

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Delta Centre Ltd
Centre ID:	OSV-0003842
Centre county:	Carlow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Delta Centre Ltd
Provider Nominee:	Jim Gogarty
Lead inspector:	Ide Batan
Support inspector(s):	Caroline Connelly;
Type of inspection	Announced
Number of residents on the date of inspection:	12
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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 September 2014 10:15	22 September 2014 19:00
23 September 2014 09:00	23 September 2014 18:00

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

Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of this centre by the Health Information and Quality Authority (the Authority). As part of the inspection, the inspectors met with residents, management and staff members. Inspectors reviewed documentation such as the centre's statement of purpose, person centred care plans, medical records, activities, staff training records, staff files, policies and procedures, fire safety records and the resident accommodation.

The designated centre is comprised of two community houses that are located close together. Seven residents (which includes one respite resident) live in one house, and, six residents live in the other house. The centre supports people with a variety of disabilities and with different levels of abilities and needs. One of the community houses is a bungalow located on the periphery of the local town area and the second community house was operated from a large, detached bungalow in a residential area. In both houses residents have high dependency in terms of support needs.

One of the houses provides care and support to people with an intellectual disability who have additional needs associated with an older age profile. The service provided

at this house is based on a profile of a semi retirement model and typically the residents have a slower pace and movement where their activities and interests are customised to the preferences and energy levels of residents.

All residents attend the organisations day services which provides a range of day activities, learning and development opportunities. The day services also include a multi sensory facility, jacuzzi, large cafe which residents work in, craft shop and sensory gardens. The centre also offers rehabilitative training programmes, adult education links programmes, Sonas, and supported employment in catering and retail. The ethos of the designated centre as outlined in the centre's statement of purpose and function is to ensure that the rights of each individual resident are upheld, including a right to equality, dignity, respect, privacy and safety.

The centre is governed by a voluntary board of directors which also has a number of subcommittees to aid with the development of particular aspects of the service. Services are provided with the financial assistance of the Health Service Executive (HSE) and fundraising. Inspectors engaged at length with the nominated provider, director of services and person in charge during the inspection. Inspectors found that they were all fully engaged in the governance and management of the designated centre.

Overall, inspectors found that residents received a good quality service. There was evidence of compliance, in some areas, of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and this was reflected in a number of positive outcomes for residents.

Staff interactions were seen to be respectful, dignified, and genuine. Residents appeared to be very relaxed in their home and in the care of the staff. The inspectors saw that residents were supported to achieve their best, possible health and to participate in meaningful activities appropriate to their wishes, abilities and needs. Residents were supported to be as independent as possible and to develop and maintain links with their family and friends and the wider community.

While systems were in place to support residents to achieve their personal goals, there was a lack of a comprehensive multi disciplinary assessment to inform the personal planning process. Access to allied health professionals was not satisfactory for some residents. Residents had good opportunities for meaningful social engagement.

The findings of the inspection are set out under ten outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons(Children and Adults) with Disabilities) Regulations 2013.

The inspectors found that the service was also non compliant in other areas of the Health Act 2007 Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, contraventions included:

medication management practices
risk management
evidence based clinical risk assessments
resident and family consultation in development of personal plans and annual reviews
infection control.

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 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

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

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

Findings:

The admissions process was managed by the admissions committee which included the nominated provider/director of services and other allied health professionals. There were policies and procedures in place to guide the admissions process which included residential, respite and emergency admissions. The director of services informed inspectors that all prospective residents and their representatives were afforded an opportunity to visit the centre on numerous occasions and speak to staff prior to admission. However, inspectors observed that the policy did not take account of the need to protect residents from abuse by their peers.

Tintain is a voluntary housing association and residents pay weekly rent through the centre. Residents are provided with a weekly receipt record in a pay slip format. Inspectors saw that all residents had a tenancy agreement in place.

Inspectors found that the centre did not have any written agreements with residents in relation to the terms and conditions of residing in the centre. These contracts/written agreements should detail the support, care and welfare of the resident and details of the services to be provided for that resident and the fees to be charged in relation to residents care and welfare in the designated centre as required by the regulations.

