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

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**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002463
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Deborah Harrington
Lead inspector:	Vincent Kearns
Support inspector(s):	Julie Hennessy;Michael Keating;Noelle Neville;Kieran Murphy;Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 May 2016 10:00	25 May 2016 20:00
26 May 2016 09:00	26 May 2016 19:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

On 6 November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds or within close proximity of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to a follow-up inspection of Oakvale centre to identify if progress had been made since the commencement of the court order granted in November 2015.

An immediate action plan was issued to the provider representative in relation to fire safety. It was not demonstrated that fire drills as completed, considered all likely scenarios and conditions, in particular night-time conditions and actual staffing arrangements in place (both day and night) and recorded findings and actions required by regulation 28(3)(d). A satisfactory response was received by the provider representative in relation to this immediate action plan.

How we gathered our evidence

As part of the inspection, the inspectors met with residents and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, incident/accident logs, policies and procedures, staff files and training records. Interviews were carried out with a variety of staff members including the person in charge and clinical nurse manager.

Description of the service

The centre is a relatively new development which opened in October 2011 with the final bungalow opening in 2013. It consists of five bungalows interconnected by a link corridor each with their own front door and was developed as a stepping stone facility for service users transitioning to community living accommodation. The stated purpose of the centre is to provide a safe secure home for the service users who are supported to live there. Each bungalow can accommodate six residents with a range of needs including intellectual disability, mobility issues, autism and mental health issues.

Overall judgment of our findings

Overall, inspectors noted that there had been considerable progress since the last inspection, residents spoken with stated that they were happy living in the centre and inspectors observed that many residents were busy attending various activities over the course of the two days of inspection. However, there were still a number of failings identified including the aforementioned inadequate fire evacuation drills. In addition, there were failings in relation to personal care planning, health and safety including infection and control issues, restrictive practices and some incompatibility of residents.

The action plan at the end of the report includes the immediate action that was issued. The action plan also outlines the areas of non-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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Residents informed inspectors that they were well supported by staff in the centre and knew the staff who supported them very well. Inspectors noted that the interactions between staff and residents seemed very positive and it was clear to inspectors that residents were relaxed and appeared well cared for. Residents reported to inspectors that they were very busy and had many examples of the activities that they enjoyed pursuing including attending the local activities centre, shopping, socialising and participating in a number of sporting activities such as swimming and football. On the first day of the inspection inspectors were informed that there was a special social event called the "Gathering", which involved live music, a barbeque, oven baked pizzas and residents reported to inspectors that the event was great fun.

Inspectors noted that there were multi-disciplinary assessments for some residents. A care plan reviewed was noted to be signed by the resident and their key worker. The residents' personal centred plan (PCP) was detailed and outlined several areas including eating and drinking, behaviours that challenge, personal hygiene and personal information. A daily record of the residents' day was kept, giving a brief outline of any issues of behaviours that challenge. There was a record of aromatherapy on a weekly basis. There was evidence of regular contact with residents' family and representatives recorded in the PCP's and as appropriate residents had access to advocacy services.

From reading the sample of PCP's inspectors formed the view that specific details had been assessed and identified in relation to individual residents' needs and supports. Staff spoken with informed inspectors that PCP's had been a particular focus over the past six

months and that much work had been put into their development. The person in charge outlined how he had been working closely with the clinical nurse managers and staff to progress PCP's towards being as person centred as possible including the formation of a key worker system to promote continuity of care and support.

Inspectors noted that there were details recorded in the PCP for the residents' communication needs, keeping safe, personal and intimate care, likes/dislikes, daily record of personal care provision, hospital passport, disability distress assessment, health action plan, medication management plan, record of GP appointments, record of psychiatry appointment, records of dentist, optician and podiatry appointments, weight monitoring log, weekly observation chart, consent to the use of the residents' photograph, records of family contact made, an easy read version of the PCP, an activity record, a goal review, safeguarding and safety information, a moving and handling assessment and a protection/safeguarding plan.

