

**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-0011215
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Mary Warde
<b>Person in charge:</b>	Harry Kenny
<b>Lead inspector:</b>	Nan Savage
<b>Support inspector(s):</b>	Finbarr Colfer;
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	99
<b>Number of vacancies on the date of inspection:</b>	5

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

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

From:	To:
26 May 2014 12:30	26 May 2014 17:30
27 May 2014 09:30	27 May 2014 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 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**

This unannounced monitoring inspection took place over two days. As part of the inspection, inspectors met with residents, the provider, the person in charge and staff members. Inspectors observed practices and reviewed documentation including personal plans, policies, procedures and staff files.

The centre comprised of two units and seven bungalows. Inspectors visited a variety of areas within the centre and found them to be clean, warm and there was a pleasant atmosphere throughout.

The inspectors also followed up on the required actions which were identified during the previous inspection in February 2014. These actions related to nutrition, the use of restrictive practices and provision of training to all staff on the protection and safeguarding of residents from abuse. Inspectors found the provider and person in charge with the support of staff had significantly improved practice in relation to these areas and the specific issues identified on the last inspection had been addressed. The inspectors also found that in response to a required action from the previous inspection, the provider had put in place an effective management system and this had resulted in a significant improvement in the provision of quality and safe care for residents.

Inspectors observed good practice in all areas of the service that were inspected although improvements were required. Some fire safety and risk management measures were not adequate and required significant improvement in order to meet with the requirements of the Regulations and Standards. The provider and person in charge were aware of the non-compliances raised by inspectors and outlined plans in motion to address these issues. The provider was required to address these areas as a matter of priority.

Other areas of non-compliance with the Regulations were identified relating to aspects of the staffing arrangements, residents' personal plans, complaints management and the implementation of some draft policies.

The non-compliances are discussed in the body of the report and included in the action plan at the end of this report.

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 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 - Moderate

**Findings:**

Residents had access to an advocacy service. Arrangements were in place to ensure residents and or their representatives were consulted with and had opportunity to participate in decisions about the organisation of the centre. Inspectors saw examples of staff promoting residents' privacy and dignity and there were facilities available where residents could receive visitors in private. There was evidence that residents were able to exercise choice in accordance with preferences and to maximise their independence.

There was a complaints management process in place although some improvement was required to ensure compliance with all requirements of the Regulations and to promote the rights of the complainant. Inspectors saw that a copy of the complaints procedure was displayed in different areas of the centre. The procedure was in an accessible format and included details of persons appointed to deal with complaints. However, the appeals process was not clearly outlined.

While there were Health Service Executive (HSE) guidelines available on complaints management, the provider had not developed a centre specific complaints policy in accordance with the Regulations.

Inspectors viewed the complaints register and found that there had been no complaints received since November 2013. Inspectors noted that a previous complaint had not been finalised. The provider had put in place an action plan to address this outstanding complaint.

**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

**Findings:**

Inspectors found that arrangements were in place to promote the welfare and wellbeing of residents, although improvements were required. Inspectors found that while most residents' had regular opportunities to participate in meaningful activities appropriate to their individual interests and preferences, some did not have sufficient opportunity. Arrangements were in place to meet a number of residents' assessed needs although these arrangements were not consistently documented in individualised personal plans for each resident. There was evidence that some residents were actively involved in the development of their personal plans and that staff provided social support. However, this had not been completed with all residents or their representatives as required.

From the sample of residents' files reviewed each resident had an assessment of their social and healthcare support needs. This assessment was used to develop a personal plan for residents. Generally, the plans were written in a respectful manner and provided clear guidelines to staff on the supports that residents required. While many of the personal plans had been reviewed regularly, there was inconsistency with some plans containing outdated information and some plans not being reviewed when required. The plans were also cumbersome and at times, inspectors found it difficult to locate the most recent and up to date information. While the plans provided direction to staff, they tended to be responsive to issues of concern rather than being outcome focussed and a number of the plans reviewed did not incorporate the wishes and aspirations of residents.