There have been no recent discharges from this service.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The centre consists of two individual houses in the community and residents are provided with access to day services at the main centre. Most residents attended day services however some of residents attended intermittently and participated in activities in their house at other times.

Each resident had access to a written personal plan that detailed their individual needs and choices. This was available to residents in an accessible format. There was a system of key workers in operation whose primary responsibility was to assist the individual to maintain their full potential in relation to the activities of daily living. Inspectors were informed that social care workers and social care leaders who worked with the residents fulfilled the role of individual residents' key workers in relation to individual residents care and support.

These key workers were responsible for pursuing objectives in conjunction with individual residents in each resident's personal plan. There was evidence of monitoring of residents needs including residents' interests, communication needs and daily living support assessments. Some of the plans had agreed time scales and set dates in relation to further identified goals and objectives.

Inspectors were informed by staff that there were a number of options available for all residents in relation to social activities. Inspectors saw that residents with profound disability attended the multisensory day services on the main campus. Many of the residents enjoyed art, music, drama and playing cards. Residents were supported to access and take part in social events and activities of their choices, apart from the activities provided in the centre the rest are community based, are age appropriate and reflect the goals chosen as part of their person-centred plan. Transportation was available at all times for both houses. Inspectors were informed that residents were involved in the day to day running of their homes' including shopping, preparing and cooking of meals within each premises. Inspectors saw evidence of house meetings/discussions taking place.

The inspectors noted that each resident's person-centred plan identified the key people involved in supporting the resident which included family and friends as well as staff and other professionals. There was evidence in some residents' person-centred plans that the resident and their family members, where appropriate, were involved in the assessment and review process and attended review meetings. However, this was not consistent in all plans and in some there was no evidence of ongoing review or of review meetings. In a number of person-centred plans there was no evidence of resident and family involvement and plans were not signed off by family and staff and some were not dated. There was some evidence multidisciplinary team involvement in residents' care including, medical and GP, speech and language therapy, dentist and behavioural therapy. These will be discussed further in Outcome 11 healthcare needs.

There was evidence that residents were supported moving between services and were given guidance in life skills required for the transition to more independent living. When residents health needs increased they were also facilitated to move to a part of the service that met their needs providing higher support if required.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The centre consisted of two different premises located in the residential suburbs of the local town. Tintean voluntary housing is a not for profit organisation and they are responsible for maintenance and management of both houses. All repairs and maintenance matters are reported to them and they employ registered companies such as electricians, plumbers to carry out these works. All aspects of the houses are subject to an annual inspection also and repairs are carried out as required.

Both houses were easily accessible, bright, well ventilated, had central heating and were decorated to good standard. Each of the houses was homely and generally met the needs of residents by making good use of soft colours, suitable furniture and comfortable seating. Inspectors noted that the design and layout of each premises was compatible with the aims of the Statement of Purpose.

There were adequate showers and toilets with assistive structures in place including hand and grab rails to meet the needs and abilities of the residents. There were adequate sitting, recreational and dining space separate to the residents' private accommodation and separate communal areas, which allowed for a separation of functions. Inspectors saw that residents had personalised their rooms with photographs of family and friends. Inspectors observed that the bedrooms in both houses were spacious with adequate storage space. However, in a house inspectors saw there were two shared bedrooms. The residents' privacy and dignity was not maintained in the shared bedrooms as there was no provision of screening between the bed spaces.

Equipment for use by residents or people who worked in the centre included wheelchairs, specialised chairs, hoists, and other specialist equipment were generally in good working order and records seen by the inspectors showed that they were up to date for servicing of such equipment.

Laundry facilities were provided within each premises and were adequate. Staff said laundry is generally completed by staff but residents are encouraged to be involved in doing their own laundry. Inspectors saw that in each premises there was an accessible external outdoor area/garden that was kept safe, tidy and attractive and inspectors observed a number of residents using these facilities. Generally there was garden seating provided and car parking spaces available. Residents could also access a series of interconnecting gardens which offered a multi sensory experience to residents at the main day services campus.

