed the resident without an accompanying staff, and were informed that both staff had gone to make the resident's tea. Also, one of the houses had a normal roster whereby a nurse was on duty both day and night, however there were regular occasions where a nurse was not available, and only care staff were on duty. There were also occasions where the usual level of

three day staff was reduced to two due to lack of availability of staff, in the absence of any evidence that this was in accordance with the assessed needs of residents.

There was a significant reliance on agency staff in the centre, and the person in charge reported that all efforts were made to ensure that agency staff were known to residents. However there were two recent occasions where incidents of challenging behaviour had occurred in one of the houses when two agency staff were on duty, one occasion requiring on call support There had been no follow up to ascertain whether the presence of agency staff was a trigger to the behaviours. Staff reported that if there were agency staff on duty the regular staff would always accompany a particular resident. There was no written protocol, support plan or risk assessment which documented this practice.

There were behaviour support plans in place for some of the residents, and these included guidance for staff in the management of these behaviours. There was insufficient evidence however, that any meaningful changes were made following any incidents of behaviours of concern.

Not all required notifications had been submitted to HIQA. There had recently been two serious choking incidents which required staff intervention and the transfer of residents to hospital, but these incidents had not been reported to HIQA.

In addition, senior management reported that while the agency had assured them that all the required documentation was in place for agency staff, they had not provided any evidence, for example that garda vetting was in place. There was no memorandum of understanding between the agency and the service. Where agency staff were used there was no written induction plan. Staff described the induction as being a verbal description of residents and of the duties required of them.

A sample of staff files of regular staff were reviewed by the inspectors and found to contain all the information required by the regulations. However there was no structured supervision or performance management of staff. The inspectors were informed that a system of 'support meetings' had been introduced, but there was no evidence available that this had been implemented.

Overall the provider did not demonstrate effective oversight and governance of the designated centre.

Regulation 14: Persons in charge

The arrangements for the post of person in charge met the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, skills mix and deployment of staff were not always appropriate to meet the needs of residents. There was a reliance on agency staff which was not always managed appropriately. There was no supervision or performance management in place. Continuity of care was not always ensured by the use of consistent staff teams.

Judgment: Not compliant

Regulation 23: Governance and management

There was a lack of monitoring and oversight throughout the centre in relation to quality and risk. There was no consistent management presence throughout the centre. There was no system of audit or any method of quality monitoring or improvements. There were no audits, only sporadic staff and manager meetings, and agreed actions from any management processes were not monitored, and frequently were not implemented. An annual review had been developed, but did not include the views of the resident. Six monthly unannounced visits wee not conducted by representatives in behalf of hte provider,

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all required notifications had been submitted to HIQA. Recent incidents requiring emergency hospitalisation had not been notified.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints procedure in place, but no oversight of complaints. A complaints log had been developed but it had not been implemented.

Judgment: Not compliant

Quality and safety

The quality and the safety of some aspects of care and support offered to residents was not of an adequate standard. The lack of oversight included inadequate monitoring of risk in the centre, and of the quality of life for residents. This resulted in poor outcomes for residents, and a lack of any quality improvement.

Inspectors requested the risk register, and were presented with a folder of risk assessment documents, including certain activities, transport and lone working. There were also individual risk assessments in the files of residents, however the same four areas were risk assessed for each, even where they were not relevant, for example there was a risk assessment for each individual in relation to self injurious behaviour, even when this was not an identified risk for the person. Risks which had been identified for individuals however, were not risk assessed, for example there was no risk assessment in relation to choking for one resident at significant risk. It was therefore not demonstrated that any further such events would be managed safely.

A risk assessment for one of the residents had been reviewed following a significant incident, and an additional control measure, the need for a referral to an allied healthcare professional, had been identified. This referral had not been made.

Not all risks had been identified, for example the hot water in the community house was extremely hot, there was no temperature control, and no risk assessment in relation to the risk of scalds. On review of the evidence gathered during the inspection the provider was contacted and required to address this issue urgently.

