

# eDeposit Ireland

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

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	ORG-0008608
<b>Centre county:</b>	Cork
<b>Email address:</b>	suzanneR.moloney@hse.ie
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Suzanne Moloney
<b>Person in charge:</b>	Paudie O'Brien
<b>Lead inspector:</b>	John Greaney
<b>Support inspector(s):</b>	Breeda Desmond;
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	21
<b>Number of vacancies on the date of inspection:</b>	9

## **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 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 announced and took place over 2 day(s).

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

From:	To:
18 March 2014 09:30	18 March 2014 18:00
19 March 2014 08:30	19 March 2014 14:00

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 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was a monitoring inspection of a Health Service Executive (HSE) centre for adults with disabilities. The inspection was announced and took place over two days. As part of the inspection process inspectors met with residents, the person in charge (PIC), and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, policies and procedures and staff files. Overall inspectors were not satisfied that there was an adequate level of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults) with Disabilities) Regulations 2013.

Even though the structure and layout of the premises provided significant challenges due to the institutional design, other deficiencies were noted that could have been addressed that would not involve significant structural improvements. For example, the centre was not in a good state of repair and was generally unclean throughout. There were inadequate fire safety practices and all exits, including emergency exits, were locked and access was only through keys that were held by staff members.

Inspectors were not satisfied that there were adequate governance arrangements in place as exemplified by the absence of an effective complaints process, the lack of consultation with residents and their relatives, inadequate staff training and the absence of a systematic process for reviewing the quality and safety of care in the centre.

Following the inspection the provider was issued with an immediate action plan to address fire safety, the complaints process and staff training. Other improvements required, included:

- there was no policy available outlining the admission procedure
- residents did not have a contract of care
- person-centred plans required improvement
- the emergency plan did not address the safe placement of residents in the event of a prolonged evacuation
- there was an inadequate process for managing risk
- infection prevention and control practices were poor
- medication management practices
- the statement of purpose was not comprehensive
- there was inadequate consultation with residents/relatives
- required policies and procedures were not available
- personnel records were incomplete

The action plan at the end of the report includes the immediate action plan issued to the provider and identifies additional improvements required 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 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

**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 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

**Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

**Findings:**

Overall, inspectors were not satisfied that there was an effective complaints process in place to facilitate and support residents and/or their relatives to make a complaint. The centre is operated by the HSE, however there was inadequate evidence to indicate that the HSE complaints policy "your service, your say" was implemented in the centre.

There was a local complaints policy, however it did not outline, in sufficient detail, the process for managing complaints, it did not identify the complaints officer and even though it identified an appeals committee to address complaints when the complainant was dissatisfied with the complaints officer's findings, due to the non-implementation of the local complaints process, there were no records of referrals to the appeals committee.

The centre did not maintain a complaints log to record complaints, the outcome of the complaints process or whether or not the complainant was satisfied with the outcome. There was no evidence of a process to oversee the complaints process in order to ensure compliance. There was no signage on clear display identifying for residents, relatives and visitors how to make a complaint, the responsible person for dealing with complaints or the appeals process.

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys. A small number of residents had access to advocates, however, even though a number of staff had received training on the provision of

advocacy to residents, it was not evident that access to advocacy services was promoted and facilitated for all residents.

The programme of activities included art therapy, music therapy, aromatherapy, literacy and horticulture. Most activities were facilitated in the therapies cabin, which was a prefabricated building located in the garden to the rear of the main building. There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in accordance with their interests, capacities and developmental needs.

**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

**Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

**Findings:**

There was no policy available detailing the process for admission to the centre and as outlined later in this report under Outcome 13, the statement of purpose did not outline the specific care and support needs that the centre is intended to meet.

Residents did not have a contract of care.

**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

**Judgement:**

Non Compliant - Moderate

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

This was the centre's first inspection by the Authority.

**Findings:**

Based on a sample of records viewed by inspectors, all residents received a comprehensive nursing assessment on admission. Due to limited access to multidisciplinary supports by the centre, all residents had a comprehensive multidisciplinary (MDT) assessment carried out by an external organisation. The assessment included input from psychology, occupational therapy, social work and nursing/behavioural support. Inspectors were informed that the assessment will be used to support residents' transition from the current congregated setting to the community and four residents had completed the transition prior to the date of the inspection. The process of developing "passports" for residents, a document that provided a snapshot of each resident, including their background, likes and dislikes and other relevant information based on the MDT assessment, had recently commenced but were not yet in place for all residents.

The process of developing personal plans had recently been completed for all residents, however, on the days of the inspection there were two care plan folders available for each resident, one was based on the person centred model and the other was based on the medical model. There was no definitive date for when the transition to the person centred model would be complete, and as a result there was not one definitive plan for each resident to guide care. Even though the new care plan template supported the development of comprehensive person centred plans, based on a sample of records viewed by inspectors, the plans primarily addressed health issues but did not adequately address the social care needs of residents. The care plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to realise their goals or for de-congregation to a community setting. The plans did not adequately address:

- education, lifelong learning and employment support services, where appropriate
- development, where appropriate, of a network of personal support
- transport services
- the resident's wishes in relation to where he/she want to live and with whom
- the resident's wishes or aspirations around friendships, belonging and inclusion in the community
- the involvement of family or advocate.

There was inadequate evidence of consultation with residents and their relatives in relation to the development of plans and there was inadequate evidence that plans were based on the aspirations and choices of residents.

There was evidence that staff were provided with training on the development of person centred plans but staff members spoken with by inspectors expressed dissatisfaction with the level of training provided.

**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

**Judgement:**

Non Compliant - Moderate

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

This was the centre's first inspection by the Authority.

**Findings:**

This was a two-storey premises and comprised a male and female wing, however, residents were free to move between wings. The premises were not conducive to the provision of person-centred care due to the institutional design and layout of the building. However, accepting the limitations of the building structure, other improvements not requiring significant structural work were required to support residents' privacy and dignity such as ongoing maintenance and good hygiene practices.

Residents' accommodation comprised 30 single bedrooms, each with a wardrobe and bedside armchair, and a number had chest-of-drawers. There were wash-hand basins in a small number of bedrooms. Resident accommodation was primarily on the ground floor, however a small number of bedrooms on the first floor were still in use. There were conservatories on both sides of the building upstairs and downstairs. Dining facilities comprised separate dining space for male and female residents within large dining/living rooms. The protective surfaces of cupboard doors in the dining rooms were chipped, making effective cleaning difficult.