Judgment:
Non Compliant - Minor

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):

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

Findings:

There were systems in place to promote and protect the health and safety of residents, visitors and staff. However, improvement was required in some areas. There was a risk management policy in place however it was generic, it had not been signed off by the management team and it was undated. It did not comply with the Regulations as it did not include:

- measures to control specified risks including unexpected absence of a resident, accidental injury, aggression and self harm,
- arrangements to ensure risk control measures are proportional.

There was a centre-specific safety statement in each house dated 2012. The director of services told inspectors that an external company was contracted to conduct a health and safety review this year. Each house had their own health and safety committee. Risk assessments included fire, chemicals, lone working, medication management, and transport. However, in a selection of personal plans reviewed, inspectors noted that individual risk assessments had not been completed such as clinical risk assessments for any mobility issues such as screening for falls, choking, hearing loss and epilepsy. Inspectors saw that health and safety checks were carried out by the social care leaders in each house, the last checklist was completed in July 2014. Manual handling training was up to date for staff in both houses.

Although emergency plans were in place in relation to fire and flooding, and, staff demonstrated their knowledge of what to do in an emergency situation, this needed to be formalised and documented in a centre-specific emergency plan to take into account all emergency situations and where residents could be relocated to in the event of being unable to return to the centre.

There were some measures in place to control and prevent infection. Inspectors saw two small bottles of hand gels in one of the houses. Inspectors observed in both houses that staff did not routinely wash their hands or use hand gels. Bedrooms did not have hand-washing sinks available and some residents shared a bedroom and a bathroom. A number of residents had specific nursing procedures that required high standards of infection control. Infection control practice needs to be kept under review if staff members need to assist residents with personal hygiene in their bedrooms, they would need to be facilitated with the provision of appropriate hand-washing facilities. In one of the houses the sluice sink was in one of the bathrooms, this does not meet the requirements of infection control guidelines.

The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be comprehensive and fire risk assessments were completed. There were fire plans on display in the houses. The inspector reviewed service records and found that the fire alarm had been serviced in July of 2014. Fire fighting equipment and emergency lighting records indicated that they were serviced annually. Fire drills were completed at least six monthly and records shown to the inspector indicated that the centre carried out fire drills even more frequently. The inspector found that overall the documentation of fire drills included sufficient information to inform and develop evacuation practices. There was an emergency lighting certificate in place dated 10 July 2014.

The training records showed that there was regular fire safety training for the staff. The inspectors found that staff were aware of the fire evacuation procedures and were able to describe the procedures involved. The inspector found that staff on duty at the time of inspection had attended mandatory training in fire safety. An inspector reviewed the maintenance and servicing records for the detection, alarm and fire equipment and found that they were in order and up to date. Each resident had an up to date personal evacuation plan.

Inspectors saw that accidents/incidents were logged and directed through the appropriate channels following an incident. If an incident was related to a behavioural issue it was directed to the behavioural therapist. Clinical issues such as medication were directed to nursing staff. The director of services told inspectors that all incidents were reviewed on a monthly basis by the management team.

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):

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

Findings:

The inspectors found that there were measures in place to protect residents from being harmed or suffering abuse and residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

Policies and procedures were in place for the prevention, detection and response to abuse and were up to date. Staff with whom inspectors spoke knew what constituted abuse and demonstrated to the inspectors an awareness of what to do if an allegation of abuse was made to them. The nominated provider was the designated contact person in relation to protection of vulnerable adults. Inspectors saw that this information was clearly displayed in both houses and in the day services.

Inspectors saw that there was easy read pictorial information in relation to safeguarding also available for residents. There was a comprehensive training programme in place which was also delivered by the nominated provider. Records showed that the majority of staff had received training in 2014 and training for remaining staff that had been on leave was due to take place. There was a policy relating to delivery of personal care to residents.

Inspectors noted a positive, respectful and homely atmosphere that mainly emanated from the easy dialog between residents in their interactions with staff. The inspectors were satisfied that the provider and person in charge had taken adequate steps and safe-guarding practices to protect the residents.

There was a policy on challenging behaviour and inspectors saw that staff had received training on dealing with positive approaches to behaviours that challenge. A behaviour therapist worked onsite two days per week and also provided support to staff in relation to training and debriefing. From a selection of personal plans viewed by the inspectors they noted that behavioural interventions records gave clear directions to staff on how best to prevent or appropriately respond to behaviour that challenges.