In addition there was mould on the walls of the bedroom of one of the residents, and staff reported that it was cleaned regularly, but always came back. There was also damage to light switches resulting from challenging behaviour, which had not been mitigated appropriately.

There were various infection control issues observed by the inspectors. The kitchen work top in the community house was worn away in holes. There was a strong smell of urine in two of the bathrooms in the centre. Mops were seen to be stored outside one of the back doors, upside down in a bucket with water in the bottom. There was opened food in fridges without any labelling as to when they were opened or what the use-by date was.

There was a system in place for the recording and reporting of accidents and incidents, in the form of accident and incident forms. These forms had been completed for incidents reviewed by the inspectors, including those which had been notified to HIQA. The forms detailed any current control measures, and any changes required. There were, however, no recommended changes documented following several of the incidents reviewed by the inspectors. For example, following an incident on transport between two residents, the managers reported that the residents involved no longer travelled together. There was no documentation in

relation to this, and no evidence that a practice of travelling together at weekends had actually ceased. While it was reported to the inspectors that follow up from incidents was discussed at staff meetings, staff did not have access to the records of these meetings. Copies of any accident and incident forms were not maintained in the houses for availability to staff.

Some of the required processes in relation to fire safety were in place. There were regular fire drills, and a personal evacuation plan was in place for each resident. Weekly checks of alarm systems had been conducted and quarterly maintenance checks were documented. However there were some unsafe practices and structures which required action.

The accommodation for one resident was a suite of rooms along one corridor of the house. There were fire doors to the entrance of this area and to each of the rooms occupied by the resident. However the doors were all badly fitting and none of them could close. Another fire door in the house did not close because of coats hanging behind it. A main fire exit from the house was blocked by the wheelchair of one of the residents, and this was a daily practice, and was stipulated as such in the resident's documentation relating to the proximity of the wheelchair to the sitting chair. This practice was stopped immediately when highlighted by the inspectors.

In another house there were holes in at least one of the fire doors, and badly damaged surroundings to others, so that it was not clear that a fire would be contained. There were photocopied and laminated fire door signs on some of the doors, and no evidence that these were actually fire doors. One of these doors led to the apartment in one of the houses, and this door had been identified in a fire drill undertaken in October 2018 as not closing because it had no sensor. The fire drill record also contained the comment that fire safety staff had recommended that it 'be done', but no action had been taken.

The provider's system for internal fire checks was not effective. Where there were daily fire checks in place, these only included a check of the fire panel, not that the exits were clear. Checks did not include checking the build up of lint in tumble driers.

Staff had received training in fire safety, and received a refresher annually. Staff engaged by the inspectors were aware of the actins they should take in the event of a fire. Fire drills had been conducted in the houses on a monthly basis. However records of these drills did not include an accurate record of the time taken to evacuate the houses. This had been the practice until some months ago, but recent records only included a comment such as 'quickly'.

Some restrictive interventions were in place throughout the centre. Inspectors requested a log of restrictive practices, but the file presented was a record of occasions when restrictive interventions which had used, usually in an emergency situation. There was no document which outlined all the restrictive intervention in use in the designated centre from which to monitor their use.

A documented restriction in one of the houses was that the door to the laundry should remain locked, restricting access to the area. One of the residents had been

identified as enjoying laundry activities, and went out to 'job experience' in a laundry. There was no evidence that they had access to the laundry in their own home at any time. In addition, despite a clear risk assessment stating that the laundry door should be locked, it was actually propped open on the day of the inspection, even though there were residents in the house. It was therefore unclear as to whether the open laundry door actually presented a risk to residents.

Overall residents were safeguarded from abuse. Improvements had been made in the protection of vulnerable adults form abuse since the last inspection. All regular staff had now received training in safeguarding. There were safeguarding plans in place for some of the residents. Staff and the person in charge were aware of their roles in the protection of vulnerable adults.