Sanitary facilities comprised cubicle style toilets, some with one hand-wash basin and others with two hand-wash basins. There were no hand drying facilities in one toilet. Shower and bath facilities were available for both male and female residents. However, overall, these facilities, including wash-hand basins, were unclean, toilets were dirty and seats were missing from several toilets, There was evidence of corrosion with staining on floors, and some pipes behind toilets appeared to be leaking. Overall shower and toilet facilities were of poor quality and did not support the privacy and dignity of residents. There was a clinical waste bin stored alongside a shower in the female wing, which was not good infection prevention and control practice. Shower chairs/seats were unclean.

There were sluicing areas on both floors. The sluicing area upstairs was part of the laundry room. There was a staff shower and toilet adjoining this room, however, there was an unpleasant odour in the vicinity of the shower.

There was a small gymnasium for use by residents, containing various exercise

equipment. While the equipment appeared to be relatively new, the equipment and floor were quite unclean with visible and dried in stains. Covers to radiators on corridors throughout the premises were damaged.

There was a small kitchenette for use by staff and residents. Many of the surfaces of the equipment were eroded preventing effective cleaning.

The therapies cabin at the rear of the building was accessible from both the male and female wings. There was a paved walk-way with a well maintained garden with shrubbery leading to the therapies cabin, where activities for residents were facilitated. There was a large poly-tunnel to the rear of the cabin where residents grew fruit and vegetables and potted-up their produce.

### **Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

**Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

**Findings:**

There was a HSE safety statement dated 2009. There was a health and safety and risk management policy in place with hazard identification, assessment of risks with measures and actions to be taken to mitigate the risks identified. There was an emergency plan that addressed how to respond to emergencies, however, it did not address the safe placement of residents in the event of a prolonged evacuation.

While incidents and accidents were recorded, there was no evidence that this data was collated or analysed in order to identify trends to support quality improvement measures and minimise the risk of recurrence.

Fire safety records were reviewed by the inspectors. A fire safety audit had been undertaken in the centre on 12 March 2014 and the items identified requiring remedial action correlated with the inspectors' findings. These included:

- means of escape were locked and were only accessible by keys held by staff members
- annual fire training was not completed for all staff
- records viewed by inspectors did not demonstrate that daily fire checks, such as ensuring that fire exits were not obstructed, were completed each day
- the fire alarm was not routinely sounded/tested
- fire drills were not done routinely
- the fire alarm panel did not enable staff to identify the specific location of an alarm within the centre in the event of a fire

- many of the doors within the centre were not fire retardant doors and many were not connected to the fire alarm system

A number of residents smoked cigarettes. There was no designated smoking room and inspectors were informed by staff that residents always smoked outside, However, there was no risk assessment carried out of residents' ability to smoke independently, the level of supervision required when smoking, or the level of access to cigarettes and lighters/matches.

Training records viewed by inspectors indicated that not all staff had completed mandatory training in manual handling and lifting techniques. Improvements were also required in hand hygiene facilities and practices. There were an inadequate number of wash-hand basins available for staff and advisory signage for best practice in hand hygiene was not always displayed. There were a small number of hand hygiene foam dispensers available and inspectors observed that opportunities for hand hygiene in accordance with best practice were not always taken.

An inspector observed a wound dressing change and was not satisfied that the procedure was completed in accordance with evidence-based nursing practice. For example, the dressing change was not carried out using an aseptic technique and the inspector noted that the work surface was not decontaminated subsequent to the dressing change.

Wall-mounted dispensers with disposable aprons and gloves were stored in residents' bathrooms. The inspectors informed staff that placement of these dispensers should be reviewed cognisant of residents' dignity, and a risk assessment should be undertaken in relation to potential danger to residents having unrestricted access to these gloves and aprons. Furthermore, plastic bags and plastic clinical waste bag ties were stored in residents' bathroom cupboards where residents had unrestricted access.

Inspectors were informed that flushing of unused water outlets was done to mitigate the risk of Legionella, however, there were not adequate records maintained to determine that it was done regularly.

### **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

#### **Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

**Findings:**

Inspectors viewed three different policies on responding to suspicions and allegations of abuse. One policy was the Trust in Care document, which is a health service policy about upholding the dignity and welfare of patient/clients and the procedure for managing allegations of abuse against staff members. The second policy was based on Children First, which provides guidance for the protection and welfare of children, and the third policy was based on the protection of older people from abuse. It was not clear which policy would be used to provide guidance on the procedure to be followed in the event of suspicions or allegations of abuse in the centre.

While a number of staff had received training based on Children First guidelines, based on records viewed by inspectors, a significant number of staff had not received up-to-date training on the prevention and detection of abuse. Additionally, and in relation to the uncertainty around the appropriate policy to guide practice, it was not clear what was the appropriate training programme to support staff recognise and respond to suspicions or allegations of abuse. Even though staff members appeared to be knowledgeable of what to do in the event of an allegation of abuse, there was decreased awareness of potential abuse as evidenced by inadequate records of investigation of injuries of unknown aetiology to residents.

Based on a sample of records reviewed by inspectors and on discussions with staff, a number of residents on occasions presented with challenging behaviour. Only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of challenging behaviour. Even though staff members spoken with by inspectors were familiar with residents, triggers for behaviour changes and alleviating factors, this was not appropriately documented in personal plans. This is particularly relevant due to the fact that staffing levels in centre are dependent on agency staff, who may not have the same level of knowledge of residents' needs.

Based on a sample of records viewed by inspectors there were systems in place for the management of residents finances, however some improvements were required. While all financial transactions were recorded, receipts were available for purchases made on behalf of residents, and financial transaction records were audited independent of the centre, there was only one staff signature for transactions when best practice would indicate there should be two signatures.

**Outcome 11. Healthcare Needs**

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

**Theme:**

Health and Development

**Judgement:**

Non Compliant - Minor

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

This was the centre's first inspection by the Authority.

