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:	Sarshill House
Centre ID:	OSV-0005469
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Health Service Executive
Provider Nominee:	TJ Dunford
Lead inspector:	Julie Pryce
Support inspector(s):	Gary Kiernan
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 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:
20 July 2016 09:30	20 July 2016 17:00

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

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

Summary of findings from this inspection

Background to this inspection:
Following five inspections during 2015 and 2016 of this designated centre which had been operated by the Irish Society for Autism, all of which found sustained high levels of non-compliance with the regulations, HIQA issued a notice of decision to cancel and refuse the registration of Sarshill House on 17 June 2016. In accordance with Section 64 of the Health Act the Chief Inspector made alternative arrangements with the Health Service Executive (HSE) to take over the running of the centre.

HIQA required the new provider (the HSE) to submit weekly reports from this time outlining progress towards bringing the centre into compliance with the regulations. These reports indicated steady and significant improvement. HIQA conducted this inspection of the centre to ensure that the actions undertaken by the new provider were sustained and resulted in continued improvements to the safety and quality of life of residents.

How we gathered our evidence:
As part of the inspection, the inspectors met staff members, the person in charge and the Clinical Nurse Managers. The inspector observed practices and reviewed documentation such as personal plans, healthcare plans, behaviour support plans, accident logs and risk assessments. An interview was carried out with the person authorised to act on behalf of the provider.

Description of the service:
The centre was a detached two story house in a rural setting which provided a residential service for five residents with disabilities.

Overall findings:
The inspectors were satisfied that the progress outlined in the weekly reports was a reflection of actions taken, and that improvements were being made within satisfactory timeframes. This resulted in improved experiences for residents.

Improved practice was identified in areas such as:
• the development of personal plans (Outcome 5)
• significant progress in positive behaviour support (Outcome 8)
• significantly improved management structures and processes(outcome 14)
• availability of staff to provide appropriate care and support for residents (Outcome 17)

Whilst there were clear plans in place to effect further changes, improvements were still required in:
• facilitation of a meaningful day for residents (Outcome 5)
• consistency of staffing (Outcome 17)

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:
Progress had been made towards the development of personal plans for residents, and in the provision of meaningful activities, although assessments and plans were not yet completed.

A template and strategy had been developed in relation to assessments and personal plans. The person in charge and staff had begun to populate these templates for residents. Although none of these were yet complete, and assessments of social care needs had not been completed, inspectors were satisfied with the progress which had been made. To support this process staff training in the development of person centre plans had been scheduled.

Steps had been taken towards the development of accessible versions of personal plans for residents, and pictorial representations of some aspects of the plan were already in place, for example in relation to preferred activities and to support night time routines.

Whilst there were still shortfalls in the provision of a meaningful day for residents, significant developments had been made. For example the provider had sourced a behaviour specialist on a part time basis, and part of the focus of this specialist was to increase the skills of residents to enable them to engage in meaningful activities.

Other improvements included the introduction of a record of activities in the personal panning template, and the increased use of communication systems of residents. All staff had now been trained in an augmentative communication system used by one of

the residents.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Systems were being put in place in relation to the assessment and management of risk, and whilst some systems were in place in relation to fire safety, improvements were required to ensure all staff were fully aware of the needs of residents in the event of an emergency.

Fire safety equipment had been tested regularly and appropriately serviced. Fire safety training had been provided to staff, regular fire drills had been conducted and there was a personal evacuation plan in place for each resident. However, the personal evacuation plan for a resident with whom staff had encountered difficulties during a recent fire drill had not been updated to reflect this. In addition not all agency staff were aware of the requirements of each individual resident should an evacuation be required in an emergency.

Risk assessment and management plans were in place for various risks, both environmental and individual, for example in relation to kitchen safety, and in relation to interactions between residents. A risk register was in place and was kept under regular review.

An appropriate safety audit had been conducted which identified areas for improvement, timeframes and persons responsible. Those actions reviewed by the inspectors had been implemented.

There was a system for the recording and reviewing of accidents and incidents. Any incidents were recorded in detail and included statements from witnesses. The records were thorough, comprehensive and outlined corrective actions required and provided for follow up and learning.

Judgment:
Substantially Compliant

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:
Significant improvements had been made in the management of challenging behaviour, and although not all residents as yet had a behaviour support plan in place, the inspectors were satisfied with the progress that had been made.

As mentioned in outcome 5, there was now a behaviour specialist on a part time basis. This specialist had completed assessments and behaviour support plans for some of the residents, and outlined plans for those that were outstanding. Of those plans that were in place there were goals set and steps identified towards reaching these goals, and detailed instructions for staff as to how the support plans should be implemented. There were also clearly documented records of the implementation of the plans.
There had also been improvements in the management of restrictive interventions, for example doors to living areas which had previously been locked for portions of the day were no longer locked.

The procedure for the management of residents' personal monies had been revised, and two signatures were now required for each transaction in order to make the process more robust. However this had not been implemented in the records examined by the inspector, and there was still only one signature for each transaction.

Judgment:
Substantially 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:
Significant improvements had been made in the management of healthcare needs for residents, in particular in relation to highly restricted diets, and in the access to members of the multi-disciplinary team (MDT).

Resources had now been made available to facilitate residents to access appropriate members of the MDT. Each resident had now been assessed by a dietician and there was a report on the appropriateness or not of the restrictive diets which had been in place. A nutritional care plan had been developed for each resident and a meeting had been set to involve families of residents in any suggested improvements in diets prior to the implementation of the new care plans. These plans included menu suggestions.

Whilst comprehensive assessments including the need for involvement of members of the MDT were not yet complete, assessments had been carried out on all residents by the speech and language therapist.

