Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Oakvale
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:	Geraldine Ryan
Support inspector(s):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 December 2016 08:50	12 December 2016 17:00

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

Outcome 02: Communication
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was the fourth inspection of this centre. On 6th November 2015, the Health Information and Quality Authority (HIQA); hereafter called 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, under the auspices of the provider; this centre comprised one of the three centres identified in the district court order. The provider consented to the application and the court applied the conditions.

This report relates to an inspection undertaken on the 12 December 2016 to monitor compliance and identify if continued progress was sustained since the most recent inspection undertaken on the 25 May 2016.

How we gathered our evidence

Inspectors met with 20 residents and staff members. Inspectors sought residents' permission to view their home and review their documentation. The inspectors

observed practices and reviewed residents' personal care plans, medical records, incident and accident logs, policies, procedures, staff files, staff training records, fire safety documentation and risk assessments. The inspectors met with the person in charge, the clinical nurse manager (CNM) two, the CNM one and various staff in each of the units.

Description of the service
The provider's statement of purpose, as required by regulation, described the services provided. The centre opened in October 2011 with the final bungalow opening in 2013. It comprised five bungalows, interconnected by a link corridor, each with their own front door. The centre was developed as a stepping stone facility for residents transitioning to community living accommodation. The stated purpose of the centre was to provide a safe secure home for the service users who were supported to live there. Each bungalow could accommodate six residents with a range of needs including intellectual disability, mobility issues, autism and mental health issues.

Overall judgement of our findings
Overall, inspectors noted that there had been continued progress since the last inspection and evidence of how good practices enhanced the residents' lives; for example, going on outings, achieving goals and access to the community. Staff engaged in a very positive manner with the residents and with the inspectors. Staff, particularly relief staff, demonstrated in-depth knowledge of the residents accommodated in the centre. Residents gave permission for the inspectors to be in their home and stated that they were happy living in the centre. Residents were busy attending various activities or outings over the course of the inspection. Housekeeping was of a high standard. Actions generated from the previous on inspection undertaken on the 25 May 2016 were addressed.

Significant improvements were noted in the following areas:
• communication (outcome 2)
• residents' goal setting (outcome 5)
• submission of notifications (outcome 9)
• the person in charge provided good leadership and was engaged in the operational management and administration of the centre on a regular and consistent basis (Outcome 14).

However, some improvements were required in the following areas:
• premises (outcome 6)
• risk assessment (outcome 7)
• residents' health and clinical care plans (Outcome 11)
• medicines management (outcome 12)
• staff training (outcome 17)
• maintenance of records (outcome 18).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are 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, 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 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors evidenced detailed communication tools which had been developed to guide and inform staff as to the needs of each resident. Staff were aware of the different communication requirements of the residents. Residents' plans captured non-verbal techniques used by residents to communicate. Key information, for example, in relation to fire and complaints, was available in an accessible format.

A number of the residents were non-verbal and engaged in a number of communication techniques. Staff demonstrated their knowledge with regard to the individual communication strategies adapted and used by residents. For example, if a resident wished to go out, have something to eat, were in pain or wished to rest. Each resident had a comprehensive communication plan outlining their particular needs. There was evidence of input from external professionals, (the speech and language therapist (SALT), where necessary and evidence that their recommendations informed the residents' care plan. The SALT's recommendations were incorporated in a visual display to guide staff on residents' specific dietary requirements and of any assistance a resident may require with their meal or fluids.
A distress assessment tool (DISDAT) was used for residents who may not be able to communicate verbally if they were in pain or discomfort.

Residents were facilitated to access assistive technology and aids where required to promote the residents' full capabilities. Residents had access to radio, television, office computer, social media, internet and information on local events. Most residents had their own television or music system and one resident had a computerised tablet.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Residents' personal plans were organised and information was easily retrieved. Plans were available in an accessible format and there was evidence that residents and relatives were involved in planning and reviews. In addition, residents in some units had a personal folder outlining specific information about themselves.

While there was evidence that a comprehensive assessment of the health, personal and social care and support needs of each resident was in place, residents' access to psychology services was limited. The person in charge confirmed that if residents required access to psychology, this was arranged and paid for by the provider. Residents had access to physiotherapy, speech and language therapy and dietetics up to November 2016. These posts had been recently vacated and the person in charge described efforts to engage the aforementioned services.