**Findings:**

Based on a sample of records viewed by inspectors, residents were regularly assessed by a general practitioner (GP) and had access to out-of-hours services when required. The centre provided a consultant psychiatrist led service and residents had regular psychiatric reviews, including medication reviews. As discussed in Outcome 5, there was limited access to allied health/specialist services. However, when required, there was evidence of referral and review to services such as dietetics and chiropody and all residents had a multidisciplinary team review in 2013.

There were records of nursing assessments based on the activities of daily living model. While care plans were developed based on these assessments and some of these were comprehensive, other issues that were identified either in the nursing assessment or medical assessment were not always addressed in care plans. For example, there was not always a care plan in place for residents that had a diagnosis of epilepsy or for residents that were incontinent.

Residents' food was prepared in the kitchen off-site but within the same campus as the centre and was delivered in a heated food trolley. Residents were offered choice of food at mealtimes and based on observations of inspectors, it appeared to be nutritious and was available in sufficient quantities. Staff had created individual place mats for residents that identified their name on one side and contained information regarding issues such as food preferences and supervision requirements on the underside. This quality initiative was primarily developed because of the centre's reliance on staffing agencies and the place mat provided a quick reference guide for staff.

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

**Judgement:**

Non Compliant - Moderate

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

This was the centre's first inspection by the Authority.

**Findings:**

There was an up-to-date medication management policy in place which was scheduled

for review in September 2014. However, a nurses' signature sheet as described in An Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines, was not in place.

Nursing staff demonstrated a clear understanding of appropriate medication administration, and recording of regular medications. Residents' medication was stored securely in a locked trolley within the nurses' station which was secured with a key lock. Other medication was stored within a locked cupboard in the nurses' station.

Photographic identification was in place as part of residents' prescriptions in line with best practice. Residents' prescriptions were reviewed regularly by the medical team, signed and dated and items were discontinued appropriately. Maximum dosages for PRN (as required) medications were documented as well as the rationale for administration of PRN medicines.

There were no controlled drugs in use at the time of inspection. However, inappropriate medications were stored in the locked cupboard that was designated for storing controlled drugs, and this was not in compliance with relevant professional guidance. The controlled drug book was full and not replaced. In addition, a record of checking controlled medications as described in An Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines, was not in place.

### **Outcome 13: Statement of Purpose**

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

#### **Theme:**

Leadership, Governance and Management

#### **Judgement:**

Non Compliant - Moderate

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

This was the centre's first inspection by the Authority.

#### **Findings:**

A written Statement of Purpose was in place. While it outlined many of the items listed in Schedule 1 of the Regulations, it did not adequately address the following:

- the number of residents to be accommodated in the centre
- the facilities which are to be provided by the registered provider to meet the care and support needs of residents
- a description of the rooms in the designated centre, including their size
- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in Regulation 14 and 15
- the organisation structure

- arrangements made for dealing with reviews and development of the resident's personal plan
- supervision of use of specific therapeutic techniques
- specific arrangements for respecting the privacy and dignity of residents
- arrangements for residents to engage in social activities, hobbies and leisure interests
- arrangements for residents to access education, training and employment
- arrangements made for consultation with and participation of, residents in the operation of the designated centre was not included
- arrangements made for residents to attend religious services of their choice
- the arrangements made for dealing with complaints.

#### **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

#### **Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

#### **Findings:**

The post of person in charge was full time but the incumbent was also the person in charge for another designated centre. The person in charge had the appropriate qualifications and experience for the post.

The centre was operated by the HSE and there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. However, inspectors were not satisfied that the governance and management arrangements provided an adequate level of supervision of care and practice in order for the centre to be in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was supported by the findings of this inspection. For example, there was no complaints process in place and there was no evidence of consultation with residents and their relatives with regard to the running of the centre. There was inadequate evidence of a systematic process for the ongoing review of quality and safety in the centre. Staff were not facilitated with adequate training to support them to provide evidence-based care.

**Outcome 15: Absence of the person in charge**

*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Leadership, Governance and Management

**Judgement:**

Compliant

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

This was the centre's first inspection by the Authority.

**Findings:**

There was no period in excess of 28 days when the PIC was absent from the centre. The PIC is supported in his role by a Clinical Nurse Manager 3 (CNM 3) and is responsible for the management of the centre in the absence of the PIC. When the CNM 3 is absent there is a CNM 3 in another centre available to support and guide staff, when required.

**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

**Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

**Findings:**

Personnel records were located off-site and inspectors reviewed these records prior to the monitoring inspection. Additional records were maintained on-site and a sample of these were also reviewed. Many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

- photographic identification
- details and documentary evidence of any relevant qualifications or accredited training of the person

- a full employment history, together with a satisfactory history of any gaps of employment
- two written references including a reference from a person's most recent employer (if any).

Training records viewed by inspectors indicated that training was facilitated for staff on issues such as infection prevention and control, the management of challenging behaviour, cardiopulmonary resuscitation, advocacy, Children First and manual handling. However, many of the records indicated that staff had received approval from management to attend training but there were not always records available to indicate that staff had attended or had successfully completed the training. In addition to inadequate records, there were deficits in training to support staff in the provision of evidence-based care. For example, as discussed in Outcome 8, a large number of staff had not received training in the protection of residents from harm and abuse, not all staff had up-to-date training in manual handling, not all staff had up-to-date training in fire safety and not all staff had received training in the management of challenging behaviour. As discussed in Outcome 5, person centred planning had been introduced in the centre. The Corporate Safety Statement detailed that 'training must be provided on the introduction of a new system of work or changes to existing systems of work' and records indicated that staff received a presentation on person-centred plans but staff members spoken with by inspectors expressed the view that more detailed training was required to support the effective implementation of this biopsychosocial care model to enhance the lives of residents' in their care.

The centre provides a consultant psychiatrist led service and all of the residents have an intellectual disability. The centre is staffed predominantly by registered psychiatric nurses, and only a small number of nurses have a qualification in intellectual disability nursing. On the days on inspection there were seven staff nurses on duty from 07.30hrs to 19.30hrs to care for residents and two nurses on duty in the therapy unit. Usually there are no healthcare assistants, however on the day of inspection there was one agency healthcare assistant on duty. In order to maintain the required staffing levels the centre is heavily reliant on staff working overtime and on agency staff. On the first day of inspection four of the nine nurses on duty were from an agency. Two staff members were designated to 'special' one resident and another staff member was designated to 'special' another resident. (This is usually done for residents with high care needs, such as in extreme challenging behaviour). The over reliance on agency staff coupled with inadequate care planning does not support the provision of person-centred care and created the potential for inconsistencies in care delivery due to the frequent changes in personnel delivering care.