There was CCTV in use for one resident, and a clear rationale for its occasional use was described. However there was no evidence that consent had been sought for this intervention, or that the resident had been informed of its use.

There was occasional use of p.r.n. (as required) medication for the management of behaviour. A protocol for the use of one of these medications was in seen by the inspectors. The protocol included sufficient information to guide decision making, and it had been reviewed regularly. However protocols were not in place for all the p.r.n. medications. It was therefore not demonstrated that decisions relating to the administration of p.r.n. medications would be objective, consistent, or appropriate.

A rescue medication for one of the residents in relation to the management of epilepsy was not appropriately managed. There was no protocol in place to guide the decision to administer the medication. The resident was not always accompanied by a staff member who was qualified to administer the medication, so on those occasions the medication was not available. While the resident's epilepsy was well controlled, a review had been conducted by the GP who had continued the prescription for the rescue medication.

Medications were stored safely and ordering and collection of medication was managed appropriately. There was a policy in place in relation to medication management. However there were errors and omissions in some of the documentation. Several of the prescription kardexes had the start date of medications written in as the stop date, and the route of medications was sometimes unclearly indicated.

There was no stock control of medications. A stock count was conducted, but this was not checked against previous stock or stock delivered, so was in effect just a count of the content of the medication cupboard. The stock of a short term medication was checked by the inspectors, and there was insufficient stock to complete the course. There was no process in place to identify this shortfall.

Medication errors were recorded on accident and incident forms, and reported to management, but the managers were unable to give any indication of the frequency of such errors.

The premise were not appropriate as living accommodation for the residents. The

houses on the campus were institutional and lacked homelike decor or structure. The house in the community was, for the most part in a state of disrepair.

Of the two houses in a campus setting, one comprised interlinked corridors, some of which were corridors of offices, leading to the living accommodation, which also looked like a series of offices, even though the rooms off the corridors were the bedrooms and living areas for residents. There was signage throughout the accommodation with instruction or guidance for staff, for example hand hygiene instruction, and instructions for the use of equipment or how to manage a choking incident. This did not support a home-like environment.

One of the bedrooms was particularly unhomelike, for example there were no window dressings, and although behaviours of concern made the use of curtains problematic, no solution to this was in place. There was an old mattress dumped in the back yard of one of the houses. Bathrooms were in a state of disrepair, one of them had a strong smell of urine, and another had no toilet seat. On the second day of the inspection, one of the bathrooms was being refitted.

There were multiple maintenance issues in the community house which had not been attended to, often for a significant period of time. There were broken and damaged fixtures and fittings, painting was required throughout, and furniture both inside and in the garden was in a state of disrepair.

Bathroom facilities in this house were not appropriate to meet the needs of residents. There was a strong smell of urine in the main bathroom, and mould on the ceilings and walls.

The bathroom of the apartment of this house had a broken shower door, so the resident was unable to use their own bathroom, and was therefore sharing the main bathroom despite compatibility issues with other residents. There was no bath in the house, and one of the residents who had recently been discharged form hospital had been advised to bathe daily.

Residents did not have access to appropriate transport. The vehicle of one of the houses was out of service, and the two vehicles attached to the community house both had recurrent maintenance issues, sometimes leading to breakdowns while out. Recently one of the vehicles had to be evacuated at the road side.

These issues relating to vehicles was having a significant impact on the activities of residents. Activities identified for a resident while the vehicle was out of service included 'talk time'. However, the records of these talk times were a description of a brief interaction, always on the same topics. This resident was observed by the inspectors to be alone for significant periods. The resident's first comment to the inspectors related to the lack of transport. Residents' social care needs were not being met.

Residents meetings were not meaningful in that many of the residents were unable to engage in the meetings, and also that issues were not followed up. For example the issues of the apartment being cold and the lack of curtains in one of the bedrooms were repeatedly mentioned over a few weeks, but no action had been

taken.