Some residents had an additional accessible version of their plan, however, a significant number of residents did not have this type of personalised plan. Information that had been recorded in available plans, was individualised and person centred on the residents' needs and choices. However, residents' current goals and aspirations had not been documented for a number of residents along with details on how these objectives would be achieved.

Some residents were able to tell the inspector of their involvement in developing their personal plan. However, many other residents or their representatives, where appropriate, had not been involved in the development of their plans and there was

limited evidence of a multidisciplinary approach. The provider acknowledged this and told inspectors about arrangements for the introduction of "key worker" staff that was in the process of being introduced. She stated that one of the responsibilities of the key worker would be to ensure the maximum participation of residents in the development of their personal plans.

The arrangements in place to support residents transition between services was not reviewed on this inspection.

## **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 - Moderate

### **Findings:**

The provider and person in charge had measures in place to promote and protect the safety of residents, staff and visitors to the centre. However, significant improvements were required in aspects of risk management and fire safety.

There was a risk management framework in place, which included a health and safety statement and risk register for each area. There was also a master safety statement dated April 2014 and a draft policy on risk management which included guidance on the identification, recording, investigation and learning from incidents. Formal precautions were in place for specific risks such as missing persons but documented precautions were not available for identified risks in the Regulations including self harm and aggression and violence.

The provider had established a health and safety committee and a health and safety representative had been appointed. Inspectors read minutes of the most recent meeting that took place on 24 March 2014. A range of items were discussed including risk registers, the safety statement and emergency plan.

Risk assessments had been completed by nurse managers in each area. An inspector viewed the risk register in one area and noted that the risk assessments had been recently reviewed. Hazards relating to individual residents and areas including manual handling, slips, trips and falls had been risk assessed although clinical risk assessments had not been undertaken. Control measures had been identified and implemented for identified risks. However, some hazards identified by inspectors had not been formally risk assessed in this area and may pose a potential risk to some residents. For example, inspectors found that the heated water available at residents' hand-wash basins was very hot and that units containing plastic gloves and aprons were readily accessible to all residents. While there were mixer taps available at hand-wash basins inspectors were concerned that the supply of very hot water placed some residents at potential risk of

being burnt. Prior to the inspection, the provider had taken steps to address this risk and reported that measures were being taken to ensure that the hot water supply would be adequately regulated at each hand-wash basin.

Although there was evidence that some fire safety measures were adequately implemented, inspectors identified aspects of fire safety that required significant improvement to ensure the safety of all residents. Inspectors noted gaps between some doors that were used for compartmentalisation in the event of a fire and it was not clear if all doors were adequately fire proofed. Inspectors also found that the way-out from some fire exits was restricted to one fire exit. This could impact on the effectiveness of evacuation procedures in the event of a fire in this area. The provider was requested to furnish to the Authority with a report from a competent person regarding fire safety compliance in the centre including a plan to address any identified fire safety works and timeframe for completion of such works.

The procedures to be followed in the event of fire were not displayed in prominent locations in some areas including a user friendly version for residents.

Inspectors read records that demonstrated staff had completed internal safety checks including daily checks of fire extinguishers. While these checks were up to date in some areas they had not been consistently carried out in all areas. Fire drills had taken place and the effectiveness of the drill and any subsequent corrective action was clearly documented in some areas but not consistently in all areas. Inspectors also found that it was not evident from records viewed that all staff had attended these drills.

Inspectors noted good practice in other areas of fire safety. Staff spoken with were familiar with the centre's procedures on fire evacuation. Staff and the sample of training records viewed confirmed that staff had received up to date formal fire safety training. Personal evacuation plans had been developed for residents and there was a programme for the servicing and checking of fire safety equipment.

There was a comprehensive emergency plan in place which identified what to do in the event of a range of emergencies. The plan also included evacuation procedures and arrangements for emergency accommodation.