There was a policy in place on restrictive procedures. However, there was inadequate evidence available with regard to risk assessing any resident that required the use of restraint. Where restrictive practices were required, a clear system of tracking was not in place which should include the date, time, duration and level of restraint used. There was no evidence available to suggest that procedures for the use of any physical, chemical or environmental restraint were in line with national policy and legal requirements.

There was a policy on residents' personal property, personal finances and possessions. Inspectors saw that residents had easy access to personal money and generally could spend it in accordance with their wishes. Inspectors viewed the systems in place in the houses to safeguard residents' money. Inspectors saw that that residents were provided with receipts and a weekly record in a pay slip format of their charges and contributions. However, the system of allocating and distribution of residents' pocket money was not sufficiently robust in that it was to be taken to each of the resident's houses and then put into the resident's box there. There was little evidence of double checking and signatures in place and the system did not protect the residents or the staff member. The director of service told inspectors that residents' finances were subject to checks and audit internally on a regular basis and externally on an annual basis.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The inspectors found that residents' health care needs were met but improvement was required in accessing allied health professionals. Inspectors saw that residents were assisted to access community based medical services such as their own GP, physiotherapy, speech and language therapy. They were supported to do so by staff

that would accompany them to appointments such as psychology, neurology or psychiatry. Records of these appointments were maintained. However, inspectors saw that resident's files did not outline regular GP reviews and a record was not maintained of all referrals/appointments to allied health professionals. Inspectors saw that in some files residents had not seen speech and language therapist or dietician for over two years.

Inspectors also found that many of the residents had complex physical and nursing needs yet there was no evidence that resident's wellbeing and welfare was maintained by a good standard of evidence-based care and appropriate medical and allied health care as there was little evidence of validated tools in use in the service. There was no evidence of multidisciplinary attendance at residents review meetings in their person-centred plans. As outlined under Outcome 8 a behavioural therapist worked on site. However, there was no evidence that behavioural interventions records were reviewed regularly.

As discussed under outcome 5 care plans for managing residents' specific medical conditions had not been developed. The inspector found that this posed a risk to residents as it could lead to inconsistent delivery of care in areas such as epilepsy, and where residents had medical conditions which required routine monitoring. Inspectors saw in a care plan that a resident had several falls over a period of time. However, no risk assessment had been completed by staff therefore it was difficult to ascertain the measures in place to achieve the best possible outcome for the resident.

Inspectors did not observe any nutritional assessments being completed. The advice of dieticians and other specialists was not evident in accordance with each resident's personal plans. For example inspectors saw that some residents required a soft diet. However, there was no evidence of regular weights being recorded. Therefore there was no evidence of weight loss or gain to assist in evidenced based individual assessment.

Inspectors saw that in each house residents were involved in the menu planning. House meetings were held with the residents to plan out the meals for the week. The staff demonstrated an in-depth knowledge of the residents likes and dislikes. Inspectors saw that where residents required assistance with food it was carried out in a discreet sensitive manner. The residents' where possible, assisted in the food preparation and in the cleaning afterwards.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Practices in relation to medication management required improvement. Inspectors saw that nursing staff were transcribing medications which were not signed or dated and were not co signed by another staff member. This practice was not in accordance with best practice in medication management as the transcriber is accountable for the accuracy of the prescription. There was no evidence that the practice of transcribing was subject to regular audit.

In another instance inspectors saw that a medication had been given to a resident without being prescribed up by a general practitioner. Staff told inspectors that a prescription had been faxed to the GP by the pharmacist. However, there was no evidence of the prescription being verified in any manner in the center which creates a potential risk of error.

There were medication management procedures available. However, it required review in order to meet legislative and best practice guidelines as it did not outline the arrangements in place for disposal of unused or out of date medicines.