Residents had access to appropriate services; for example, psychiatry, a general practitioner (GP), clinical nurse specialists (CNS) in positive behaviour support, occupational therapy, chiropody, podiatry, optical and dental services.

From the sample of documentation reviewed, there was evidence that residents were reviewed by a multi-disciplinary team in November 2016. Inspectors reviewed of a sample of plans in each of the five units and found that a detailed person-centred synopsis of residents' needs and routines was in place. There was evidence that plans were updated if there was a change in a resident's need. Some residents' plans were due their annual review in January 2017 and plans were in place for the residents' review meetings.

Considerable progress had been made with regard to residents setting their short and long term goals. There was evidence that status of the residents' goals were regularly reviewed to ensure the goals were being progressed and achieved. Plans reviewed had measurable and specific goals for 2016 and early 2017.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre comprised five ground floor units accommodating 30 residents. Each unit had it's own separate entrance and was linked to the other units via a main corridor. All units had a kitchen, dining room, sitting room, quiet room, bedrooms, housekeeping room, assisted bathrooms, laundry room, sluice rooms, stores room and access to an external paved area. The main reception accommodated administrative offices. Two of the units had a designated staff office and the secure unit had an additional activation room and a games room.

Residents' rooms were comfortable, homely with storage for belongings and individualised with personal items and photographs. Furnishings and décor were well maintained. Residents had access to appropriate equipment such as hoists and slings, shower chairs, seated weighing scales, specialised dining utensils, mobility aids and profiling beds.

However, the following was noted:
- the provision of lighting in the two 2-bedded rooms required review by a suitably qualified person as one central light covered both beds and neither resident had control of lighting; the light was operated from a single switch located by the bedroom door
- insufficient provision of privacy curtaining in the two 2-bedded rooms; only one bed had a privacy curtain
- the door frame to the sitting room in one unit required review and repair
- the lock on a door leading to an internal garden was not functional. The person in charge acknowledged this and stated that he had brought this matter to the attention of the maintenance department and on a number of occasions.

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

Findings:
The centre had systems and processes in place in relation to fire safety and risk management. This included a centre specific risk register; each unit had it's own specific register and each resident had their own suite of individual risk assessments. Inspectors found that risk assessments outlined the actual risk, the existing controls and any required additional controls.

Risk assessments reviewed were up-to-date and staffs' knowledge of risks associated to individual residents concurred with the risk assessment document. Risks discussed included for example, falls risk, residents' skin integrity, behaviours that challenge, restrictive practices and safe manual handling practices.

There was evidence that an audit, safety and risk meeting was convened on a daily basis. Membership comprised management staff from the units. Minutes reviewed evidenced that areas such as incidents, accidents, restrictive practices and residents' individual risk assessments were discussed. There was evidence that resulting action plans were put in place, complete with a staff member identified as responsible for completing the action and by a determined date; for example; scheduling additional training for staff, analysis of residents' incidents, falls and use of a restrictive practice.

The centre had an up-to-date health and safety statement.

Aspects of fire safety were reviewed and records reviewed evidenced the following:
- all fire equipment was serviced annually
- daily checks of escape routes were performed by a designated person
- fire drills were completed and on a regular basis in each unit. A sample of documentation pertinent to fire drills reviewed indicated evacuation times of one to two minutes. There was evidence that residents participated in fire drills.

Residents had a personal emergency evacuation plan (PEEP) capturing their mobility requirement, their cognitive understanding and outlined information in relation to residents who were not mobile. However, fire safety training was outstanding for eight staff and fire evacuation training was outstanding for 18 staff.

The housekeeping and cleanliness in each unit was of a high standard. Staff were observed using protective personal equipment while undertaking housekeeping duties. Doors to sluice and housekeeping rooms were safely secured.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
Measures were in place to protect residents from abuse. Staff demonstrated their knowledge in both safeguarding residents and managing behaviours that challenge. However, some deficits were noted in the provision of staff training in safeguarding vulnerable adults and in the management of behaviour that was challenging.