### **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:**

Compliant

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

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

**Findings:**

Inspectors found that the provider had put in place adequate measures to protect residents from being harmed or suffering abuse.

Inspectors reviewed the centre's policy on prevention of abuse and responding to allegations or suspicions of abuse. The policy had been reviewed and updated in January 2014 and had been localised to reflect the arrangements in the centre. It provided clear information on how to identify abuse and set out the responsibilities of staff and management in responding to any suspicions or allegations of abuse in a manner that protected the wellbeing of residents.

In response to the previous inspection all staff had now been provided with training in relation to the policy and the protection of vulnerable adults. Staff members were able to tell inspectors how residents were protected from being harmed or suffering abuse and were very familiar with the requirements of the policy and their responsibilities. Inspectors observed staff working in a respectful manner with residents and residents who spoke with inspectors said that they felt safe in the centre.

Inspectors reviewed the arrangements for the management of restrictive practices in the centre and found that the provider had ensured that these practices were being managed in a way that resulted in the minimum adverse impact for residents. There was a register of restrictive practices in the centre which allowed for the identification and oversight of these practices. An inspector reviewed the restrictive practices that had been put in place for three residents. In each situation, the practice was informed by an assessment of need and an associated risk assessment relating to the use of the restrictive practice. There was evidence that the proposed practices had been reviewed by a multidisciplinary team which included mental health professionals, medical professionals and nursing staff. Notes of review meetings recorded the regular review of the measures and actions being taken to reduce the requirement for restrictive practices. In one of the situations, it had been possible to remove the restrictive practice after a period of time. It was very clear from the documentation that careful consideration had been given to the measures being put in place, that they were reviewed regularly and that staff were actively working to develop alternative measures that reduced or eliminated the need for restrictive practices.

Inspectors observed staff working with residents who presented with behaviour that challenges. They found that staff were calm, confident and competent in responding to challenging situations. At all times, they were respectful of the residents and sought to alleviate the anxieties of residents. Staff were very knowledgeable about the residents and were able to tell inspectors about the most appropriate and effective way to work with residents that reduced residents' anxieties and promoted their wellbeing. The interventions and responses of staff reflected the guidelines contained in the personal plans for residents.

The provider had appointed a clinical nurse specialist as a resource to staff in supporting residents who presented with behaviour that is challenging. Inspectors found that this staff member was closely involved in the development of appropriate supports for residents and in ensuring the consistent implementation and review of interventions. In addition, there had been two recent audits of restrictive practices in the centre. Each audit included recommendations and inspectors saw evidence that these recommendations were being implemented. The audits also indicated a significant reduction in the use of restrictive practices in the centre.

Systems in place to manage residents' finances were not reviewed on this inspection.

### **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 - Moderate

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

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

**Findings:**

Arrangements were in place to support residents' health care needs although some improvement was required. There was good access to a medical practitioner and the provider had recently put in place adequate arrangements for residents to access other health professionals including dietetics and speech and language therapy (SALT). However, residents did not have appropriate access to occupational therapy (OT) and physiotherapy services as required. The provider outlined to inspectors plans that were in place to address this issue.

In response to the previous inspection the provider, person in charge and staff had made significant improvements in the area of food and nutrition. The residents' mealtime experience had also improved significantly as there was now a person-centred approach evident in practice and residents' dignity, choice, respect and independence was promoted.

Effective systems were in the process of being implemented to ensure residents' nutritional requirements were met. Since the last inspection, the draft policy on nutrition had been reviewed by the recently established nutritional committee and implemented into practice on 13 May 2014. Nutritional assessments had been undertaken for residents identified at risk and nutritional reviews that had been completed on the last inspection now guided practice. Inspectors noted that the nutritional assessment and reviews carried out by the dietician and SALT had been used to inform personal plans for these residents to ensure that their nutritional needs were consistently met.