Residents were not supported to make choices. Not only was there no evidence that any of the residents had made an informed choice to live in the centre, there was insufficient evidence that they were making choices in their daily activities, for example meals were made in rotation in one of the houses, and not all residents were supported in activities of their preference. Residents did not have free and unlimited access to their money.

Residents' individual money was managed by each having a bank account. A small set weekly allowance was made available to each resident each week, and if any more was required staff had to request this in advance from the central location. Staff reported that individual spending money had previously been managed locally, but this practice had been stopped because of errors.

Each resident had a personal plan in place, and each section of the plan included a brief description or assessment, and some guidance for staff. Additions and reviews had been added to some sections. The structure of personal plans was inconsistent, for example not all residents had a money management assessment.

There was evidence that sections of the plans were kept under review, and updates and reviews were added, However only one of the personal plans reviewed by the inspectors had involved the resident or their family members. None of the personal plans were available in a format accessible to residents.

There were some healthcare plans included in the personal plans, for example, there were swallow care plans in place for those residents with dysphagia, these had been updated and staff were implementing the recommendations. Reviews had taken place for residents with medical conditions such as diabetes. Some healthcare checks had been conducted for residents, however the documentation in relation to this reviewed by the inspectors was out of date, and not readily available to staff. There was evidence that implementation of healthcare plans was recorded.

Residents had access to a family GP, and to some members of the multi-disciplinary team. However referrals were not always made in a timely manner, and there was no system of monitoring to ensure such referrals were made. On one occasion an appointment had been secured with a specialist where there was a long wait time for appointments. The appointment had not been either kept or rescheduled.

However, not all healthcare needs were managed appropriately. Where residents smoked there was no evidence of health promotion. There was mould on the the walls of the bedroom of a resident with a significant healthcare need.

Improvements were required in the communication with residents. For example, there were activity schedules on whiteboards outside some of the residents' rooms. Sometimes activities were written onto these boards, although the residents could not read. By the second day of the inspection improvements had been made on these boards to make them meaningful for residents.

A policy on communication had been developed by the person in charge, and this

policy included the introduction of weekly meetings in one of the houses using a symbol supported agenda, although it was reported by staff that residents were still not engaging in the process.

There had been some improvement in the provision of activities, although this was inconsistent. Some residents were now receiving an individual day service, either with one-to-one staffing, or with a more suitable day service. For others though there was no evidence that activities were arranged in accordance with their needs and preferences. While plans and activation programmes were in place, none of the information had been made available in an accessible format, and for some residents there was no evidence that the decisions to include activities was based on the needs or preferences of the residents.

Regulation 10: Communication

Communication with residents was not always appropriate to their needs, and information was not made accessible to residents.

Judgment: Not compliant

Regulation 13: General welfare and development

Not all residents had the opportunity to engage in activities of their choice, or to have meaningful occupation. Both the lack of transport and deficits in personal planning had an impact on this.

Judgment: Not compliant

Regulation 17: Premises

The premises were not appropriate to meet the needs of residents, and were not maintained. Two of the houses were based on a campus and there was no evidence of plans to provide community based accommodation, in the absence of a choice by residents to live in these premises. The premises were institutional and did not provide a home-like environment Some of the bathroom facilities did not meet the needs of residents and were in a state of disrepair

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider was not identifying or managing risk in the centre. Risks had not been appropriately identified or mitigated, and there was insufficient oversight of risk management..

Judgment: Not compliant

Regulation 27: Protection against infection

Premises and practices were not of a standard to ensure infection control. Disrepair of various areas of the centre represented an infection control issue.

Judgment: Not compliant

Regulation 28: Fire precautions

Structures and processes in relation to fire safety were inadequate. Some fire doors were in a state of disrepair, and daily checks were not effective. The provider had not reviewed the adequacy of fire safety systems.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Documentation in relation to medication management was not adequate, and stock of medication was not managed safely.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place, but the quality was inconsistent, and they had not

been made available to residents. residents and their families or representatives had not been involved in the planning process.