Staff spoken with were knowledgeable in regard to safeguarding vulnerable residents and were observed interacting with residents in a respectful manner. Residents were observed mobilising at their own pace or accompanied by staff and were observed interacting with, chatting and responding to staff. However, staff training in safeguarding vulnerable adults was outstanding for seven staff.

Notifications were submitted to HIQA in a timely manner.

Residents had detailed personal care plans in relation to intimate care and efforts to preserve the privacy and dignity of residents attending to their personal care requirements were evident.

Where required, residents had a multi-element behaviour (MEB) plan. This was underpinned by the centre's adult protection guide which clearly outlined the types and levels of behaviours. The multi-behavioural support team comprised the person in charge, PPIM, staff and the staff specialist in positive behavioural support. A consultant psychiatrist visited the centre on a regular basis. Staff demonstrated a detailed understanding of why a resident may exhibit a behaviour, and knowledge on how to manage an incident. A review of the residents' MEBS plans reflected clear guidance for staff on how to support a resident who may exhibit a behaviour that may challenge. However, not all staff (18) had received training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Judgment:
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A review of the record of incidents occurring in the centre concurred with notifications forwarded to HIQA.

Notifications as required by the Regulations had been forwarded to HIQA.

Judgment:
Compliant

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Inspectors reviewed a sample of healthcare plans in each unit. Staff spoken to demonstrated detailed knowledge of the care requirements of the residents. While there was robust evidence to indicate that efforts were made to ensure that the service provided was inclusive, safe and appropriate to the residents' needs, a cohort of residents accommodated in some units required review.

Residents with palliative care requirements were accommodated with residents who had differing care needs and who exhibited behaviours that challenge. This was discussed with the person in charge who stated that this matter had been discussed with senior management and all were in agreement that this accommodation required review.

Residents were facilitated with regular and timely access to specialist medical services, and their GP, who was on site on the day of inspection. Residents had access to a

consultant psychiatrist who visited regularly and as required. However, residents' access to psychology services was limited. This was confirmed by the person in charge.

There was information concerning residents' choices and preferences at end of life. However, some residents' personal plans required review to ensure that the assessed healthcare and clinical care needs of residents were met at this time. The clinical oversight of the health and clinical care plans for residents, who required specialist pain management and associated care plans for constipation, oral care, fluid and food intake required review. The following observations were found:

- recommendations from a clinical nurse specialist in palliative care were not included in a resident's care plan for pain management
- while there was evidence that a pain assessment tool was used, a resident's pain management plan contained no reference to guide staff that a pain assessment tool should be used to assess residents' pain
- a resident's care plan for eating and drinking contained no mention of the resident's weight loss or that the resident was prescribed nutritional supplements
- residents with particular oral hygiene requirements and where the dental hygienist recommended stringent oral care had no plans of care to address this matter
- a resident, who required particular bowel care management, had no information in their care plan to guide staff on the resident's recommended daily fluid intake
- care plans for residents with indwelling urinary catheters contained no guidance or a protocol for staff to follow if a resident's catheter was not functioning
- residents' plans of care for safe manual handling required review. Conflicting information with regard to the mobility requirement of residents was documented. For example, one resident's information stated that the resident sat out for a maximum of two hours at a time. However, the healthcare and clinical care needs of the resident required that the resident be nursed full time in bed. Staff confirmed this matter.

Residents' clinical observations (temperature, pulse, respirations, blood pressure and weight) were carried out on a monthly basis. All residents had an annual health check.

Where residents had a noted weight loss, staff recorded the type of food residents consumed. However, the quantity of the food residents consumed was not recorded. The person in charge gave an undertaking to address this matter.

There was evidence of choice at meal time and residents had access to snacks and drinks throughout the day. There was an ample stock of food in the refrigerators and kitchen presses. Daily food temperature checks were recorded.

Judgment:
Non Compliant - Major

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:
This outcome was examined by a specialist medicines management inspector. Medicines management practices were examined throughout the centre. The inspector identified that there was a lack of oversight in relation to medicines management practices in the centre. This lack of oversight had led to inconsistent medicines management practices which posed a significant risk to residents who were prescribed critical medicines where a medication error could have a potentially major negative impact on their health and wellbeing.