Staff reported and training records viewed confirmed that the dietician appointed on 3 March 2014 had provided training on the nutritional assessment tool to a number of staff and further training had been planned for other staff. Inspectors noted that residents' weights and body mass index (BMI) were monitored regularly. All residents were weighed monthly and more frequently when required. From the sample of residents' files reviewed there was evidence that residents previously identified as under the recommended measurements had gained weight and their BMI had increased. The provider had also put in place a SALT service with expertise in dysphasia on 6 March 2014. The SALT had completed an initial review and an assessment for some residents with swallowing difficulties. Staff had also received training on dysphasia and modified diets and fluids. Inspectors found that staff spoken with were knowledgeable of residents' dietary requirements.

Throughout the two day inspection, inspectors found that significant changes had been made during the mealtime experience which resulted in positive outcomes for residents. Inspectors were satisfied that residents were provided with food and drinks adequate for their needs. Residents were offered a varied diet that included choice at mealtimes and in a way that met their needs.

Since the last inspection the menu plan had been reviewed in conjunction with the dietician and a new two week menu-cycle had been implemented. Residents were consulted regarding their meal choices and sufficient food was available should a resident change their mind at mealtime. Meals were served in accordance with residents' special dietary requirements and suitably heated. Refreshments were offered to residents and where appropriate residents were encouraged and assisted to take drinks. Inspectors observed that the mealtime experience was unrushed and dignified. Staff communicated and interacted appropriately with residents during this time, offering assistance in a sensitive manner and second helpings to residents. Inspectors saw that residents were appropriately positioned although one resident was not suitably supported at times. An inspector was informed that this resident had been referred to OT for a seating assessment.

Inspectors reviewed personal plans for residents with a range of other health care needs and found that they generally contained sufficient information to inform staff practice although some plans contained generic information that did not provide up to date and clear instruction to ensure continuity of care in all aspects of their care. An action relating to this matter is documented under Outcome 5.

Residents with diagnosis of epilepsy had a personal plan in place which identified the advanced care required by a resident when a seizure occurred and a seizure management chart was maintained which recorded information including the date, time, duration and management of the seizure. Monitoring included blood screening and review of anti-epileptic drugs (AEDs) took place.

There were no residents actively receiving end-of-life care at the time of inspection. Inspectors noted that resident's end-of-life wishes were recorded as part of an initial assessment that had been completed. There was a policy in place on end-of-life care but this was in draft format.

**Outcome 12. Medication Management**

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

**Theme:**

Health and Development

**Judgement:**

Compliant

**Findings:**

Inspectors found that medication management practices were safe although the policy on medication management required review as referenced under Outcome 18.

Nurses were knowledgeable about the safe administration of medication. Medication was stored in individual containers for each resident and kept in a secure cupboard in each unit. All medication had been individually signed by the doctor, including discontinued medication. Inspectors reviewed the administration charts for a sample of residents and found that they contained the required information. However, some of the entries were very small and difficult to read. A nurse showed inspectors a proposed new prescription and administration chart which would provide more appropriate space for recording medication related information.

**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:**

Compliant

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

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

**Findings:**

Since the previous inspection, a person in charge had been appointed and the provider nominee had increased her presence in the centre and was more actively involved in the management of the centre. These measures had resulted in much clearer and more accountable management arrangements in the centre and had ensured that actions

taken since the previous inspection were effectively implemented and resulted in a significant improvement in the quality and safety of care for residents.

The person in charge and the provider had established processes to facilitate the engagement of all staff involved in the delivery of care to residents. A number of working groups of up to seven staff had been established to work on a range of areas such as the review of work practices and the development of new policies. Some of these pieces of work had been implemented and others were in the process of being adopted. The groups were focussed on improving outcomes for residents and in doing so, achieving compliance with the Regulations and Standards.

Important weekly meetings had also been established since the last inspection to ensure effective management of the centre. For example, a group on nutrition and hydration had been formed which included the person in charge, catering manager, dietician and speech and language therapist. Inspectors saw that the outcome of this group had resulted in positive outcomes for residents.