The prescription sheets reviewed were clear and distinguished between PRN (as needed), short-term and regular medication. The maximum amount for PRN medication to be administered within 24 hour period was stated on all of drug charts reviewed. The signature of the GP was in place for each drug prescribed in the sample of drug charts examined. Inspectors saw that references and resources were readily accessible for staff to confirm prescribed medication with identifiable drug information. This included a physical description of the medication and a colour photograph of the medication which is essential in the event of the need to withhold a medication or in the case of a medication being dropped and requiring replacement.

Photographic identification was available for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error Staff who spoke to the inspectors were knowledgeable about the resident's medications and demonstrated an understanding of appropriate medication management. Training records indicated that 23 staff had completed medication management training. Medication that required refrigeration was appropriately managed. There were no controlled drugs in use at the time of inspection.

Although the process of medication audits had commenced there was no evidence available that medication management audits were being completed in other houses by either staff or the pharmacist. The inspectors recommend that regular audit and updated training in medication management would establish review and processes to evaluate the use of medication policies and protocols as part of quality care provision and risk management programmes.

There were two registered nurses on site who monitor any near misses or medication errors through the incident reporting system.

Judgment:
Non Compliant - Moderate

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):

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

Findings:

The statement of purpose consisted of a statement of the aims of the centre and a statement as to the facilities and services which were to be provided for residents. The statement of purpose contained all of the information required by Schedule 1 of the Regulations. The statement of purpose was kept under review and last reviewed in September 2014 and was available to the residents in an accessible format. The inspectors found that the statement of purpose was implemented in practice.

Judgment:
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):

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

Findings:

Overall inspectors were satisfied that there were effective management systems in place to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. The nominated provider told inspectors that a

formal system for carrying out an unannounced visit of the designated centre as required by the Regulations was in the process of being organised. Inspectors saw that the management team had commenced audits of the services provided against the national standards and that this was an ongoing process.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre. Staff who spoke with the inspector were able to demonstrate a good awareness of the management team and told inspectors that those involved in the management of the centre were responsive and approachable.

The person in charge for the centre works full-time and has managed the service for a number of years. There was evidence that the person in charge had a commitment to her own continued professional development. The person in charge is a social care leader and also had completed a supervision and management course. Inspectors formed the opinion that she had the required experience and knowledge to ensure the effective care and welfare of residents in the centre. However, she is included in the staffing compliment for the centre and has limited time specified for managerial responsibility.

The nominated provider, the director of services and the person in charge were actively engaged in the governance and operational management of the centre, and based on interactions with them during the inspection, they had an adequate knowledge of 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. Inspectors saw that there was a copy of the National Standards and the Regulations were available to staff in each house along with other relevant documentation.

Inspectors noted that residents were very familiar with the person in charge, nominated provider and director of services. Inspectors saw that residents approached them with issues and to chat during the inspection. Residents and staff in the houses identified the person in charge as the one with authority and responsibility for the service. Staff who spoke to the inspectors were clear about whom to report to within the organisational line and of the management structures in the centre.

Staff who spoke with the inspectors said they had regular team meetings and received good support from the person in charge. Inspectors saw that staff received formal support or performance management in relation to their performance of their duties or continuous personal development.

Inspectors observed that throughout the inspection the nominated provider, person in charge, director of services and staff demonstrated a positive approach towards meeting regulatory requirements and a commitment to improving standards of care for residents.

Judgment:
Non Compliant - Minor

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):

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

Findings:

There was safe recruitment systems in place to ensure that staff employed in the centre were suitable to work with vulnerable adults. Staff files were reviewed and it was found that they contained the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. There was a policy on recruitment and selection.

The inspectors spoke to staff on duty during the inspection; all staff appeared to be competent and were aware of their roles and responsibilities. Staff that worked alone stated they felt well supported by the person in charge and management and could call for advise or assistance at any time. There was a lone worker policy available.

Inspectors saw that in the houses designated nursing hours were provided for residents. The inspectors were satisfied that the staff available during the inspection in the houses was appropriate to meet resident's needs. However, a validated dependency tool had not been completed or used by the organisation to determine the skill mix of staff. Due to the complex healthcare needs of residents, as outlined throughout this report in relation to care planning, healthcare and medication management, inspectors formed the judgement that staffing levels should be formally reviewed.