The inspector reviewed medication prescription and administration records and spoke to nursing staff on each unit. The inspector also counted the doses of short term medicines to confirm that medicines were administered as prescribed. Gaps in medication administration records were identified on two units; the medication administration record was left blank with no reason recorded. Therefore, it could not be demonstrated that medicines were administered as prescribed. The pharmacy had dispensed 56 capsules of an antimicrobial medicine for a resident with the instruction to administer two capsules four times a day. The medication administration record indicated that 22 capsules should have been administered but the inspector saw that 17 capsules had been administered. Medication administration records did not adequately indicate when the resident was present or absent from the centre. Therefore, it could not be demonstrated that all medicines, including critical medicines for the management of complex medical conditions, were administered as prescribed for the duration of the resident's stay in the centre.

Residents were prescribed medicines to be administered 'when required'. There were clear individualised protocols in place to guide staff in relation to the administration of emergency medicine for the management of seizures. However, care plans in relation to pain management and constipation did not contain adequate information to guide staff in relation to the administration of 'when required' medicines. Therefore, it could not be demonstrated that these medicines were administered as prescribed. Where a resident's pain management care plan clearly stated that a resident was to be administered a particular medication to alleviate pain 20 minutes prior to personal care, there was evidence on the daily staff record, that this instruction was not always concurred with. Staff administered the medication during or after personal hygiene and not as prescribed. Medicine to manage a resident's pain was prescribed to be administered by injection via a particular route. However, the resident's care plan contained conflicting guidance on how the medicine was to be administered to the resident.

Medicines for residents were supplied by a local community pharmacy. The person in charge and nursing staff confirmed that the pharmacist was facilitated to meet obligations to residents under the relevant legislation and guidance issued by the

Pharmaceutical Society of Ireland. Medicines were supplied and labelled for each resident. However, the inspector saw that some medicines had been removed from their labelled containers and tablets from unlabelled blisters of medicines were administered to residents. Therefore, it could not be demonstrated that the medicines administered were those dispensed to the resident.

Secure storage was provided for prescription only medicines. A secure system of storage was in place for medicines requiring refrigeration. Medicines requiring additional controls (Schedule 2 controlled drugs) were in use in some parts of the centre. However, the arrangements in place for the storage of these medicines was not in accordance with the relevant provisions of the Misuse of Drugs (Safe Custody) Regulations.

Medicines 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. However, the inspector noted that some medicines with a reduced expiry date when opened or removed from refrigerator did not have the date of opening or removal recorded. Therefore, staff could not identify the date of expiry for these medicines and segregate for disposal as appropriate.

The medicines management policy outlined that residents were encouraged to take responsibility for their medicines, in line with their wishes and preferences. A comprehensive and individualised risk assessment was available which took into account cognition, communication, reception and dexterity. Appropriate controls were outlined in the policy to ensure compliance and concordance. At the time of the inspection, residents did not take responsibility for their medicines. A CNM outlined that compliance aids had been recently introduced to one bungalow to involve and educate residents in their medicines management.

Judgment:
Non Compliant - Major

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre had a statement of purpose that described the service that was provided in

the centre. While it contained most of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Adults and Children) with Disabilities) Regulations 2013, membership of the senior management personnel required updating.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
Clear lines of responsibility and accountability at individual, team and service level were evident and staff spoken to were aware of their responsibilities and who they were accountable to. The person in charge was in post since October 2015 and arrangements were in place in the event the person in charge was absent. It was evident that the centre was managed by a suitably qualified, skilled and experienced person with the authority, accountability and responsibility for the provision of the service. A culture of quality and safety was evident; a safety, audit and risk committee meeting convened daily. Furthermore, staff voiced how supportive the person in charge was.