The centre had undertaken audits of different aspects of the service over the previous year. Inspectors found that a recent review process which focussed on such areas as the management of restrictive practices, nutrition and hydration practices and medication management were more effective than audits alone, in achieving tangible improvements in the quality of care and safety for residents in the centre. The provider and person in charge had developed a programme of further reviews and audits for 2014 which they were in the process of implementing.

The person in charge had been appointed since the previous inspection and inspectors found that he had already established a strong leadership presence in the centre. Inspectors interviewed the person in charge as part of the inspection and had discussions with him throughout the inspection. Inspectors found that he was very knowledgeable about the service and the needs of residents. He was also knowledgeable about staffing arrangements and worked closely with managers in the centre as part of proactive changes. While he fully acknowledged the challenges in the centre as highlighted in the previous inspection report, he was also able to identify very important strengths in service provision in the centre. Inspectors found that he was also familiar with the Regulations and Standards, and engaged with the regulatory process in a positive manner.

### **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 - Moderate

**Findings:**

Recruitment processes were in place although some required documentation to indicate whether staff were fit to work in the centre had not yet been obtained. There were adequate staffing arrangements in most areas to meet residents' needs and the safe delivery of the service. However, during part of the inspection staffing levels in one area did not enable timely support to some residents. From staff rosters viewed there was evidence that residents' received continuity of care. Since the previous inspection, the provider had introduced an accelerated programme of training for staff although a number of staff did not have up to date training in manual handling.

During the inspection, inspectors met with staff and observed staff practices. Inspectors found that staff had responded positively to the significant changes in service provision that had been introduced since the last inspection. Staff told inspectors of the changes that were required in relation to the culture and certain practices within the centre and were aware of the further service developments and changes that were required. Throughout the inspection, inspectors observed staff interacting respectfully with residents in a manner that promoted the dignity of the resident.

Since the last inspection, the provider and person in charge had utilised agency staff to increase staffing levels in some areas. However, an inspector found that staffing levels were insufficient during part of the midday meal in one area. During the inspection, inspectors were informed that there were staff absences in a number of units and that staff had been redeployed from other units to provide cover. Inspectors found that in most areas staff ensured that such arrangements did not impact negatively on the support that residents received. However, an inspector noted that some residents in one location had to wait a considerable length of time before they received their meal while staff attended to the needs of other residents. In other areas inspectors saw evidence of staffing arrangements being effectively put in place to respond to residents who needed additional support. There was also evidence that agency staff had been retained at times when cover was not possible within the centre's staffing resource.

There was no formal assessment of the required staffing levels for each unit based on the assessed needs of residents. The person in charge informed inspectors that staffing allocations tended to be based on historical information about the centre rather than based on the assessed needs of residents. The person in charge was aware of the need for a formal assessment based on residents assessed needs and told inspectors of plans to introduce a more formal decision making process in relation to staffing levels.

The centre had a staff roster in place which accurately reflected staff allocation within the centre. There was a paper based roster which provided information on staff on duty and an electronic roster which included the specific times that staff were on duty.

Since the previous inspection, the provider had introduced an accelerated programme of training for staff, including dignity at work training, mandatory training in fire safety and protection of vulnerable adults. Not all staff had up to date training in manual handling.

The provider informed inspectors that an external trainer had been retained to provide up to date manual handling training to all staff. The provider had developed a training programme for the remainder of 2014, which included such areas as care planning for nurses, further opportunities for staff to attend training on attitudes and behaviour towards client nutrition and hydration, crisis prevention intervention training and nursing practice framework training.

Not all of the required documentation to indicate whether staff were fit to work in the centre had been obtained. The provider had conducted an audit of staff files and had identified the outstanding documentation in relation to each staff member. The provider had requested staff to submit the required documentation by the end of May 2014. Inspectors reviewed the audit and a sample of staff files and found that the audit results were accurate and reflected the outstanding documentation.