## **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

### **Judgement:**

Non Compliant - Major

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

This was the centre's first inspection by the Authority.

### **Findings:**

Inspectors carried out a partial review of this outcome and a number of deficiencies were identified. For example:

- a significant number of the policies listed in Schedule 5 of the regulations were not available in the centre
- there were three policies on the protection of residents from abuse but it was not clear which policy would be implemented in the event of suspicions or allegations of abuse
- all of the items listed in Schedule 2 of the regulations were not available in personnel records and there was not an adequate system in place for recording training completed by staff or to support the identification of required training.

## **Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

### **Report Compiled by:**

John Greaney  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	ORG-0008608
<b>Date of Inspection:</b>	18 March 2014
<b>Date of response:</b>	29 June 2014

### 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 and the National Standards for Residential Services for Children and Adults with Disabilities.

#### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** DCAD10 Individualised Supports and Care

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

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre.

**Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

1. Consultation will take place with the National Advocacy Service (NAS) as to the support, guidance or facilitation they can offer to develop a Service User Forum. NAS have been contacted and negotiation around supports and access to their service for

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

the residents will be ongoing.

2. Training for all staff on person centred care planning, has been arranged for 7th, 8th and 20th May. Following this up-skilling, staff will on an individual basis and as part of the care planning process, address the current deficits in relation to engagement with families and residents. To be commenced following the training.

3. As part of the overall response to the deficits identified by HIQA regarding engagement with families, an overall programme of communication will be developed. This will include an introductory letter to families and identify the key themes that will the service will be engaging with the families around, including advocacy, activities, organisational changes, care planning, contracts of care, service statement of purpose, admissions policy and potential to develop a family forum. This is not an exhaustive list. Introductory letter is in draft as at 02/05/14, but requires further amendment. Communication Plan and Introductory Letter to be completed by 9nd May 2014.

4. Through the care planning process, key workers will engage directly with the families and residents to support this communication and document feedback/actions. Based on this feedback, a decision will be made as to whether a family forum would be feasible, or whether communication is focussed on an individual basis at this time.

**Proposed Timescale:** 30/06/2014

**Theme:** DCAD10 Individualised Supports and Care

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

There was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities were in accordance with their interests, capacities and developmental needs

**Action Required:**

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

1. A review of all current programmes will be undertaken through the development, circulation and completion of a feedback form for each resident. This will be completed for/by each resident with the support of their key worker/ advocate and in consultation with relatives to determine the suitability of the appropriateness of the current activities.
2. The PIC will oversee the review of the existing resident files by key workers to determine what interests, capacities and developmental needs are currently identified for residents.
3. Any deficits in the service arising from this review will be documented and a business plan developed regarding accessing the activities.
4. The interests, capacities and developmental needs for each resident will be robustly documented as part of the care planning that will roll out following the training days in May.
5. Any deficits in the service arising from this process will be documented and a

business plan developed regarding accessing the activities.

6. Subject to service resources and feasibility based on the plans for service reconfiguration and de-congregation, activities will be developed/ accessed based on this unmet needs identified.

**Proposed Timescale:** 31/07/2014

**Theme:** DCAD10 Individualised Supports and Care

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

There was no evidence of a process to oversee the complaints process in order to ensure compliance.

**Action Required:**

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

1. As per section below on complaints, a complaints log has been introduced and is reviewed on a regular basis at staff meetings, to ensure issues are progressed and managed in accordance with the policy.
2. The service is nominating a staff member from another service to satisfy Regulation 34 (3) as it is not feasible to assign this responsibility to any of the staff internally due to the small size of the service. Completed

**Proposed Timescale:** 23/05/2014

**Theme:** DCAD10 Individualised Supports and Care

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

Even though a number of staff had received training on the provision of advocacy to residents, it was not evident that access to advocacy services were promoted and facilitated.

**Action Required:**

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

1. A number of individual residents are already supported by staff from the National Advocacy Service
2. The service will promote the National Advocacy Service further within the centre by:
  - a. Displaying information

- b. Advising each residents and noting the interaction in their care plans
  - c. Writing out to families to advise them of the service.
3. The National Advocacy Service will also be contacted with regard to what other steps could be taken to promote their service and advocacy in general

**Proposed Timescale:** 01/06/2014

**Theme:** DCAD10 Individualised Supports and Care

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

There was no effective complaints procedure for residents in an accessible and age appropriate format and

- residents and their families were not made aware of a complaints procedure
- a copy of a complaints procedure was not on display in a prominent position
- the complaint's policy did not identify the person responsible person for dealing with complaints
- records of complaints were not maintained and it was not possible to determine whether complaints were investigated promptly; whether the complainant was informed promptly of the outcome of their complaint; or if measures required for improvement in response to a complaint were put in place.

**Action Required:**

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

1. A robust complaints procedure, based on the Your Service, Your Say policy has been sourced from another disability service and adapted for local use within the centre.  
Action Completed
2. A comprehensive memo has been drafted and will be sent to all staff identifying the current suite of policies relevant to the service with regard to complaints and identifying the Complaints Officer. This memo indicates that the local complaints policy and procedure has been upgraded. Action Completed
3. A letter memo has been drafted and will be sent to all families identifying the current suite of policies relevant to the service with regard to complaints and identifying the Complaints Officer. A copy of the new local Complaints policy and procedure and easy read version have been attached. Action Completed.
4. Training for designated Complaints Officers has been requested from HSE Consumer Affairs. This department, which is responsible for the training of CO's in the HSE, is

currently sourcing a Trainer. The nominated staff for training have been identified and will be released for training once places are made available. A staff nurse has been designated as the Complaints Officer and will be supported by the Consumer Affairs department with regard to the management of any complaints that arise. Action Completed.

5. The local complaints procedure for residents and families has been developed in an easy read version. Action Completed

6. All the residents in the Unit will be assisted by their key worker or the day therapy staff, to go through the complaints procedure, so that they are aware of this and how to make a complaint. A copy of the easy read version will be placed on the person's care plan file once this is completed and the engagement will be noted on their file. The staff members will notify the CNM3, as each resident is advised on the procedure and the CNM3 will keep and monitor a central log to ensure this is completed for each resident within a 3 week time frame.