Since commencing in post, the person in charge had put the following in place:
- a bi-monthly local managers meeting. Minutes reviewed evidenced that agenda items included policies and procedures, staffing concerns, resident updates, reporting structures, complaints, staff training, care planning and review and residents' community transition plans. All matters raised had associated actions with an identified person responsible for addressing the action and by when. The progress of each action was followed up on at subsequent meetings.
- a safety, audit and risk committee meetings. Minutes reviewed evidenced that agenda items included a review and tracking of information on key performance measures (governance, risk and compliance), identifying non compliance and tracking actions to ensure adherence to the best practice and regulation. Other agenda items included staff training, residents' falls risk assessment, audits, incidents general health and safety concerns, organisational updates and dissemination of relevant information to staff. All matters raised had associated actions with an identified person responsible for

addressing the action and by when. The progress of each action was followed up on subsequent meetings. Learning gleaned included; consistency in recording of incidents, analysis of resident falls, convening monthly fire drills, a reduction in peer to peer incidents.
- unit staff meetings
- daily management health and safety review meetings
- a staff performance appraisal programme had commenced in October 2016.

A staff recruitment initiative was in progress. Inspectors met with staff recruited within the last 12 months. Staff stated that they felt part of the team and were supported in their respective roles. Staff stated how the additional staff had enhanced the lives of the residents, reduced peer to peer incidents and enabled residents to access the wider community. Residents had ready access to transport and this was evident on the day of inspection.

A copy of the unannounced visit undertaken by a director of nursing from a nearby centre under the same entity was made available to the inspector. Where associated actions were generated, there was corresponding evidence in meeting minutes perused that actions were addressed or in the process of being addressed; for example; staff appraisals, an audit of staff training needs.

An annual report was in the process of being completed for 2016.

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

Findings:
The staff numbers and skill mix in the units comprising the centre were appropriate to meet the assessed needs of residents and the safe delivery of services from Monday to Friday. However, the weekend staffing complement required review. Staff training on communication, dysphagia and medicines management also required review.

A particular incident which had occurred the previous weekend necessitated a transfer

to hospital for a resident. A review of the staff rosters indicated that while a clinical nurse manager (CNM) was on duty on the weekend and responsible for managerial oversight of five units, the CNM was not supernumerary. In addition, they were part of a rostered staff complement. The CNM, as senior manager, was required to leave their unit and deal with an incident in another unit. The negative impact of this arrangement was that the staffing in the secured unit was reduced and for a period of time. The person in charge was asked to assess and review this arrangement to ensure that the staffing arrangements met the assessed needs of all residents.

The person in charge and staff confirmed that the introduction of one to one staff for residents who exhibited behaviours that challenge reduced the number of peer to peer incidents. Records reviewed also confirmed this matter.

A training programme was in place for staff and this was confirmed by staff. Staff informed inspectors that they had recently completed a course in palliative care. Staff spoken to confirmed that they had attended mandatory training. However, no staff had attended training in dysphagia (difficulty in swallowing) and the person in charge confirmed this. This was of particular note cognisant of the number of residents accommodated in the centre who experienced difficulty with swallowing and had associated dietary modifications. The person in charge identified that:
- one staff member required training in medicines management
- 24 staff were due training in the prevention of infection. A plan was in place to address this.

Considering that some residents had hearing difficulties with resultant communication barriers, training for staff in alternative ways of communicating with residents who were hard of hearing was not in place. Staff confirmed that while training for staff in this matter had been in place, a decision had been taken by the centre's organisational management team to discontinue the training. There was no clear rationale for this and no alternative training put in place.

A sample of staff files reviewed indicated that the requirements of Schedule 2 of the Regulations in relation to staff documentation were met and that staff had an up-to-date registration with their relevant professional body.

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

Findings:
Only the aspects relating to the outcomes examined on this inspection are included. Some staff did not demonstrate adequate working knowledge of the medicines management policy. For example, some nurses were not aware of the designated section in the medication administration record for recording the administration of medicines prescribed by telephone, facsimile or verbal instruction.

Inspectors saw and staff outlined that the space afforded in the medication administration records to record the administration of medicines prescribed by telephone, facsimile or verbal instruction was inadequate to record the required details at all times.

Medication administration records were not always accurate. An inspector noted that the administration of a pain relieving medicine was not recorded in chronological order.

The medicines management policy required review to ensure that practices met the relevant legislative practices in relation to the disposal of medicines, reporting of adverse drug reactions and the management of controlled drugs.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Geraldine Ryan
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[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002463
Date of Inspection:	12 December 2016
Date of response:	14 February 2017

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:
Residents' access to psychology services was limited.