However, inspectors noted that annual reviews were not formally recorded and this was confirmed by staff. In addition, there was no evidence of multi-disciplinary team (MDT) involvement in the annual reviews, no assessment of the effectiveness of the plan, no proposed changes recorded and no names of persons responsible for pursuing objectives in the plan as required by the regulations.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

An immediate action plan was issued to the provider representative in relation to fire safety. It was not demonstrated that fire drills as completed, considered all likely scenarios and conditions, in particular night-time conditions and actual staffing arrangements in place (both day and night) and recorded findings and actions required by regulation 28(3)(d). A satisfactory response was received by the provider representative in relation to this immediate action plan.

Inspectors reviewed fire safety records. It was noted that staff conducted daily checks of fire equipment and escape routes. The fire alarm and emergency lighting were noted to be serviced on a quarterly basis and the fire extinguishers were serviced annually. Records of fire drills were viewed by inspectors with the most recent drill taking place in

February 2016 as part of a fire training session. It was noted that this drill took 3 minutes and 55 seconds to complete.

Inspectors also noted that each resident had a personal emergency evacuation plan (PEEP). Resident PEEPs contained a recent photograph of each resident, details of support needs including any mobility needs and the residents level of understanding regarding following any fire evacuation instructions or not.

However, in relation to fire training and records provided by the centre, inspectors noted that five staff were not trained in fire evacuation and one staff was overdue this training since 1/4/14, 18 staff were not trained in fire safety and five staff were overdue this training since 11/4/16, 9/4/16 and 23/7/15. Inspectors were provided with a copy of the 2016 staff training schedule which outlined that this scheduled training was intended to rectify the above gaps.

Following enquiries by inspectors a report in relation to facilitating bed evacuations was provided regarding each unit in this centre. This report outlined that the site specific risk register for this centre had identified fire as a high risk. Additional controls that were identified included fire training to be provided to all staff, regular fire drills to be scheduled and concerns regarding evacuation of residents in the event of a fire to be discussed with the Fire Safety Officer when they visited the centre. Inspectors noted that the Fire Safety Officer issued the centre with an immediate action plan following a fire evacuation of one unit in January 2016. This immediate action plan stated that 'the doors to bedrooms accommodating immobile residents must be widened immediately and beds which are suitable for evacuation provided'. However, inspectors noted that this action had not been completed at the time of the inspection.

Individualised risk assessments were viewed in a residents' PCP's including risks of being a victim of monetary abuse, road safety, the risk of leaving the unit without staff being aware, the risk of choking, the risk of fire and of becoming a victim of any form of abuse.

An 'environmental risk factors' record dated November 2015 was viewed. The frequency of review of the record was stated to be three-monthly. This record outlined restricted access to a unit of the centre which was a locked entrance door that had been risk assessed. The rationale recorded for this locked door was 'to provide a safe environment while maintaining the least restrictive environment possible'. However, inspectors were informed by staff that the current locking mechanism for this entrance door into this unit was unsuitable as there was a risk of the door locking mechanism not securing this door unbeknown to staff. In addition, inspectors noted that there had been a recent recorded incident in March 2016 of a resident who required staff support to maintain their safety whenever leaving the unit however, the resident had left the unit without the knowledge of staff. Inspectors were informed that a request had been sent to maintenance regarding this issue. However, it was noted that this issue had not been remedied at the time of inspection and this identified hazard remained.

The site specific risk register dated September 2015 and reviewed in May 2016 was reviewed by inspectors. The risks identified included abuse, physical and verbal aggression, self-injurious behaviour, unexplained absence, medication management

error and use of restrictive interventions.

Inspectors were informed that there was a weekly health and safety meeting which was held to review any incidents or accidents. Inspectors reviewed incident records, it was noted that there was a system in place for escalating each incident to the person in charge and provider. One resident who was involved in many of the recorded incidents of behaviours that challenge was noted to be scheduled to shortly attend a multi disciplinary case conference, had commenced on a 'functional behavioural assessment plan' and was also being supported by an external agency in relation to these behaviours that challenged.