### **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 - Moderate

#### **Findings:**

As detailed in Outcomes 7 and 11 some policies were under review or in draft format and had not yet been implemented. As noted in Outcome 1, there was no centre specific policy on the handling and investigation of complaints.

The medication management policy was not reflective of practices and did not provide sufficient direction to staff. The provider was aware of this and the person in charge told inspectors a revised medication management policy was nearing completion.

### **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:***

Nan Savage  
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-0011215
<b>Date of Inspection:</b>	26 May 2014
<b>Date of response:</b>	07 July 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:**

One complaint had not been finalised promptly.

**Action Required:**

Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

Residents file to be reviewed by two managers to elucidate issues of concern as expressed by the complainant and identify and implement learning for the organisation. The complainant contacted by the Person in charge to set up a meeting for 09/07/2014 at which point a decision will be made on action plan which will be acceptable to the

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

complainant.

**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:**

The appeals process was not clearly described in the complaints procedure.

**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:**

Complaints procedure updated to reflect appeals process.

Name person in centre available to residents to assist to make a complaint

**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:**

Some residents' personal plans contained generic information and did not provide up to date and clear instruction to ensure continuity of care.

**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:**

Key worker model of service delivery introduced in the centre on 1st June-this will assist in bringing clarity to personal plans and reflect the lives of the resident through continuity of care and support

Policy on key worker including roles and responsibilities developed and disseminated throughout the centre

Evaluation of key worker process will be undertaken in Quarter 4.

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

**Theme:** Effective Services

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

Some residents did not have sufficient opportunity to participate in meaningful activities tailored to their individual capabilities and interests.

**Action Required:**

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

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

Reconfiguration of day services at an advanced stage-the purpose is to focus on the education training and leisure needs and activities of the residents

Working group in place with key stakeholders including staff and residents from day services, recreation and residential services to develop a cohesive and collaborative approach to the development of a menu of meaningful activities to meet the needs of all residents in the centre. Draft terms of reference developed.

Invitation for expressions of interest for two staff to participate in a pilot project to extend and enhance the activity programme in the centre in progress. The effectiveness of this initiative will be evaluated at the end of 2014.

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Services

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

A significant number of residents did not have access to a user friendly version of their personal plan.

**Action Required:**

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

One of the key roles of the key worker is to develop a user friendly version of their personal plan. This is a priority for Quarter 3 & 4. The aim is all residents will have a person-centred plan in accessible format appropriate to their needs by 31st December

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Services

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

Many residents or their representatives, where appropriate, had not been involved in

the development of the resident's personal plan and a number of residents' current goals and aspirations had not been documented in their plan along with details on how these objectives would be achieved.

**Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Key worker model of service delivery introduced in the centre on 1st June-this will allow for the resident to be involved in the development of their personal plan.

Annual reviews will commence in the centre by 31st July-there is schedule in place for reviews to the 31st December. The key worker has the responsibility of ensuring maximum participation by the resident and /or their family if the resident so wishes.

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Services

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

There was limited evidence of a multi disciplinary approach in some residents personal plans.

**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:**

Members of the newly appointed Multidisciplinary team will be involved in the annual reviews this will be reflected in the person plan.

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

**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:**

Inspectors identified some hazards that had not been formally risk assessed to ensure adequate control measures were in place to prevent potential harm to residents. These hazards related to the unsafe temperature of the hot water supplied at residents' hand-wash basins and residents' accessibility to plastic gloves and aprons that were not stored securely.

**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:**

Risk assessment has been undertaken on the water temperature at hand wash basins. Works to commence the installation of temperature control valves initially in high priority areas will commence week beginning 11/08/2014

Danicentres(storage for gloves and aprons) have been risk assessed in all areas and appropriate control measures put in place to ensure safe environment

**Proposed Timescale:** 12/09/2014

**Theme:** Effective Services

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

Formal precautions were not in place for some specific risks identified in the Regulations including self harm.