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

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

Please state the actions you have taken or are planning to take:
Requirement for psychological input was escalated from the site specific risk register to the corporate risk register on 16/01/17.

Proposed Timescale: 16/01/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provision of lighting in the two 2-bedded rooms required review by a suitably qualified person as one central light covered both beds and neither resident had control of lighting as the light was operated from a single switch located by the bedroom door.

There was insufficient provision of privacy curtaining in the two 2-bedded rooms; only one bed had a privacy curtain.

The door frame to the sitting room in one unit required review and repair.

The lock on a door leading to an internal garden was not functional.

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

Please state the actions you have taken or are planning to take:
• Provision of access to lighting for each resident in each of the two 2-bedded rooms was completed on 03/02/17.
• Privacy curtain for each resident in each of the two 2-bedded rooms was requested and approved on 01/02/17 and will be completed by 15/03/17.
• Door frame to sitting room was repaired on 19/12/16
• Lock on door leading to internal garden was repaired is now fully functional.

Proposed Timescale: 15/03/2017

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:
Fire safety training was outstanding for eight staff.

Fire evacuation training was outstanding for 18 staff.

3. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
• Fire Safety officer completed Fire Evacuation training with 18 staff on 18/01/17.
• Fire Safety officer completed Fire Evacuation training with 19 staff on 19/01/17.
• Fire Safety Training was completed for 4 staff on 04/01/17 and will be completed for the remaining outstanding 4 staff by 10/02/17.

Proposed Timescale: 10/02/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Please state the actions you have taken or are planning to take:
• All staff have up-to-date PMAV/MAPA training of which course content includes de-escalation and intervention techniques.
• 13 staff have additional training in Positive Behaviour Support. This additional training will be provided to all staff by 30/04/17.

Proposed Timescale: 30/04/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended training in safeguarding vulnerable adults.

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

Please state the actions you have taken or are planning to take:
All staff will have attended training in safeguarding vulnerable adults by 30/04/17

Proposed Timescale: 30/04/2017

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:
The current cohort of residents accommodated in some units required review to ensure that the assessed needs of all residents were met. Residents with palliative care and end of life requirements were accommodated with residents who had differing care needs and who exhibited behaviours that challenge.

6. 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:
• Set up meeting with Continuing Care Placement Coordinator for East Cork area (responsible for public beds in East Cork as well as assessment of applicants for Fair Deal) to identify how a more responsive service could be developed for residents in Oakvale, for example accessing palliative care or other short terms beds in public units, accessing existing respite or Intermediate Palliative Care bed in Marymount or beds in private nursing homes by 20/03/2017
• As part of the reconfiguration of Oakvale, undertake a mapping of residents needs so provide for a more suitable mix of residents across all 5 bungalows by 28/02/2017.

Proposed Timescale: 20/03/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Recommendations from a clinical nurse specialist in palliative care were not included in a resident's care plan for pain management.

A resident's pain management plan contained no reference to guide staff that a pain assessment tool be used to assess residents' pain.

A resident's care plan for eating contained no mention of the resident's weight loss or that the resident was prescribed nutritional supplements.

Residents with particular oral hygiene requirements and where the dental hygienist recommended stringent oral care had no plans of care to address this matter.

A resident, who required particular bowel care management, had no information in their plan to guide staff on the resident's recommended daily fluid intake.

Care plans for residents with indwelling urinary catheters contained no guidance for staff on the protocol to follow if a resident's catheter was not functioning or was blocked.

Residents' plans of care for safe manual handling required review and updating to ensure that the mobility assistive requirements of residents were correct.

Where residents had a noted weight loss, staff recorded the type of food residents consumed. However, the quantity of the food residents consumed was not recorded.

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

Please state the actions you have taken or are planning to take:
• Every resident who is palliative/end of life care will have a care plan developed appropriate to their specific health care requirements. A template care plan will be developed and trialled by 31/03/17.
• Every resident who is palliative/end of life will have an appropriate plan of health care in place by 30/04/17.
• All identified care plans identified as requiring review will be audited, reviewed and updated accordingly by 31/05/17

Proposed Timescale: 31/05/2017

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:
Antimicrobial medicines were not administered as prescribed.