7. A copy of the easy read complaints procedure will be sent to the National Advocacy Service, with a covering note, to make them aware of the new complaints policy and procedure for the centre. Action Completed

8. Your Service Your Say signage had been sourced and displayed to identify the complaints procedure. Action Completed

9. A complaints log and complaints log summary sheet has been developed and will be introduced on the unit. Action Completed.

10. A Standard Operating Procedure will be developed to further strengthen and support the implementation of the Complaints Log process. Revised Completion Date 2nd May 2014

11. The Person in Charge will meet with the senior staff to roll out the new complaints log and the local complaints policy will be discussed. Action Completed

12. The senior staff will cascade down the complaints log process and new local complaints policy to all the staff across the unit as they come on shift. A copy of the Complaint's policy and procedure will be held on the unit's policy and procedure handbook and all staff will be required to sign to verify they have read and understood the policy. Action Date: Incremental as staff come on shift.

13. Further formal training on the complaints policy and procedure will be rolled out to all the staff from the Complaints Officer. Dates will be scheduled around other external training - for completion by 13th June 2014

14. The CNM3/PIC will monitor compliance with the completion of the complaints log and review the complaints for status report etc on a weekly basis at the unit team meeting.

15. The complaints log will be transcribed and updated into electronic format on a

weekly basis.

**Proposed Timescale:** 13/06/2014

#### **Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

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

There was no policy available detailing the process for admission to the centre.

**Action Required:**

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

The service does have a documented admissions policy, but it was not furnished during inspection and is not robust or effectively operated. The current admissions policy will be reviewed and revised. Completion Date 30th May 2014

**Proposed Timescale:** 30/05/2014

**Theme:** Effective Services

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

Residents did not have a contract of care.

**Action Required:**

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

1. A template for the Contract of Care has been sourced from other services. A template contract of care is being drafted using these versions for application within the service. Completion Date 17th May 2014

2. The contract of care will be developed for each resident commencing 18th May 2014, target completion date 30th June 2014. The service acknowledges the importance of this document and wishes to advise that it will give careful consideration to the development and introduction of same. In order to ensure the documentation is robust and comprehensive and that the service develops each contract consistently and correctly, only a target completion date is given, which makes allowance for the work involved.

**Proposed Timescale:** 30/06/2014

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

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

There were two care plan folders available for each resident, one was based on the person centred model and the other was based on the medical model. There was no definitive date for when the transition to the person centred model would be complete, resulting in no one definitive plan for each resident.

**Action Required:**

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

1. Training for all staff on care planning is arranged for 7th, 8th and 20th May.
2. Following the completion of training the key staff member for each resident will implement a review of the folders and develop and introduce the definitive care plan for each resident. Completion Date 30th June 2014
3. The ongoing support and training needs of the staff to ensure this is effectively implemented will be monitored by the PIC and if required additional follow on training and support for staff will be provided.

**Proposed Timescale:** 30/06/2014

**Theme:** Effective Services

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

Even though the documentation in the new care plan supported the development of person centred plans, based on a sample of records viewed by inspectors, the plans tended to have a health rather than a social focus.

**Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

1. Training for all staff on person centred care planning is arranged for 7th, 8th and 20th May.
2. Following the completion of training the key staff member for each resident will implement a review of the folders and develop and introduce the definitive care plan for each resident which will include the development and identification of personal goals, wishes, preferences etc. and the supports required to deliver these.
3. The ongoing support and training needs of the staff to ensure this is effectively implemented will be monitored by the PIC and if required additional follow on training and support for staff will be provided.

**Proposed Timescale:** 30/06/2014

**Theme:** Effective Services

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

There was inadequate evidence of consultation with residents and their relatives in relation to the development of plans and there was inadequate evidence that plans were based on the aspirations and choices of residents.

**Action Required:**

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

The service can confirm that a process of consultation and engagement with the families was undertaken as part of the MDT resident assessments undertaken by the COPE Foundation. This is documented in the individual reports.

1. Training for all staff on person centred care planning is arranged for 7th, 8th and 20th May.
2. As part of the communication plan with families identified under Outcome (01), letters will be drafted and issued to all families advising that person centred care planning processes are being enhanced in the service and they will be invited to engage with a named key worker 30th May 2014.
3. Following the completion of training the key staff member for each resident will review the existing files and commence engagement with the residents, their family, advocates and circle of support to develop and introduce the definitive person centred care plan. Completion Date 30th June 2014
4. All families will be invited to attend at least one care planning meeting or a meeting arranged to visit them by 30th June 2014.

5. The ongoing support and training needs of the staff to ensure this is effectively implemented will be monitored by the PIC and if required additional follow on training and support for staff will be provided.

6. All residents and their families will be invited to participate in a formal care plan review on a three monthly basis with the key worker.

**Proposed Timescale:** 30/06/2014

### **Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

Overall there was evidence of inadequate cleaning practices as exemplified by:

- unclean wash-hand basins
- unclean shower chairs/seats
- unclean equipment in the gymnasium

**Action Required:**

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

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

1. Review has been completed by Infection Control Nurse regarding cleaning rota, practises, equipment, products etc ,
2. Training for Housekeeping staff by Infection Control Nurse is ongoing.
3. A cleaning checklist is being developed and introduced, that will be signed off by housekeeping staff and Nurse Manager to ensure appropriate cleanliness levels are upheld and to highlight issues arising from under staffing. Currently in draft and due for completion 9th May 2014
4. Review of facilities to ensure that any equipment / area not in regular use or not required to be kept in use is appropriately secured. Completed and subject to ongoing review

**Proposed Timescale:** 09/05/2014

**Theme:** Effective Services

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

The centre was not in a good state of repair. For example:

- seats were missing from several toilets
- radiator covers were damaged
- cupboards and worktops were damaged making them difficult to clean
- there was evidence of corrosion with staining on floors and behind toilets and some pipes appeared to be leaking

**Action Required:**

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

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

1. All missing toilet seats have been replaced.
2. Damaged Radiator covers on the "male side" have been removed, as they are no longer required. The covers of on the "female side" are not damaged and are being left in situ. The newly exposed radiators are being painted and this work is in progress and due for completion by 9th May 2014.
3. The maintenance department in consultation with the Inf. Control Nurse have reviewed all fixtures and fittings and identify the priority works for completion Carpentry work is in progress on the priority works and is due for completion by 9th May 2014.