The units appeared generally clean. However, in relation to infection prevention and control, inspectors observed a strong smell of urine in one unit. This matter was brought to the attention of the person in charge who agreed with the finding. It was also evident that brown staining was present on the floor of some toilets and on the wall directly behind one toilet bowl. Inspectors received a copy of an email dated 11 May 2016 detailing a number of issues in the centre that had been identified by the infection prevention and control nurse. These issues included the requirement to replace the current sinks in one unit, the requirement to install wall mounted towels and soap in the office, the requirement for the installation of toilet bowls suited for assisted ambulant/disabled wheelchair users and the need to replace toilet bowls in certain units. However, to date none of these actions had been taken. In addition, inspectors noted that a toilet seat was missing from one toilet in one unit.

Inspectors reviewed documentation in relation to vehicles used to transport residents. There were records of regular servicing, vehicle registration certificates and the National Car Testing (NCT) certificates in place for these vehicles.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:

Inspectors reviewed the procedure regarding the management of residents' finances. It was demonstrated that this procedure was adequate with receipts kept, double signatures recorded and clinical nurse manager oversight and review was evident.

Inspectors were informed that a 'safety audit and risk committee' reviewed all restrictive practices. The policy and guidelines for the prevention of/use of restrictive interventions was dated as approved in February 2016 and was signed by the positive behaviour support manager was reviewed. Inspectors noted that the document referenced the rights review committee (RRC). The person in charge/clinical nurse manager in consultation with the residents' 'circle of support' submitted the relevant documentation to the RRC. However, inspectors were informed by a number of staff that this policy had yet to be implemented and this was of particular relevance for six residents living in one unit with the locked entrance door. Inspectors noted that none of the residents had access to the key to this door and while four residents had been risk assessed as requiring this restricted access arrangement, two residents did not require this restriction. In addition, the centre's policy required that all restrictive practices and limitations of restrictive interventions were to be documented in the persons' behaviour support plan. However, from a review of the residents' PCP's and according to a number of staff spoken with including the person in charge, such documentation had not been implemented. Inspectors formed the view that the locked entrance door to this one unit in the centre was not in keeping with the centre's own specific restrictive practice policy, national policy or evidence-based practice. Alternative measures had not been considered before the restrictive practice was implemented. It was not evident that the least restrictive procedure, for the shortest duration necessary was being used. In addition, there was no record of any consultations with the residents or their representatives in relation to this locked door arrangement. Inspectors noted that this arrangement had not been discussed within a multi-disciplinary team.

It was noted that one resident in the centre presented with behaviours that challenge including regularly hitting or slapping other residents. This was evidenced by from speaking with staff and records of incidents seen, PCP records and a copy of a case conference held which detailed a number of these incidents. Inspectors noted that there had been 25 recorded incidents of this resident hitting or slapping at both peers and staff in the period from 4 January 2016 to 30 April 2016. There were four recommendations made with regard to further actions to be taken, with details of those responsible for completing the actions and timelines for completion of same. As already acknowledged, this resident was also scheduled to attend a further multi-disciplinary case conference, had commenced on a 'functional behavioural assessment plan' and was also being supported in relation to behaviours that challenge by an external agency. However, this continued level of behaviours that challenge in relation to this one resident was of concern to inspectors, particularly in the context of the subsequent impact of this behaviour on other residents living in this unit.

Inspectors spoke with staff regarding identifying different types of abuse and the management of allegations of abuse. Staff were noted to give an adequate response and stated that they had received training in adult protection and Prevention and Management of Aggression and Violence (PMAV) training.

Residents' meetings were reviewed and were recorded as having occurred each week generally. It was noted that in one particular unit of the centre, five out of six residents regularly attended such meetings. The most recent meeting was recorded as having taken place on 20 May 2016. Issues discussed included menu planning, fire safety, advocacy, complaints, social outings, health and safety and safeguarding and safety.