Inspectors saw that regular supervision for staff took place and that a training needs analysis was aligned to the appraisal system to support staff. Training records confirmed that a number of staff had received training in managerial issues such as supervision, clinical issues such as infection control, training on person-centered plans, occupational first aid, management of behaviour that challenges and medication management.

Inspectors saw that there was a comprehensive induction in place for new staff members. Regular staff meetings took place as observed by inspectors.

There was a planned and actual rota which corresponded with the staff on duty during inspection. There were no volunteers working in the residential service at the time of inspection.

Judgment:

Non Compliant - Minor

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:

Ide Batan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Delta Centre Ltd
Centre ID:	OSV-0003842
Date of Inspection:	22 September 2014
Date of response:	22 October 2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the 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.

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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Inspectors observed that the policy did not take account of the need to protect residents from abuse by their peers.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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:

Admission policy to be amended and updated to ensure inclusion of relevant information/statement regarding safeguarding and protection concerning peer to peer abuse. The admission checklist currently refers to the provision of a residents information pack which includes accessible format information on safeguarding and abuse.

Proposed Timescale: 30/11/2014

Theme: Effective Services

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

Inspectors found that the centre did not have written agreements with residents in relation to the terms and conditions of residing in the centre.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Design, approval, completion and roll out of contract of care (Accessible Format) to each resident. Contract of Care has been designed, completed and approved at organisational board level and is currently being shared, discussed and agreed with each resident.

Proposed Timescale: 31/12/2014

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 of the person-centred plans did not have any evidence of ongoing review or of annual review meetings.

Action Required:

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

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

Person Centred Processes to include annual reviews, including all relevant stakeholders. Annual Timeframe to be instigated and agreed in advance with residents and relevant stakeholders. The first reviews have been completed and remainder to be instigated by 30 November 2014.

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:

In a number of person-centred plans there was no evidence of resident and family involvement and plans were not signed off by family and staff and some were not dated.

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:

Internal review of resident and family involvement in person centred processes to be conducted immediately. Where identification of lack of involvement is highlighted, issue to be acted upon, resolved and documented. This review process to be included on an ongoing basis as part of person centred processes at person In charge level of responsibility. Family satisfaction questionnaire to be distributed to capture additional information from families' perspective – subsequent data to be collated and documented.

The internal review resident and family involvement to be completed by 30 November 2014; Family satisfaction questionnaire to be sent to families by 30 November 2014.

Proposed Timescale: 30/11/2014

Theme: Effective Services

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

Some of the person-centred plans did not reflect the individual residents' goals and lacked a plan of how these goals can be achieved.

Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

While all residents have access to a range of allied health professionals, the organisation will establish a dedicated multi disciplinary team, to include both internal disciplines and invited professionals from external allied support agencies, for example, Health Service Executive personnel. The multi disciplinary team will have responsibility

for ensuring a system of effective and comprehensive assessment is provided to each resident on an ongoing basis and subject to review and this information will be documented and held on residents care plans and person centred plans. Process to be immediately instigated, multi disciplinary team to convene by 28 February 2015.

Proposed Timescale: 28/02/2015

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 residents' privacy and dignity was not maintained in the shared bedrooms with no provision of screening between the bed space.

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:

A dialogue has taken place with affected residents and a system of moveable appropriately designed screens will be trialled for a period of two months. Ongoing feedback will be sought and recorded from residents affected by this intervention.

Proposed Timescale: 30/11/2014

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:

The policy did not include sufficient detail of the measures and action in place to control the specified risks of unexpected absence of a resident.

Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

Current Missing Resident Policy (SD-21) to be reviewed and updated where necessary and updated content to be incorporated into risk management policy folder.

Proposed Timescale: 30/11/2014

Theme: Effective Services

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

The risk management policy did not include measures in place to control violence and aggression.

Action Required:

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

Safety management folder contains safety arrangement SD-14, on management of aggression and violence. Relevant information (re control of violence and aggression) currently held within policy folder SA5-19 (C4) and challenging behaviour policy folder – this content will be reviewed and included/duplicated within safety management folder.

Proposed Timescale: 30/11/2014

Theme: Effective Services

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

Emergency plans were not in place in relation to all emergency situations and where residents could be relocated to in the event of being unable to return to the centre.

