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:	St. Anne's Residential Services - Group M
Centre ID:	OSV-0005162
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Provider Nominee:	Michelle Doyle
Lead inspector:	Kieran Murphy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. 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:
11 April 2017 15:00	11 April 2017 17:00

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

Outcome 05: Social Care Needs

Summary of findings from this inspection

Background to the inspection:
This was the fourth inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 19 May 2015, the second on 3 November 2015 and the third on 24 and 25 October 2016. On all three inspections it was found that the designated centre did not meet the assessed needs of all residents. In particular, the centre failed to meet one individual resident's emotional or social needs.

Following the inspection in October 2016 a meeting was held on 23 November 2016 with the management of HIQA and representatives of the Daughters of Charity Disability Support Services namely, the assistant chief executive officer and the residential services manager. At that meeting the service said that the placement issue had been highlighted by the service themselves and they had escalated the matter to the Health Service Executive (HSE). The purpose of this inspection was to follow-up the on the single issue of whether progress had been made in relation to the placement issue.

In addition, it is a requirement of the regulations that all serious adverse incidents, including allegations of abuse are reported to HIQA. There were four such issues submitted to the Chief Inspector since October 2016. Documentation in relation to these incidents was also reviewed during the inspection. All incidents had been "screened" by the designated officer and a safeguarding plan approved following each incident.

Description of the service:
The centre comprised one house located in a rural village. The centre provided care and support to five residents, two women and three men. All of the residents

attended either work or a day service with one resident participating in a day service coordinated from the designated centre.

In relation to governance of the centre, the person in charge was a registered nurse in intellectual disability. The remit of the role of the person in charge remained unchanged from the previous inspection as she still had responsibility for four designated centres. Since the last inspection, HIQA had been notified that the residential services manager had left the organisation and an interim appointment to this position had been made.

How we gathered our evidence:
The inspector met and spoke with one of the five residents who currently lived in this centre. The inspector also met the person in charge of the centre, staff and the assistant chief executive officer. The inspector also reviewed some residents' personal plans and meeting minutes.

Overall judgment of our findings:
As on the previous three inspections, it was again found that the designated centre did not meet the assessed needs of all residents. In particular, the centre failed to meet one individual resident's emotional or social needs. There was no definitive plan place to resolve this inappropriate placement.

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.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
As on the previous three inspections, it was again found that the designated centre did not meet the assessed needs of all residents. In particular, the centre failed to meet one individual resident's emotional or social needs. There was no definitive plan place to resolve this inappropriate placement.

Following the last inspection a meeting was held on 23 November 2016 regarding this issue, with the management of HIQA and representatives of the Daughters of Charity Disability Support Services namely, the assistant chief executive officer and the residential services manager. At that meeting, the service acknowledged that placement was inappropriate and that the service had escalated this issue to the Health Services Executive (HSE) at regional level.

In relation to residents' assessed needs, care plans had been developed for one resident in relation to "transitioning to a new living environment". This care plan outlined that a funding application had been made to the HSE to progress a transition to a new place to live. The care plan also outlined that a multidiscplinary case review meeting in relation to this resident's placement had taken place in December 2016 and the matter had subsequently been escalated to the Daughters of Charity Disability Support Services internal admissions, discharge and transfer committee. In addition, it was confirmed by the assistant chief executive officer, that this placement was on the waiting list with the local county council.

There was evidence that residents were consulted about any proposed move. A service

user questionnaire regarding accommodation had been completed in November 2016. In addition, an independent advocate had been appointed. The complaints folder had also recorded a complaint from one resident who said they would prefer to live somewhere else other than the current centre.

The service provider had ensured that a formal annual review of the quality and safety of care of the service had taken place in November 2016. This review also identified the inappropriate placement issue. As part of the annual review the service had interviewed residents, with one resident recorded as saying they would like to live elsewhere.

The inspection by HIQA in October 2016 had identified a substantial number of incidents described as "challenging behaviour" that had not been reviewed at staff meetings, by management of by the multidisciplinary team. The formal annual review of the quality and safety of care of the service in November 2016 had identified that not all incidents were clear in their recording or were required. This review had also identified that some incidents should have been referred to the service user protection and welfare policy following a number of "challenging behaviour episodes" directed at specific residents. Since the previous inspection in October 2016 four serious adverse events had been submitted to the Chief Inspector. Documentation in relation to these incidents was reviewed during the inspection. All incidents had been "screened" by the designated officer and a safeguarding plan approved following each incident.

Residents who required support to manage their behaviour had care support plans in place. There was also a "challenging behaviour" risk assessment in place, dated December 2016. This had rated the hazard as high risk. The person in charge confirmed that a psychologist had been recently appointed to the service and their advice and support had been requested in relation to these care support plans.

Judgment:
Non Compliant - Major

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:

Kieran Murphy
Inspector of Social Services
Regulation Directorate

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 Daughters of Charity Disability Support Services Company Limited by Guarantee
Centre ID:	OSV-0005162
Date of Inspection:	11 April 2017
Date of response:	02 May 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:
The centre was not suitable for the purposes of meeting the needs of each resident due to the unsuitable mix of residents in the centre.

1. Action Required:

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

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A business case has been submitted to the HSE in respect of this resident to progress to transition to a new place to live. The resident in question has been provided with the opportunity to view another service and while initially she declined such an opportunity she subsequently agreed to visit on the 27th April 2017. This appointment was postponed by the other provider due to a HIQA inspection in their centre on that day and rearranged for the 3rd May 2017. Should this option not be suitable to the resident other possibilities have also been discussed which she is considering. A referral was made by the social worker to the independent advocate and a meeting was held between them on the 27.4.17.

The ACEO will feedback to the HSE on the outcome of the visit by the resident as to the suitability of it as an alternative placement and the case will be further discussed at the next Service Admission, Discharge, Transfer meeting on the 9th May 2017. The ACEO will continue to communicate with the HSE in respect of this case and the nominee provider will update HIQA as soon as any new information is provided.

Proposed Timescale: 30/05/2017