Judgment: Not compliant

Regulation 6: Health care

Not all healthcare needs were supported. There were missed appointments and some recommended referrals had not been made.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents rights were not upheld in some areas including the standard of living accommodation, and consultation. The state of disrepair of many aspects of the centre did not show respect for residents. There was no evidence of a choice of accommodation being available to residents.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Damien House Services OSV-0002442

Inspection ID: MON-0021698

Date of inspection: 28/11/2018 and 04/12/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
Schedule 2 documents for agency staff;
All agency staff to provide copies of all required documents to the PIC under schedule 2 of the Health Act 2007. Actions to be completed for existing agency staff by 15. 02.19 and for all new agency staff on commencement of employment.
An Induction pack for the designated centre will be compiled by 24.02.19 to include the procedure of induction and accessing relevant and necessary information for service users to enhance the existing induction procedure and also the HSE Induction Guidelines. This will be carried out with new HSE and agency staff on commencement of employment and as an integrated ongoing process. This process will be overseen and validated by the person in charge.
Formal Supervision Schedule of one to one supervision meetings for all staff to be in place and commenced by 28.02.19.
Rosters
Staff have access to the forecasted roster of all HSE employees and agency relief cover as notified to the service. Surnames are now included on rosters and a copy the roster in place in each house – completed on 18.01.19.
Recruitment and staff continuity
Memorandum of Understanding between employment agencies and Damien House Regional Services to be explored separate to existing national contract. Arranging meetings with the agencies to engage agency staff members on contracts – 28.02.19

Continue recruit drives for all grades of staff to fill vacancies, full and part time. Currently there is a local campaign for staff nurses with interviews to be scheduled for February 2019. Overseas recruitment for staff nurses is also ongoing and recruitment through the National Recruitment Service of the HSE for posts vacant.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

A set schedule of regular meetings and accompanying agenda is in place for the year. This includes staff team meetings in each house, Local Management meetings and Quality and Safety meetings. Completed. The notes of these meetings will be printed, filed and accessible appropriately.

In addition a schedule of meetings, including Quality and Patient Safety, between senior Damien House Services managers, PIC and PPIM, and the Provider Representative and the General Manager is scheduled and records will be retained. These meetings will commence in February 2019.

Audits have commenced and a set audit cycle will be introduced for all houses. Audit cycle process to be finalised by 22nd January 2019. Audits include medication management, including administration, personal plans, Health and Safety including fire drills and documentation

Staff recruitment – agency use and induction as above in regulation 15.

Annual review and 6 monthly unannounced to be completed as due and will be conducted by the Director of Nursing.

A standardised system of tracking maintenance requisitions has been put in place in all of the houses – Completed

Risk Assessment systems are being reviewed and a register of all risk assessments that have been carried out is completed and present on each person's file.

Review of complaints to be followed through at meetings on an ongoing basis. Training on the use of the complaints logs to be provided for staff on use of same. 30.04.19

Incident Reviews will take place at monthly quality and safety meetings and documented. Agenda taken from National QID and first meeting is scheduled to commence on 14.02.19 with monthly dates from then.

Rationalising Governance for optimal effectiveness

Submit application to divide the pre-existing designated centre into 2 designated centres (Centre 1 Damien House and Sonas ; Centre 2 Avila and the apartment in Cashel) and operate the centre as 2 separate designated centres with 2 registered PICs and distinct governance structures.

Roster CNMs to each centre to ensure management presence to allow for onsite oversight of each house.

Separate workspace for the CNM2s allocated from 14.01.19 to support this with preparation of required documentation to be completed.