Action Required:

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

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

Contingency Plans have been explored and agreement has been reached with a local hotel to provide alternative emergency accommodation if the need arises. The hotel to provide detail of this facility in writing. Agreement has also been reached with a local estate agent to provide a facility of short let housing on an emergency basis if the need arises. He has as of 16 October 2014 provided detail of this facility in writing. Tintean Housing Association will also provide a commitment in writing of their intention to provide alternative accommodation when required by residents.

Proposed Timescale: 31/10/2014

Theme: Effective Services

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

The policy did not adequately cover the precautions to be in place to control the following specified risks such as accidental injury to residents or staff

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:

Use of risk assessment and manual handling of residents form C4 – 087 (C4) to be reviewed and included in residents care plan and risk management folder. This process is to be Initiated by 30 November 2014 and completed by 28 February 2015.

Proposed Timescale: 28/02/2015

Theme: Effective Services

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

The risk management policy did not adequately cover the precautions to be in place to control the following specified risk of 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:

Internal audit of relevant policy documents to be conducted to ensure precautions regarding self harm are adequate and located within relevant policy folders, including risk management folders.

Proposed Timescale: 30/11/2014

Theme: Effective Services

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

In one of the houses the sluice sink was in one of the bathrooms, this did not meet the requirements of best practice infection control guidelines. The inspectors formed the opinion that regular hand hygiene practices were not fully embedded into the culture of the centre.

Action Required:

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

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

Following the monitoring visit, a site visit was conducted by appropriate personnel and the sluice sink has been relocated to an alternative appropriate location within the house – a shower facility attached to the staff room has been adapted as the new location.

A review of hand washing practice and culture is currently being conducted and outcomes of this review including necessary adjustments to practice will be documented and implemented. Relocation of sluice completed by 13 October 2014.
Review of hand washing culture to be completed by 30 November 2014.

Proposed Timescale: 30/11/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There was no record of when physical restraint was put in place and when removed and how frequently the resident was checked when restraint was in place as required by best practice guidelines and by legislation.

Action Required:

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

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

A review of the use of padded bed rails is currently being conducted from a risk assessment perspective – including all relevant allied professionals - and the outcome of this review will ensure the least restrictive alternative system of bed rails will be implemented and reviewed on a regular basis for individual residents.

Proposed Timescale: 31/12/2014

Theme: Safe Services

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

The systems in place for the overall management of residents pocket money was not sufficiently robust to protect residents.

Action Required:

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

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

The system of double checking residents pocket money and finances by two staff members within the centre and double signature documentation is now being implemented across the organisation. An internal review of financial systems regarding all residents monies will be initiated immediately – the results of which, including any adjustments required to improve the current systems, will be implemented.

All staff members involved in management of residents monies will participate on future safeguarding training. An internal review has commenced and outcomes will be implemented by 31 December 2014. Safeguarding training will be delivered by 31 March 2015.

Proposed Timescale:

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:

There was little evidence of multidisciplinary attendance at residents review meetings in their person-centred plans.

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:

As outlined under Outcome 5; (Effective Services) While all residents have access to a range of allied health professionals, the organisation will establish a dedicated multi disciplinary team, to include both internal disciplines and invited professionals from external allied support agencies, for example, Health Service Executive personnel. The multi disciplinary team will have responsibility for ensuring a system of effective and comprehensive assessment is provided to each resident on an ongoing basis and subject to review and this information will be documented and held on residents care plans and person centred plans.

The process to be immediately instigated, multi disciplinary team to convene by 28 February 2015.

Proposed Timescale: 28/02/2015

Theme: Health and Development

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

There was no evidence that resident's well-being and welfare was maintained by a good standard of evidence-based care and appropriate medical and allied health care as there was little evidence of validated tools in use in the service. Inspectors saw that some residents had multi complex care needs. Inspectors observed that there was no link between the person-centred plan and the actual care being delivered. Inspectors saw that there was significant lack of evidence based assessment tools being used for nutrition, skin integrity, behaviours, falls or epilepsy.