**Proposed Timescale:** 09/05/2014

**Theme:** Effective Services

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

Overall shower and toilet facilities were of poor quality and did not support the privacy and dignity, for example some communal toilets were located in shower rooms.

**Action Required:**

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

- Remedial plumbing works are in progress and due for completion 9th May 2014
- Repairs / replacement of flooring is on progress and due for completion 9th May 2014

**Proposed Timescale:** 09/05/2014

**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:**

There was an emergency plan that addressed how to respond to emergencies, however it did not address the safe placement of residents in the event of a prolonged

evacuation.

**Action Required:**

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

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

Under the emergency plan, provisionally the Therapy Units adjacent but separate from the main residential building will be identified for use for a prolonged evacuation of up to 4 hours. These building have bathroom, kitchen, seating and lounge facilities with independent electric storage heating. Verbally agreed with Unit staff, documentation to be completed 9th May 2014

- Further discussion with the Fire and Safety Officer and HSE Estates regarding the emergency plan and evacuation will be undertaken.

**Proposed Timescale:** 31/05/2014

**Theme:** Effective Services

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

While incidents and accidents were recorded, there was no evidence that this data was collated or analysed in order to identify trends to support quality improvement measures and minimise the risk of recurrence.

**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:**

1. The HSE has a computerised web based system for recording and managing incident and accident reports- Stars web. Local access to this system will be examined. Completion Date 16th May 2014.
2. In the event local access is not feasible, due to staff/IT constraints, the service will consider the possibility of data being collated and uploaded to the system at another site, who could facilitate this and provide analytical reports. If required- completion date 30th May 2014
3. The current documentation arrangements have been reviewed and a system is being developed to ensure all data is collated centrally using a log book system. This will be paper-based initially, due to the limited ICT resources in the service. Completion Date 16th May 2014
4. An SOP will be developed to support this log system, which will be communicated out to all staff. Completion Date 16th May 2014

5. On a monthly basis, data will be reviewed by the Quality and Patient Safety Committee subgroup (to be established under Outcome 15). This subgroup will document discussions, actions, outcomes.

**Proposed Timescale:** 30/05/2014

**Theme:** Effective Services

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

There was no risk assessment carried out of residents ability to smoke independently, the level of supervision required when smoking or the level of access to cigarettes and lighters/matches.

**Action Required:**

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

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

1. There are 4 residents within the Centre that smoke. An individual risk assessment has been completed on each of these four residents regarding their smoking habit that identifies:

- Ability of the resident to smoke independently
- Details of specific smoking habit/routine where this is defined and managed
- Level of supervision required
- Level of access to cigarettes and lighters/matches

**Proposed Timescale:** 01/05/2014

**Theme:** Effective Services

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

There was no risk assessment of the risks posed by:

- free access by residents to wall-mounted disposable apron and glove dispensers
- free access by residents to clinical waste bag ties

**Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

- Clinical waste bag ties have been removed from resident's cabinets and are stored in the Surgery. Completed

- Currently there are no residents in the Unit whose behaviour would place them at risk of sustained an injury from the wall mounted apron or glove dispensers, due to ingestion, ligature, suffocation. Risk assessment completed on residents who use the materials to block water outlets. Units have been re-located as a control measure against this risk. Completed.

**Proposed Timescale:** 01/05/2014

**Theme:** Effective Services

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

Effective infection prevention and control measures were not in place, including:

- there were an inadequate number of wash-hand basins available for staff
- advisory signage for best practice in hand hygiene was not always displayed
- only a small number of hand hygiene foam dispensers were available and inspectors observed that opportunities for hand hygiene in accordance with best practice were not always taken
- wound dressing changes were not always in accordance with evidence-based nursing practice
- routine water flushing of unused water outlets was not routinely completed to mitigate the risk of Legionella

**Action Required:**

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

1. The Infection Control Nurse has reviewed all wash hand basin facilities and indicates the facilities are in line with HCAI Guidelines and that current facilities are adequate and appropriate for the setting based on the nature of the service, space available and the level of medical care needs. Some sinks are small, but are appropriate to size of building and meet identified need.
2. Placement of hand hygiene signage has been reviewed and additional signage has been displayed and all staff have personally been sent documentation. Action Completed.
3. The service has two trained hand hygiene instructors. All staff are scheduled for refresher training in hand hygiene best practise with the trainers. Completion Date 2nd May 2014.
4. Staff have indicated that a dressing was applied to a blister (skin not intact) in the day room and staff fully accept that appropriate aseptic technique was not observed.
5. Routine Flushing is being carried out. The requirement for flushing was documented

by Maintenance who provided a sheet each week indicating which outlets need to be flushed. There was some discrepancy regarding the terminology used by Maintenance and the staff to identify which outlets should be maintained. Clarification on the terms used to identify the locations has been agreed. A document identifying that this has been carried out is now in place.

6. An additional nebuliser has been ordered to facilitate single use should the need arise.

**Proposed Timescale:** 02/05/2014

**Theme:** Effective Services

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

Effective fire safety management systems were not in place, including:

- means of escape were locked and were only accessible by keys held by staff members
- annual fire training was not completed for all staff
- records viewed by inspectors did not demonstrate that daily fire checks, such as ensuring that fire exits were not obstructed, were completed each day
- the fire alarm was not routinely sounded/tested
- fire drills were not done routinely
- the fire alarm panel did not enable staff to identify the specific location of an alarm within the centre in the event of a fire
- many of the doors within the centre were not fire retardant doors and many were not connected to the fire alarm system

**Action Required:**

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

1. A documented checklist has been drafted and introduced to ensure that all external doors with locks are checked weekly and any faults reported are actioned immediately. Action completed.
2. The Fire and Safety Officer will schedule fire safety training for all staff that have not received training in the last year. This will be carried out in conjunction with an evacuation drill. Completion of action by 31st May 2014.
3. This fire safety training and an evacuation drill will be repeated before the end of 2014 for a further group of staff.
4. Ongoing training on the use of fire equipment is being organised for all staff. Training for all staff to be completed by 31st May 2014.
5. A daily fire safety checklist is in place in the unit and is in operation. Documentation is in place to demonstrate this. The monitoring of this will be strengthened by A) completion of the checklist on a central basis, rather than in the two areas of the unit and B) weekly review/monitoring of this in the management team meeting. Action Completed.