Records of complaints were reviewed. The most recent record was dated 20 May 2016. It was noted that 11 complaints were made by the same resident regarding being unhappy living in the centre since December 2015. It was also noted that a case conference was scheduled for 10 June 2016 with the resident, their psychiatrist, an advocate and key worker to discuss this matter.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

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

Findings:

Inspectors viewed records of resident annual health checks. It was noted that the following MDT resources were available to residents including speech and language therapy, occupational therapy, dietician, behavioural nurse specialist, general practitioner (GP) and psychiatrist.

It was seen that pictorial menu options were generally available throughout the centre and choice in meals was offered. A 'Baseline Protected Mealtime Audit' of one unit in the centre was viewed by inspectors. An action plan was in place following this audit and included individualised assessments for residents' ability to be as independent as possible. It was noted in this audit that some improvements were required including a picture menu was not available, non-verbal residents were not adequately supported to make choices and that nurses should not leave during meal times to conduct the medication rounds. The PIC informed inspectors that efforts had already been taken to ensure these issues were addressed and informed inspectors that the purpose of this audit was to identify good practice and bring about improvements were necessary.

Inspectors reviewed PCP's for residents who were deemed in need of end of life care. Some residents had an end of life care plan. However, inspectors noted that one resident who was receiving end of life care did not have any end of life care plan in

place. Staff spoken with stated that they had been in contact with the residents' representatives as to possible end of life arrangements and in relation to the residents' wishes in the event of their death. The residents' PCP dated January 2015 included sections regarding end of life including 'if I was to become ill' and 'funeral arrangements' however, inspectors noted that these sections were blank. Inspectors requested the end of life care policy for the centre however, this policy was not provided. 'Care of the Deceased Service User' practice guidelines were presented to inspectors however, this document did not include guidelines on end of life care.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Medicines management practices were examined by a medicines management inspector.

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. There was a medicines management policy in place. Staff with whom the inspector spoke articulated an understanding of medicines management practices in line with professional guidance.

A sample of medication prescription and administration records was reviewed. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications.

The inspector noted that a resident was prescribed a medicine which required regular monitoring of full blood count. An individualised care plan was in place to guide staff in relation to the procedure to be followed by staff who took and sent blood samples for analysis. The care plan clearly outlined the actions to be taken when results are returned, in line with the licensing requirements for this medicine. The inspector spoke with the clinical nurse manager who demonstrated an indepth knowledge of the resident's plan and the associated day to day monitoring of the residents for signs and symptoms of a low blood count.

Staff with whom the inspector spoke confirmed that some residents were prescribed a 'rescue' medicine to be administered in the event of epileptic seizures. However, an individualised protocol had not been developed for each resident who was prescribed this medicine to ensure that the 'rescue' medicine was administered at an appropriate interval to prevent prolonged seizures, which may be potentially life threatening.

The inspector observed that secure storage was provided for prescription only medicines. A secure system of storage was in place for medicines requiring refrigeration. The inspector saw that medicines requiring additional controls (Schedule 2 controlled drugs) were in use in some parts of the centre. However, the process in place, as demonstrated by staff, for the storage of these medicines was not in line with the Misuse of Drugs (Safe Custody) Regulations. In addition, there were gaps in the documentation which demonstrated a robust chain of custody for these medicines in line with the Misuse of Drugs Regulations.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records.

The inspector saw and confirmed with staff that no resident was managing his/her own medicines at the time of the inspection. Members of the management team outlined that the tool to be used to support a risk assessment for this practice was under review to meet the requirements of the regulations.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:

Since the previous inspection of Oakvale, a new person in charge was seconded from another service and appointed to this position in this centre in November 2015. The person in charge informed inspectors that management meetings were now taking place every week to discuss progress in relation to the previous HIQA inspection report.

There was a clear management structure comprised of the acting director of services, the person in charge and clinical nurse managers. The person in charge and the clinical nurse managers spoken with were clear on their respective roles, responsibilities and reporting relationships and described positive and supportive working relationships. During the inspection process staff exercised their individual roles and responsibilities in a confident and competent manner. There were a number of non-compliances identified during this inspection of this centre however, overall inspectors were satisfied that the management systems were sufficient to ensure that the services and supports provided to residents were effectively monitored to ensure their consistency and safety.