Application to be made to HIQA by the provider representative to register 2 separate designated centres by the 13.02.19.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
NF03 notification in relation to a person who required medical intervention has been submitted. Completed.
Refresher training in relation to notification obligations has been completed locally with local managers. Completed.
System to ensure notifications will be made in the absence of PIC to be finalised and in place by 31.01.19.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Updated HSE templates and revised procedure to be adopted and templates to be available in each house by 18.01.19. PIC to review complaints on an ongoing basis and report on same at prescheduled monthly management meetings.
Complaints policy to be reviewed to include new procedure and template by 31.01.19.
Training for staff on revised policy and procedure to take place at prescheduled January and April team meetings

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Activation plans will be put in picture format following completion of review of same, 15.02.19.
Current individual daily schedules are in picture format, completed.
A Speech and Language Therapist to carry out communication assessments and put communication plans in place has been identified and is currently putting a work plan in place. Same to commence by 28.02.19

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: Reliable transport is being rented while the procurement of appropriate replacement transport is being finalised, completed Reviewed activation plans in picture formatted will be finalised by 15.02.19 These will include activity plans which will involve the person to the level of their ability in the general maintenance and upkeep of their home; this will include cooking, laundry, cleaning, decorating and outdoor maintenance and gardening. Staffing support requirements will be included in updated activation plans, same will also be risk assessed. To ensure that each service users reaches their full potential HSE Management have submitted a business Plan for funding for an additional resources of an Occupational therapist and Dietetics - 31.01.19	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Current premises HSE Management have requested HSE estates to carry out an assessment of repair works and renovations required in two of the houses in the designated centre. This involves a onsite preliminary assessment – completed Further assessment is now required by an architect. - This completed assessment of the work to be carried out on the 2 identified houses and associated costs and proposed work plan is to be completed by estates and submitted to the General Manager by 31.03.19 Future planning Strategic planning regarding decongregation of parts of the designated centre to commence immediately. This will be in line with the South East Community Healthcare operational plan and this will be supported through the HSE National Office of Social Care.	
Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Assessments

A register of all risk assessments that have been carried out for each person is completed and present on each person's file. As a result the overall risk register is being reviewed and updated.

Interdisciplinary team meetings (IDT) are scheduled to address review of each persons individual risk assessments ensuring that they are specific to the individual. These individual risks will be reviewed at scheduled IDT meetings going forward and the designated centre risk register will be updated annually to reflect any changes. (Immediate and ongoing)

Restrictive Practices (RPs)
Develop list of all RPs – list of review dates to be maintained as an index on the person's file to be completed by 31.01.19.
Develop list of RP's at personal, house and service levels with review dates included to be completed by 20.02.19

Incident Analysis
Document analysis of incidents in the notes of team and local manager meetings. These meetings have now been prescheduled for the year. Ensure recording and shared learning at these meetings. Immediate and ongoing.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Standard procedures for storage of mops and buckets and food storage in fridges written and included in all house profiles. (Completed)

Minor jobs as set out in regulation 17 (Immediate and ongoing)

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Officer to carry out an assessment of fire safety systems and internal fire doors as

part of estates assessment for completion and reporting by 31.03.19. All recommendations to be carried out as a matter of priority. This report will be taken into consideration in terms of the strategic plan outlined in regulation 17.

A daily checklist has been compiled to include checking of items such as access and egress and appliances. The shift co ordinator will be responsible for carrying out this daily check and report any concerns to the person in charge / CNM 2 immediately. The CNM/person in charge will have oversight of this practice on the audit schedule as outlined in regulation 23. (Completed and ongoing)