**Action Required:**

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

Guideline in place for managing self-harm as part of the risk management policy of the centre as required under regulation 26(1)(c)(iv)

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

**Theme:** Effective Services

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

Formal precautions were not in place for some specific risks identified in the Regulations including aggression and violence.

**Action Required:**

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Risk management policy amended to take cognisance of accidental injury to residents

visitors and staff in order to comply with Regulation 26 (1) (c) (ii)

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

**Theme:** Effective Services

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

Inspectors were not satisfied that adequate precautions were place in all areas to support effective evacuation procedures in the event of a fire.

**Action Required:**

Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

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

A whole centre fire safety risk assessment commenced on 23rd June by Associates Chartered Fire Engineers and Event Safety Consultants. Awaiting a draft report at the end of July. Recommendations from this report will be carefully considered by HSE Senior Management team.

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

**Theme:** Effective Services

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

The procedures to be followed in the event of fire were not displayed in prominent locations or made readily available in some areas including a user friendly version for residents.

**Action Required:**

Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

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

Review of display procedures in the event of fire in progress to ensure they are in a prominent place.

Fire procedures are being transferred into easy read format with the with advocacy group

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

**Theme:** Effective Services

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

Fire drills had taken place but the effectiveness of the drill and any subsequent corrective action was not clearly documented in all areas and it was not clear from records viewed that all staff had attended these drills.

**Action Required:**

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

Audit of fire register will be completed before 31st July  
Action plan based on outcome of audit will be put in place immediately to ensure compliance with 28 (4) (b)

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

**Theme:** Effective Services

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

Some internal fire safety checks had not been consistently completed when required in all areas.

**Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Audit of fire register to be completed by 31st July to identify inconsistencies and ensure fire precautions and safety checks are consistent going forward throughout designated centre

Fire alarm system checked quarterly by external contractor

Emergency lighting checked visually daily and quarterly

Fire fighting equipment serviced annually by external company

**Proposed Timescale:** 30/09/2014

**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:**

Residents did not have appropriate access to occupational therapy and physiotherapy

services, as required.

**Action Required:**

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

Occupational Therapist commenced employment in the centre on 23rd June  
Physiotherapist will be in post by 31st August

**Proposed Timescale:** 31/08/2014

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Some required documentation to indicate whether staff were fit to work in the centre had not been obtained.

**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:**

All documentation Under Regulation 15 (5) and outlined in Schedule 2 has been obtained in respect of all staff working in the centre

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

**Theme:** Responsive Workforce

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

There was no formal assessment of the required staffing levels for each unit based on the assessed needs of residents. During part of the inspection staffing levels in one area did not enable timely support to some residents.

**Action Required:**

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

Additional staff has been sourced and allocated to the area identified by the inspectors,

issues with regard to untimely support identified during the inspection are now resolved.

Working group consisting of representatives of all grades of staff working in the centre to be set up by 18/07/2014 with the specific purpose of developing a plan to ensure compliance with Regulation 15(1). This work will be completed by 31/12/2014

External expertise will be made available to the group

Link with National Disability Authority on progress of assessment tool being developed nationally so that best practice will be accessible to the working group

**Proposed Timescale:** 31/12/2014

**Theme:** Responsive Workforce

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

Not all staff had up to date training in 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:**

There are four moving and handling training days planned for July and August and a further two days in September. All staff will have up to date training on moving and handling by 30th September

**Proposed Timescale:** 30/09/2014

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

**Theme:** Use of Information

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

There was no centre specific policy on the handling and investigation of complaints.

The medication management policy was not reflective of practices and did not provide sufficient direction to staff.

Some other policies were under review or in draft format and had not yet been implemented.

**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:**

All policies under regulation04(1) set out in Schedule 5 of the Health Act 2007 have been developed, signed off and disseminated to all staff in the centre.

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