For the past six months the person in charge had worked full-time within this centre which was his only defined area of responsibility. The person in charge was an experienced manager with significant experience within the sector and it was clear he had established a positive working relationship with staff including both the clinical nurse managers. The person in charge was suitably qualified for his role and also engaged in all training facilitated by the provider. While relatively new to this centre the person in charge had established experience in the provision of social care supports and services and had completed education and training in relevant areas. The person in charge had a sound understanding of and was willing to undertake the roles and responsibilities associated with this role. There was evidence from the findings of this inspection, from speaking to residents and staff that the person in charge had over the past six months made considerable progress in improving the administration and operational governance and management of the service.

On a day-to-day basis the person in charge was supported by the clinical nurse managers (CNM's) who were also employed on a full-time basis. Both CNM's that inspectors spoken to had established experience in the provision of social care supports and services and had completed education and training in relevant areas. Both CNM's had a sound understanding of residents' needs and supports and were positively engaged to proactively undertake their roles and responsibilities. The person in charge informed inspectors that he attended weekly senior management meetings and provided copies of minutes of such meetings.

Staff said that they had ready access to their respective managers including the person in charge and there were regular staff meetings. In addition and as required by regulation 23 the provider had completed an annual review and an unannounced visit to the centre to monitor and establish the quality and safety of the services and supports provided to residents; these reports had been made available to HIQA prior to this inspection.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Inspectors found that there were adequate numbers of staff on duty in the centre. However, staff informed inspectors that there had been some challenges to both recruiting and retaining staff primarily due to the geographical location of the centre. A planned and actual staff rota was maintained and it reflected the agreed staff to resident ratio as described by staff and as seen by inspectors. Staff spoken with confirmed that there was an adequate number and skill mix of staff appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Staff records indicated that staff had core qualifications suited to their role and records were maintained of training completed post employment. However, it was confirmed by the person in charge that there was no structured staff supervision process or structures established in the centre 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.

A sample of staff files were reviewed by inspectors. It was noted that the provider had not obtained all of the documentation required in Schedule 2 of the regulations for the person in charge of the centre including their relevant qualifications, hours of work and job description. Inspectors noted that the person in charge commenced employment in the centre in November 2015. These gaps were brought to the attention of the acting director of services who informed inspectors that the person in charge is on secondment from another service and their personnel file was not transferred with them on commencement of employment.

Staff training records provided by the centre were reviewed by inspectors and it was noted that there were gaps in mandatory training for a number of staff. For example, from the records reviewed, six staff were not trained in safeguarding, four staff were not trained in Prevention & Management of Aggression & Violence (PMAV), two staff were overdue this training since 05/12/14 and 15/4/16, two staff were not trained in patient moving and handling and one staff was overdue this training since 07/10/15. In relation to fire training, five staff were not trained in fire evacuation and one staff was overdue fire evacuation training since 01/4/14, 18 staff were not trained in fire safety and five

staff were overdue fire safety training since 23/7/15, 09/4/16 and 11/4/16. However, staff presented a copy of the 2016 training schedule to inspectors and outlined that the scheduled training was intended to rectify the above identified training gaps.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

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

Findings:

Only the aspects relating to the outcomes examined on this inspection are included. The medicines management policy required review as it did not adequately detail the requirements in relation to recording medicines administration and self-administration. It was outlined to an inspector that the policy had been reviewed, was in draft form and was awaiting implementation.

Judgment:

Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Vincent Kearns
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002463
Date of Inspection:	25 May 2016
Date of response:	27 June 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

Annual reviews were not formally recorded and this was confirmed by staff. In addition, there was no evidence of multi-disciplinary team (MDT) involvement in the annual reviews, no assessment of the effectiveness of the plan, no proposed changes recorded and no names of persons responsible for pursuing objectives in the plan as required by the regulations.