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The audit tool for medications system management to be reviewed and streamlined in each house of the designated centre as per the HSE Clinical Strategy and Programme Division, by 31.01.19. This will include 1. Examination of medication charts
2. Examination of residents care plan supports around medication management 3. Staff training records in medication administration 4. Other records associated with the ordering, receipt, stock taking of medicines, adverse events and errors. PIC will check and approve these audits once completed. These audits as per policy will be carried out bi annually. Reporting of these will happen at team meeting, local managers meetings and will be included in the 6 monthly and annual report of the designated centre. PRN usage will be notified as per regulations to HIQA quarterly.
Care plans outlining the emergency response if a person has a seizure are reviewed and updated regarding the availability of emergency medication for the person 21.01.19.
More in-depth analysis of individuals medications usage to be discussed at prescheduled IDT meetings and overall prn usage to be analysed in conjunction with the use of restrictive practices and incidence occurrences' at prescheduled local managers meetings and learning's shared at prescheduled team meetings. Any immediate actions required to be instructed immediately by the PIC/ CNM and directed to the appropriate staff member to implement.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

All personal plans to be reviewed and updated with a particular emphasis on residents involvement in their own homes and external meaningful activities. This will include residents' involvement along with their family if they choose and this involvement will be documented. Annual reviews to be completed by 31.07.19

All personal plans to be assessed to determine suitable accessibility for each individual resident and redesigned to easy read documentation/ picturesque format where necessary and as appropriate, 31.07.19

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Chronology of Health Promotion efforts and current advice to be included in a care plan e.g smoking and smoking cessation. 15.02.19

Copy of referrals made by GP or CNM to be present on the person's file 18.01.19
Annual healthcare check – index maintained on each file and review by managers, completed by 31.01.19 and ongoing.

A procedure is now in place if a service users is unable to attend a specific appointment – Completed

The specific issue in relation to the ongoing Mould on the wall of a bedroom is currently being addressed by Estates as part of the overall assessment of works to be carried out. – 31.03.19

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Restrictive Practices addressed as per regulation 26, 20.02.19.
Communication and SLT involvement in carry out assessments for each person as outlined in regulation 10 to ensure optimal involvement of service users in their life planning and at their weekly house meetings as per regulation 10, 28.02.19.
House meetings with service users will continue to be held on a weekly basis. The level of engagement by individual service users will be recorded and as necessary efforts to enhance this engagement will take place. CNMS will regularly review this and discussion will take place at local management team meetings, 20.01.19 and ongoing.
System to allow more ready access to each person's money to be developed and implemented in line with National Financial Regulations to allow ready access to person's

money locally. Monthly check and reconciliation of monies and balances to be included on an ongoing basis to minimize errors. 31.07.19
Meal planning - Food logs are maintained to allow rotation and planning. Completed
Evidence of involvement in decision making to be recorded and reviewed by CNM in each house, in particular in relation to activities (Documented by 08.02.19) and meals (ongoing weekly from 21.01.19).

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	28/02/2019
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	15/02/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents;	Not Compliant	Orange	15/02/2019

	opportunities to participate in activities in accordance with their interests, capacities and developmental needs.			
Regulation 15(1)	The registered provider shall 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.	Not Compliant	Orange	15/02/2019
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/03/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/03/2019
Regulation 17(1)(c)	The registered provider shall ensure the	Not Compliant	Orange	31/03/2019

	premises of the designated centre are clean and suitably decorated.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	28/09/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Substantially Compliant	Yellow	25/01/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	22/01/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review	Substantially Compliant	Yellow	31/01/2019

	of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/01/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/07/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Orange	14/02/2019

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Not Compliant	Orange	20/02/2019
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	31/03/2019
Regulation 28(3)(a)	The registered provider shall make adequate	Not Compliant	Orange	31/03/2019

	arrangements for detecting, containing and extinguishing fires.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	31/01/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/01/2019
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working	Substantially Compliant	Yellow	31/01/2019

	days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Not Compliant	Orange	30/04/2019
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Yellow	31/07/2019
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre,	Not Compliant	Orange	31/07/2019

	prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	18/01/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	15/02/2019
Regulation 09(2)(b)	The registered provider shall ensure that each	Not Compliant	Orange	28/09/2019

	resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	28/09/2019
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/07/2019