Medicines had been removed from their labelled containers and tablets from unlabelled blisters of medicines were administered to residents.

Gaps were noted in medication administration records.

Care plans in relation to pain management and constipation did not contain adequate information to guide staff in relation to the administration of 'when required' medicines.

A resident's pain analgesia was prescribed to be administered by injection via a

particular route. However the resident's care plan contained conflicting guidance to staff on this matter.

A resident's pain management care plan clearly stated that a resident was to be administered a particular medication to alleviate pain 20 minutes prior to personal care, there was evidence on the daily staff record, that this instruction was not always concurred with. Staff administered the medication during or after personal hygiene and not as prescribed.

8. 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:
• A system of robust audit of medicines management practices will commence at the centre by 28/02/17.
• Care plans in relation to pain management will be audited, reviewed and updated by 15/03/17.

Proposed Timescale: 15/03/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The arrangements in place for the storage of Schedule 2 controlled dugs was not in accordance with the relevant provisions of the Misuse of Drugs (Safe Custody) Regulations.

9. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
The arrangements in place for the storage of Schedule 2 controlled drugs were reviewed and updated to ensure they are in accordance with the relevant provisions of the Misuse of Drugs (Safe Custody) Regulations.

Proposed Timescale: 03/02/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medicines with a reduced expiry date when opened or removed from refrigerator did not have the date of opening or removal recorded

10. Action Required:
Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

Please state the actions you have taken or are planning to take:
• Medication management policy was updated on 25/01/17 to state that any medicines with a reduced expiry date when opened or removed from refrigerator must have the date of opening or removal recorded.
• A system of robust audit of medicines management practices will commence at the centre by 28/02/17. This audit will monitor medicines with a reduced expiry date to ensure that when opened or removed from refrigerator they have the date of opening or removal recorded.

Proposed Timescale: 28/02/2017

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose required updating with the latest senior management personnel.

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

Please state the actions you have taken or are planning to take:
The statement of purpose was updated on 27/01/17 to reflect latest senior management personnel.

Proposed Timescale: 27/01/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
On weekends, the CNM's remit included oversight and management of the five units comprising the centre. However the CNM was part of a rostered staff complement in one of the units and was not supernumerary. The negative impact of this arrangement was that the staffing in the secured unit was reduced and for a period of time.

12. 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:
The Clinical Nurse Managers who were part of the rostered staff complement will now be supported and facilitated, wherever possible and resources allow, through the rostering of additional staff at weekends, to be supernumery at weekends to ensure efficient and effective oversight and management of the five units.

Proposed Timescale: 03/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No staff had attended training in dysphagia (difficulty in swallowing).

One staff member required training in medicines management.

Considering that some residents had hearing difficulties with resultant communication barriers, training for staff in alternative ways of communicating with residents who were hard of hearing was not in place.

13. 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:
• We are currently sourcing training in dysphagia, and once same has been sourced, the outstanding staff who have not attended any training in dysphagia will have completed training by 14/04/17.
• One staff member who required training in medicines management will have same completed by 28/02/17.
• Training for staff in alternative ways of communicating with residents who were hard of hearing will be sourced.

Proposed Timescale: 14/04/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff did not demonstrate adequate working knowledge of the medicines management policy.

14. 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 will be presented in PowerPoint format to staff in the centre. This will be completed by 31/03/17

Proposed Timescale: 31/03/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medicines management policy required review to ensure that practices met the relevant legislative practices in relation to the disposal of medicines, reporting of adverse drug reactions and the management of controlled drugs.

15. Action Required:
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
Medicine management policy was reviewed and updated on 25/01/17 to ensure that practices meet the relevant legislative practices in relation to the disposal of medicines, reporting of adverse drug reactions and the management of controlled drugs.

Proposed Timescale: 25/01/2017

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The space afforded in the medication administration records to record the administration of medicines prescribed by telephone, facsimile or verbal instruction was inadequate.

The administration of a pain relieving medicine was not recorded in chronological order.

16. Action Required:
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

Please state the actions you have taken or are planning to take:
• Medication administration record for administration of medicines prescribed by telephone, facsimile or verbal instruction was reviewed on 25/01/17 and amended to allow for sufficient space to record.

Proposed Timescale: 25/01/2017