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

1. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

- Multi-disciplinary team (MDT) annual review of residents' personal plans have been scheduled to occur weekly in the centre with the first scheduled meeting commencing on 24/06/16.
- A multi-disciplinary team (MDT) annual review of every resident's personal plan will be completed by 15/10/16.

Proposed Timescale: 15/10/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Annual reviews were not formally recorded and this was confirmed by staff. In addition, there was no evidence of multi-disciplinary team (MDT) involvement in the annual reviews, no assessment of the effectiveness of the plan, no proposed changes recorded and no names of persons responsible for pursuing objectives in the plan as required by the regulations.

2. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

- Multi-disciplinary team (MDT) annual review of residents' personal plans have been scheduled to occur weekly in the centre with the first scheduled meeting commencing on 24/06/16.
- A multi-disciplinary team (MDT) annual review of every resident's personal plan will be completed by 15/10/16. This review will include assessment of effectiveness of the plan, record of any proposed changes and identification of actions/objectives and persons responsible for implementing these actions/objectives.

Proposed Timescale: 15/10/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Annual reviews were not formally recorded and this was confirmed by staff. In addition, there was no evidence of multi-disciplinary team (MDT) involvement in the annual reviews, no assessment of the effectiveness of the plan, no proposed changes recorded and no names of persons responsible for pursuing objectives in the plan as required by the regulations.

3. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

- Multi-disciplinary team (MDT) annual review of residents' personal plans have been scheduled to occur weekly in the centre with the first scheduled meeting commencing on 24/06/16.
- A multi-disciplinary team (MDT) annual review of every resident's personal plan will be completed by 15/10/16. This review will include assessment of effectiveness of each plan and will take into account changes in circumstances and new developments.

Proposed Timescale: 15/10/2016

Theme: Effective Services

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

Annual reviews were not formally recorded and this was confirmed by staff. In addition, there was no evidence of multi-disciplinary team (MDT) involvement in the annual reviews, no assessment of the effectiveness of the plan, no proposed changes recorded and no names of persons responsible for pursuing objectives in the plan as required by the regulations.

4. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

- Multi-disciplinary team (MDT) annual review of residents' personal plans have been scheduled to occur weekly in the centre with the first scheduled meeting commencing on 24/06/16.
- A multi-disciplinary team (MDT) annual review of every resident's personal plan will be completed by 15/10/16. This review will include assessment of effectiveness of the plan, record of any proposed changes and identification of actions/objectives and persons responsible for implementing these actions/objectives.

Proposed Timescale: 15/10/2016

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:

Inspectors were informed that the current locking arrangements for the entrance door into this one unit was unsuitable as there was a risk of the door locking mechanism not securing this door. In addition, inspectors noted that there had been a recent recorded incident in March 2016 of a resident who had been assessed as requiring staff support to maintain their safety whenever leaving the unit, however the resident had left the unit without the knowledge of staff. Inspectors were informed that a request had been sent to maintenance regarding this issue. However, it was noted that this issue had not been remedied at the time of inspection.

5. Action Required:

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

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

- The risk management policy will be reviewed and updated accordingly to ensure that this policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

In relation to infection prevention and control, inspectors observed a strong smell of urine in one unit. This matter was brought to the attention of the person in charge who agreed with the finding. It was also evident that brown staining was present on the floor of some toilets and on the wall directly behind one toilet bowl. Inspectors received a copy of an email dated May 11 2016 detailing a number of issues identified by the infection prevention and control nurse. These issues included the requirement to replace the current sinks in one unit, the requirement to install wall mounted towels and soap in the office, the requirement for the installation of toilet bowls suited for assisted ambulant/disabled wheelchair users and the need to replace toilet bowls in certain units. However, to date none of these actions had been taken. In addition, inspectors noted that a toilet seat was missing from one toilet in one unit.

6. 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:

•Staining on flooring discussed with maintenance manager on 23/06/16. Advised flooring replacement in bathrooms of unit with strong smell of urine and advised contracted cleaners to carry out deep cleaning in toilet areas fortnightly. This was approved by administrations manager on 24/06/16 and will be fully completed by 31/07/16.