6. A weekly lock inspection check has been implemented on existing locks. Action Completed.
7. There is a preventative maintenance contract with an external organisation in place, for the routine testing of the fire alarm system and emergency lighting system on a quarterly and annual basis. The records of same have been forwarded for the last 5 quarterly visits and are now available for inspection. The last test is kept on site and is available for review.
8. The Maintenance Department are arranging for the fire detection system to be upgraded to an addressable system. The installation of an upgraded fire detection system is planned to be complete by the 25th of July 2014.
9. It has been highlighted that the emergency lighting requires an upgrade and that it should be completed when completing the fire detection system upgrade. The installation of the emergency lighting upgrade is planned to be completed by the 25th of July 2014.
10. The Maintenance Department have completed a preventative maintenance check on all the doors within the premises. Referenced documentation will be available for each door, generally grading each door's fire integrity. During this check, doors have been repaired where necessary and where possible. However, in cases where doors are beyond repair, doors will be replaced. All doors to be replaced will support the defined fire strategy arising from the assessment outlined in 11 below. It is expected that doors, to be upgraded, as part of the aforementioned fire strategy assessment, will be installed by the 25th of July 2014.
11. The site's Project Engineer, the Maintenance Officer and Fire and Safety Officer has reviewed all the means of escape. It is planned that a fire strategy assessment will be completed. This will define compartment lines to enable horizontal progressive evacuation and vertical evacuation. Cross corridor fire doors will be defined, as an element of each compartment. The development of the 'fire strategy assessment' is planned to be completed by the 30th of May 2014.
12. A risk assessment will be completed to determine if the final exit doors should have a lock that fails open on fire alarm activation or a dead lock that is opened by a key, held by all members of staff. A risk assessment is also to be completed to determine if any of the internal doors cross corridor doors require access control, i.e. to be locked by a magnetic lock and releases on fire alarm activation. The development of the said risk assessment will be completed by the 16th May 2014.
13. If dead locks are placed on the final exit doors, a master key system will be put in place for the entire unit to facilitate the prompt opening of final exit doors in an emergency.
14. Implemented strategies and decisions, based on 11-13 above, will form part of the Fire Safety Register for the premises and staff will be trained accordingly. It is planned to implement the strategy by the 25th of July 2014.
15. As part of the aforementioned 'fire strategy' doors will be interfaced with the fire detection system, where necessary.

**Proposed Timescale:** 31/07/2014

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

Only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of challenging behaviour.

**Action Required:**

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

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

Training for all staff has been arranged for June 2014 , (see Outcome 17 :Responsive Workforce)

**Proposed Timescale:** 30/06/2014

**Theme:** Safe Services

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

Even though staff members spoken with by inspectors were familiar with residents, triggers for behaviour changes and alleviating factors, this was not appropriately documented in personal plans.

**Action Required:**

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

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

This will be addressed through the training in Positive Behaviour Management and Person Centred Care planning, that is being rolled out to all staff between 7th May and 11th June 2014. (See Outcome 17- Responsive Workforce)

**Proposed Timescale:** 11/06/2014

**Theme:** Safe Services

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

Based on records viewed by inspectors a significant number of staff had not received up-to-date training on the prevention and detection of abuse.

**Action Required:**

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and

response to abuse.

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

Staff Training is being organised on the protection of Vulnerable Adults from abuse (see Outcome 17- Responsive Workforce)

**Proposed Timescale:** 31/05/2014

**Theme:** Safe Services

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

There was only one staff signature for financial transactions when best practice would indicate there should be two signatures.

**Action Required:**

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

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

The documentation for financial transactions will be reviewed and updated as required in line with the National Financial Regulations, Completion Date- 16th May 2014.

An SOP will be developed to support the staff locally to adhere to best practice, Completion Date- 30th May 2014.

**Proposed Timescale:** 30/05/2014

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents' personal plans did not always address issues identified on assessment.

**Action Required:**

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

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

1. All staff are receiving training in person centred care planning between 7th-20th May 2014, which will support them to appropriately document how the care needs of the residents will be addressed and to identify any deficits.

2. An SOP will be developed within the service for the management of unmet needs as follows:

- The PIC/ Senior Staff will ensure that any deficits in the service provision to residents,

based on the assessed needs will be identified through the documentation and escalated by the key worker to the PIC.

- The PIC will collate information on the deficits to identify the service requirements to the Registered Provider as a business case.
- Where appropriate a risk assessment will be completed.
- The Registered Provider will endeavour to address the deficits within available resources

The SOP will be completed by 30th May 2014

**Proposed Timescale:** 30/05/2014

## **Outcome 12. Medication Management**

**Theme:** Health and Development

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

Improvements were required in medication management practices, including:

- inappropriate medications were stored in the Schedule 2 locked cupboard
- the record of drugs requiring special control measures was not replaced when full
- a record of counting drugs requiring special control measures at change of shift was not maintained
- a signature sheet for nurses was not maintained

**Action Required:**

Under Regulation 29 (4) (d) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

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

- All medicines stored inappropriately in the controlled drug cabinet have been removed.
- A replacement controlled drug book has been ordered via Pharmacy. Pharmacist providing book- but currently no controlled drugs.
- A record for counting drugs requiring special control measures at change of shift has been reactivated and is in place- this will commence in official book once received
- A signature sheet for nurses has been reactivated. Action completed.

**Proposed Timescale:** 01/05/2014

## **Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

The Statement of Purpose did not adequately address all of the requirements listed in Schedule 1 of the regulations.

**Action Required:**

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

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

The Statement of Purpose is being reviewed and will be updated in line with Regulation 03(1). Completion Date 13th June 2014.

**Proposed Timescale:** 13/06/2014

### 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:**

Inspectors were not satisfied that the management structure provided an adequate level of supervision of care and practice in order for the centre to be in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013

**Action Required:**

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

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

- The service is ensuring that the identified appropriate level of nurse management posts are in place and covered by appropriately qualified and experienced named individuals to ensure clear line management responsibility.
- On the basis that the service is actively de-congregating and the number of residents will be dropping significantly during 2014, it is not considered necessary to increase the level of managerial posts.