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:

Multi-disciplinary team including allied health professionals to be convened by 28 Feb 2015. All residents have a food plan and the malnutrition universal screening (MUST) Tool has been utilised for a number of residents across the organisation – this will be extended to all residents and reviewed accordingly. A HSE food nutrition audit has been conducted and documented within the centre in 2014. A waterlow skin condition assessment C4-104 (C4) is to be utilised across the organisation and relevant documentation will be completed and placed on individual residents care plans.

The policy folder on supporting people with behaviours that challenge contains the following elements: Policy; Care pathway for behaviours that challenge; flowchart for referrals; functional assessment tool; OK health check assessment; health of the nation outcome scale; Referral Policy; target behaviour ranking matrix; self assessment recording chart; ABC guidance and chart; consent forms; risk assessment form; motivation to change form; evaluation tools. To date, this policy folder and system has been facilitated by the organisations behavioural therapist and used across the organisation on an on needs referral basis. The documentation and data associated with affected residents will be reviewed and updated. A review will be held to determine how a relevant assessment tool can be utilised appropriately for all residents.

A periodic health and safety checklist is completed on a regular basis by social care leaders – minimum on quarterly annual basis – this checklist covers 12 areas of inspection including; accident, incident, ill health reporting and Investigation; risk assessment and hazard reporting; lone working; health and safety training; fire/emergency arrangements; first aid; slips, trips and falls; occupational road safety; safety in food preparation environments; infection control; manual handling assessment; drugs and medication.

The organisation currently has in place an epilepsy care plan for every resident with a diagnosis of epilepsy – this follows formal diagnosis by appropriate medical personnel. Assessment information regarding diagnoses will be requested and placed on residents care plans.

The malnutrition universal screening (MUST) tool roll out to be completed across the organisation by 1 April 2015. MUST update training completed by nurses. Waterlow skin condition assessments roll out to be completed for each resident across the organisation by 1 April 2015. Behaviour that challenges relevant assessment tool to be accessed by 31 December 2014 and roll out for residents by 30 June 2015.

Periodic Health and Safety Checklist to continue on quarterly basis.

Proposed Timescale: 30/04/2015

Outcome 12. Medication Management

Theme: Health and Development

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

The inspectors identified a number of areas that medication management was not meeting the requirements of legislative and professional guidelines as identified below.
disposal of medication not reviewed in line with the medication policy
transcribing medications which were not signed or dated
administering medication without a valid prescription.

Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

Adjustments have been made to the medication policy and related forms concerning policy and practices; including disposal of medications, transcribing of medications and appropriate administration of medication based on current prescription in line with Regulation requirements.

Proposed Timescale: 21/10/2014

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

At the time of inspection no unannounced visits had been carried out by a person nominated by the registered provider.

Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

An external assessor will be engaged to visit the organisations designated centres at least once every six months and will provide a report arising out of the visits. In addition to external assessment, ongoing internal visits to each residence will continue and in the future information gleaned from such visits will be collated and documented.

An assessor has been engaged and initial meeting with assessor to occur on 4 November 2014 - completed - with a view to planning future visits. First visit to be completed by 31 March 2015. Information from Internal visits to be collated and documented – process to be initiated by 31 January 2015

Proposed Timescale: 31/01/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

A validated dependency tool had not been completed or used by the organisation to determine the skill mix of staff. Due to the complex healthcare needs of residents, as outlined throughout this report in relation to care planning, healthcare and medication management, inspectors formed the judgement that staffing levels should be formally reviewed.

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:

A formal review of current staffing levels within the centre will be conducted and data collected will be used to inform appropriate staffing levels.

The organisation currently uses the support intensity scale (AAIDD) for residents – the process of conducting the assessments is ongoing. The SIS tool is used to assist in determining the appropriate skills mix of staff providing support and care to residents. Currently there are residents within the organisation with a completed SIS and the SIS will be conducted with all residents across the Organisation throughout 2015. This process is conducted jointly with appropriate personnel from Health Service Executive.

Formal staffing level review to be completed by 30 November 2014. All residents to have a completed SIS by 31 December 2015 – a half yearly review of progress on SIS process will be held mid 2015 and timescale to completion will be affirmed or readjusted if required.

Proposed Timescale: 30/11/2014