Proposed Timescale: 31/07/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The centre's policy required that all restrictive practices and limitations of restrictive interventions were to be documented in the persons' behaviour support plan. However, such documentation had not been implemented according to a number of staff spoken with including the person in charge. This issue was also confirmed following a review of the PCP's. Inspectors formed the view that the locked entrance door to this one particular unit in the centre was not in keeping with the centre's own specific restrictive practice policy, national policy or evidence-based practice.

7. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

•The organisational Rights Review Committee has developed documentation to oversee and monitor the application of all restrictive interventions within the centre.
•An application for the use of the locked entrance door was submitted to the RRC on 15/06/16 and will be discussed at next RRC meeting scheduled for 29/06/16.

Proposed Timescale: 29/06/2016

Theme: Safe Services

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

In relation to six residents living in one unit with the locked entrance door. Inspectors noted that none of the residents had access to the key to this door and while four residents had been risk assessed as requiring this restricted access arrangement, two residents did not require this restriction. Inspectors formed the view that the locked entrance door to this one particular unit in the centre was not in keeping with the centre's own specific restrictive practice policy, national policy or evidence-based practice. Alternative measures had not been considered before the restrictive practice

was implemented. It was not evident that the least restrictive procedure, for the shortest duration necessary was being used. In addition, there was no record of any consultations with the residents or their representatives in relation to this locked door arrangement. Inspectors noted that this arrangement had not been discussed within a multi-disciplinary team.

8. Action Required:

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

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

- The 2 residents identified as not at risk of unexplained absence are currently in the process of transferring to a community based house.
- A self-locking mechanism for the exit to the unit has been approved and will be completed by 31st August 2016. On completion it is envisaged that the 2 residents who do not present with risk of unexplained absence will have their own access keys to the unit until their transition to a community based house.

Proposed Timescale:

- The two residents will transfer to the community house once this is completed and has attained HIQA registration. It is envisaged that this will occur prior to 31st March 2017.
- The self-locking mechanism will be completed by 31st August 2016.

Proposed Timescale: 31/08/2016

Theme: Safe Services

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

It was noted that one resident in the centre presented with behaviours that challenge including regularly hitting or slapping other residents. This was evidenced by from speaking with staff and records of incidents seen, PCP records and a copy of a case conference held which detailed a number of these incidents. It was evidenced that there had been 25 incidents of this resident hitting or slapping at both peers and staff in the period from 4 January 2016 to 30 April 2016. There were four recommendations made with regard to further actions to be taken, with details of those responsible for completing the actions and timelines for completion of same. As already acknowledged this resident was also scheduled to attend a further multi-disciplinary case conference, had commenced on a 'functional behavioural assessment plan' and was also being supported by an external agency. However, the continued level of behaviours that challenge in relation to this one resident was of concern to inspectors particularly in the context of the subsequent impact of this behaviour on other residents in this unit.

9. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

- Additional one to one support was assigned to the resident in question on 10/06/2016.
- A detailed schedule of activities, in line with the residents' likes and interests, was developed in order to minimise further occurrences of behaviours that challenge with may impact on other residents and on staff.

Proposed Timescale: 10/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Inspectors reviewed PCP's for residents who were deemed in need of end of life care. Some residents had an end of life care plan. However, inspectors noted that one resident who was receiving end of life care did not have any end of life care plan in place. Staff spoken with stated that they had been in contact with the residents' representatives as to possible end of life arrangements and in relation to the residents' wishes in the event of their death. The residents' PCP dated January 2015 included sections regarding end of life including 'if I was to become ill' and 'funeral arrangements' but these were noted to be blank. Inspectors requested the end of life care policy for the centre however this policy was not provided. 'Care of the Deceased Service User' practice guidelines were presented to inspectors however, this document did not include guidelines on end of life care.

10. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

- An end of life care policy will be developed by the policy review group by 31/10/16 which will include guidelines on end of life care which will support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.
- Any resident requiring an end of life care plan will have an end of life care plan in place.