Timescale is ongoing.

**Proposed Timescale:** 01/05/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

There was inadequate evidence of a systematic process for the ongoing review of quality and safety in the centre

**Action Required:**

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

1. As per Outcome 07: Health, Safety and Risk Management- Theme: Effective Services, a log of incidents and accidents is being developed to support the collation of data on events and an analysis of these. The provision of and access to the HSE's web based system Stars Web, is also being examined, as this would provide a computerised system to enhance the review and management of issues arising.

2. A Quality and Patient Safety Committee is being established as a subgroup of the Management Team. The service has liaised with the Regional Quality and Risk Manager and the Cork ISA staff supporting Quality and Risk to obtain draft TOR and documentation for the roll out and development of the local committee. This committee, as defined in the TOR will have responsibility for systematically reviewing practise, incidents, accidents, events to improve quality and standards. Completion Date for establishment of committee : 13th June 2014

**Proposed Timescale:** 13/06/2014

**Theme:** Leadership, Governance and Management

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

There was no evidence of consultation with residents and their relatives with regard to the running of the centre

**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. As per Outcome 01: Residents Rights, Dignity and Consultation, a communication plan is being developed and will be rolled out to actively engage with families in a systematic planned manner across a number of key issues.

2. As part of person centred planning, engagement with families and residents will be undertaken as highlighted in the actions identified under Outcome 05-: Social Needs, and Outcome 01: Residents Rights, Dignity and Consultation

Process is ongoing

**Proposed Timescale:** 01/05/2014

**Theme:** Leadership, Governance and Management

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

Staff were not facilitated with adequate training to support the in the provision of evidence-based care.

**Action Required:**

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

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

- This has been addressed under Outcome 17: Workforce, with training arranged to cover the development of a number of skills.
- A number of staff have been supported by the service to access training. A log is being developed to accurately record this training, with copy certification etc. To be completed 30th June 2014

**Proposed Timescale:** 30/06/2014

### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The over reliance on agency staff does not support the provision of person centred care or due to the frequent changes in personnel delivering care.

**Action Required:**

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

The service is bound by the restrictions of the employment control framework which severely limits the capacity of the service to seek permanent replacement staff. As the service is de-congregating, it is not appropriate to recruit further permanent or long term contract staff. The service is working with the COPE Foundation and internally to reduce the number of residents in the service significantly by the year end. This will result in a staff reconfiguration and a drop in the requirement for agency staff.

1. In the interim a business case will be developed for the employment of HCA staff on a 6 month contract (through the agency), to alleviate the current reliance on day to day agency support. Completion Date: 30th May 2014

**Proposed Timescale:** 30/05/2014

**Theme:** Responsive Workforce

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

Staff did not have access to appropriate training, including refresher training, as part of a continuous professional development programme, including:

- fire safety training
- identifying and alleviating the underlying causes of challenging behaviour protection of residents from harm and abuse
- person centred care planning
- manual handling

**Action Required:**

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

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

1. A review of the training records has been undertaken to develop a training gap analysis of the staff with regard to fire safety and manual handling. Action Completed.
2. The fire safety training needs are being addressed by the Fire and Safety Officer (as noted above)
3. The manual handling training needs have been identified and the allocation of places for the next six months has been reviewed.(Note: training days are arranged and places are allocated on the HSE Manual Handling courses in six month blocks). Action Completed.
4. There are 9 staff that require to be updated in manual handling training and are not currently allocated a training place. Additional training places for these staff will be pursued from HSE and external providers. Ongoing.
5. PMAV (Positive Management of Aggression and Violence) one day training, will be delivered to all staff, who have not yet received training, on the recognition and avoidance of aggressive/challenging behaviour and some relevant disengagement techniques. 2 Training days were held 28th April & 1st May and a third day is scheduled for 6th May 2014.
6. Practical Person Centred Care Planning training has been arranged through an external provider for all staff. This will be provided over 3 days on the 7th, 8th and 20th of May 2014.
7. Specialist Training in Behaviours that challenge has been arranged through an external provider for all staff. This will be provided over 3 days on the 4th, 5th and 11th of June 2014.
8. Protection of Vulnerable Adults training will be delivered to all staff during three scheduled sessions by the PIC from a designated centre for older people. This will be

provided over 3 days on the 15th, 22nd and 29th May 2014.  
Days to be confirmed .Completion Date: 31st May 2014

**Proposed Timescale:** 11/06/2014

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Improvements were required in the development and implementation of policies and procedures, such as:

- a significant number of the policies listed in Schedule 5 of the regulations were not available in the centre
- there were three policies on the protection of residents from abuse but it was not clear which policy would be implemented in the event of suspicions or allegations of abuse.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

1. The service is aware that several policies in the service could not be located on the day of inspection, as the relevant folder had been removed. To overcome this entire policy folder will be replicated with spare copies kept in a secure location. To be completed 9th May 2014.
2. The service will review all current policies to determine the deficits against Schedule 5 . The development of any missing policies will commence immediately. To be completed by 5th May 2014.
3. All policies will be reviewed in line with the HSE guidelines on PPG development and review practises To be completed by 30th May 2014.
4. The policies concerning suspicious events and allegations of abuse are :
  - Trust in Care- HSE policy on allegations of abuse by staff
  - Children's First – policy for the management and reporting of concerns regarding children
  - Allegations of eldercare abuse- Generic HSE policy
5. The service is developing an overarching policy and guidance that will include a :
  - Non-accidental injury policy
  - Reference to and localisation of the HSE investigation of incidents policy
  - Allegations of Abuse policy ( client to client)

This will be completed by 30th June 2014.

**Proposed Timescale:** 30/06/2014

**Theme:** Use of Information

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

All of the items listed in Schedule 2 of the regulations were not available in personnel records and there was not an adequate system in place for recording training completed by staff or to support the identification of required training.

**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:**

- The documentation on staff will be reviewed in accordance with Schedule 2 and the deficits in the records addressed.
  - The existing training records for the staff in the service will be reviewed and collated to provide a clearer system for the recording of training and tracking of training needs.
- Completion Date 30th July 2014

**Proposed Timescale:** 30/07/2014