Proposed Timescale: 31/10/2016

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:

The process in place, as demonstrated by staff, for the storage of Schedule 2 medicines was not in line with the Misuse of Drugs (Safe Custody) Regulations.

There were gaps in the documentation which demonstrated a robust chain of custody for these medicines in line with the Misuse of Drugs Regulations.

11. 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:

- Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.
- Updated medicines management policy will be distributed to all staff by 22/08/16.
- A series of information sessions will be facilitated by the policy review group and completed by 30/09/16.

Proposed Timescale: 30/09/2016

Theme: Health and Development

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

The tool to be used to support a risk assessment for self-administration of medicines was under review to meet the requirements of the regulations.

12. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

- Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include an assessment of capacity to encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their

disability.

- Updated medicines management policy will be distributed to all staff by 22/08/16.
- A series of information sessions will be facilitated by the policy review group and completed by 30/09/16.

Proposed Timescale: 30/09/2016

Theme: Health and Development

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

An individualised protocol had not been developed to ensure that 'rescue' medicine was administered at an appropriate interval to prevent prolonged seizures.

13. Action Required:

Under Regulation 29 (4) (b) 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 medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

- Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16. Updated policy will include appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.
- Updated medicines management policy will be distributed to all staff by 22/08/16.
- A series of information sessions will be facilitated by the policy review group and completed by 30/09/16.

Proposed Timescale: 30/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

A sample of staff files were reviewed by inspectors. It was noted that the provider had not obtained all of the documentation required in Schedule 2 of the regulations for the person in charge of the centre including their relevant qualifications, hours of work and job description. Inspectors noted that the person in charge commenced employment in the centre in November 2015. These gaps were brought to the attention of the acting director of services who informed inspectors that the person in charge is on secondment from another service and their personnel file was not transferred with them on commencement of employment.

14. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

- The person in charge is on secondment from another organisation where the personnel file will remain as the person in charge is employed directly by that organisation.
- The centre is presently gathering an alternative file for the person in charge as specified in Schedule 2 and this will be completed by 31/07/16. However in the event that the inspection team wish to view the person in charge file arrangements will be made with the employing organisation.

Proposed Timescale: 31/07/2016

Theme: Responsive Workforce

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

It was confirmed by the person in charge that there was no structured staff supervision established in the centre.

15. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

- The person in charge will formally meet all staff members individually and document same as part of staff support and performance appraisal. This structured staff supervision commenced on 24/06/16 and will be completed for all staff by 31/08/16.

Proposed Timescale: 31/08/2016

Theme: Responsive Workforce

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

Staff training records provided by the centre were reviewed by inspectors and it was noted that there were gaps in mandatory training for a number of staff. For example, from the records provided by the centre, six staff were not trained in safeguarding, four staff were not trained in Prevention & Management of Aggression & Violence (PMAV), two staff were overdue this training since 05/12/14 and 15/4/16, two staff were not trained in patient moving and handling and one staff was overdue this training since 07/10/15. In relation to fire training, five staff were not trained in fire evacuation and one staff was overdue fire evacuation training since 01/4/14, 18 staff were not trained in fire safety and five staff were overdue fire safety training since 23/7/15, 09/4/16 and 11/4/16. However, staff presented a copy of the 2016 training schedule to inspectors

and outlined that the scheduled training was intended to rectify the above identified training gaps.

16. 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:

- A robust schedule of staff training is on-going in the centre since 01/01/2016.
- An updated analysis of current staff training needs will be completed by 01/09/16.
- A schedule of training dates will be developed by 15/09/16 to address any deficits identified.

Proposed Timescale: 15/09/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

An updated medicines management policy was in draft form and was awaiting implementation.

17. 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:

- Medicines management policy is currently under review by the policy review group. Policy will be ratified by 15/08/16.
- Updated medicines management policy will be distributed to all staff by 22/08/16.
- A series of information sessions will be facilitated by the policy review group and completed by 30/09/16.

Proposed Timescale: 30/09/2016