The inspectors were satisfied that sufficient progress had been made towards ensuring effective healthcare for each resident, and that adequate plans were in place for continued improvement.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
Improvements had been made in the management of 'as required' (p.r.n.) medications, and in the management of any drug errors.

Prescriptions for p.r.n. medications included all the information required by the regulations, and there were now detailed protocols in place including the conditions under which the medications should be administered.

The Clinical Nurse Manager 3 had identified a significant medication error during a medication audit, and had drawn up an action plan to ensure that drug errors were kept

to a minimum, and managed appropriately if they did occur, including the introduction of a twice weekly spot check, and the mandatory reporting of any medication errors to the general practitioner.

Plans were presented to the inspectors in relation to both formal and informal training for staff.

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

Findings:
There was evidence of much improved support for the person in charge to carry out her functions, including evidence of protected time to discharge her responsibilities.

Following the notice of decision to cancel and refuse the registration of Sarshill House, as operated by the Irish Society for Autism on 17 June 2016, the HSE took over the running of the centre, in conjunction with a third party organisation who were overseen by the HSE.

The management structure had been reconfigured to include the oversight of a Clinical Nurse Manager (CNM)3 to support and supervise the person in charge, and a CNM 1 as a full time support to the person in charge. In addition a shift co-ordinator was identified on each shift in relation to the allocation of tasks, which had led to a more structured day for residents. There was now a clear reporting relationship defined for each member of staff.

The new provider had ensured that there were sufficient funds to meet the needs of residents. The provider demonstrated an awareness of the necessity to conduct unannounced visits to the centre on a six monthly basis, and to prepare for the Chief Inspector an annual review of the safety and quality of care and support in accordance with the regulations.

The inspectors were satisfied that the new management arrangements had already resulted in improved outcomes for residents, and that the plans for continued improvement were appropriate.

Judgment:
Compliant

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Improvements had been made in staffing levels and staff training, although plans to introduce staff supervision had not yet been implemented.

Inspectors were satisfied that there were sufficient staff to meet the needs of residents, including one-to-one staff for two residents, the addition of a CNM1 and the newly introduced role of shift coordinator. There was evidence that the frequency of incidents of concern between two residents had significantly reduced since the improvement in staff numbers.

There was still a reliance on agency staff, and not all those engaged by the inspectors could display sufficient knowledge of the needs of residents, including evacuation needs or specific night time routines required in relation to challenging behaviour. However evidence of recruitment for permanent staff was presented. The CNM3 outlined plans for the management of new staff to ensure consistency and continuity for residents in the centre.

Staff training records examined by the inspectors showed that all mandatory training was up to date. In addition training had been given to staff in relation to augmentative communications system in use by one of the residents, and in relation to nutrition for some staff.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Action Plan

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Provider's response to inspection report[1]

Centre name:	Sarshill House
Centre ID:	OSV-0005469
Date of Inspection:	20 July 2016
Date of response:	07 September 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While a lot of work had been done to date towards assessing the needs of residents, developing personal plans and supporting residents to meet their assessed needs, this was a work in progress and was not completed by the time of this inspection.

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

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

Please state the actions you have taken or are planning to take:
1. Training has been completed with all staff in the area of PCP and Assessment care planning. Assessment Care Plan documentation in place and completion of same is ongoing. Daily Living and Needs Assessment sections will be completed by 05/09/2016. Assessment of Need and Support Plans will be systematically completed.
2. Person Centred Plans are in the process of being completed in line with above and will be completed by 30/09/2016.
3. Activity Plans implemented since 25/08/2016. Daily visual schedule in place in picture board format and in portable easy read folders relevant to each resident. A weekly visual timetable in easy read format will be implemented by 30/09/2016 to support the residents to plan their week.
4. Lámh, Picture Exchange, Visual Schedules and Social stories are in place to support resident's communication needs with their daily activities and Positive Behaviour Support recommendations.

Proposed Timescale: 30/09/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in personal evacuation plans and in staff knowledge in relation t individual safety needs of residents.

2. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
1. A positive behaviour support recommendation was put in place for "Promoting Awareness of Fire Drills". This commenced implementation on 13/08/2016 via a social story that includes residents becoming more familiar with the sound of the fire alarm, awareness of nearest exit doors during evacuation and location of the fire assembly point. Planned fire drills have taken place on alternate days over a two week period and unplanned drills will now commence once a week for a period of 4 weeks to further customize residents to evacuation routines.
2. All Personal Emergency Evacuation Plans will be reviewed and amended accordingly to reflect all difficulties that may be present. These Plans will be made available to all staff and will be discussed at next staff meeting on 07/09/2016. All staff will be required to sign indicating that they have read and understood same.

Proposed Timescale: 07/09/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** A new policy outlining robust systems of managing residents' personal finances had not been implemented. **3. 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:** 1. New finance records for residents implemented on 01/09/2016. 2. Spot checks will be completed weekly by PIC and an Audit form/check list will be completed and will be reviewed by CNM3. 3. Protocol put in place on 30/08/2016 for safekeeping of resident's ATM cards and signing in/signing out for same by staff and PIC.
Proposed Timescale: 02/09/2016

Outcome 17: Workforce
Theme: Responsive Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Whilst plans were in place to recruit permanent staff, this was a work in progress and was not completed by the time of this inspection. **4. Action Required:** Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. **Please state the actions you have taken or are planning to take:** Currently staff group is made up of 11 permanent staff and 7 Agency staff fill the temporary positions. All steps are taken to ensure continuity using this group of staff. The temporary staff are considered to be regular at this point as the majority have worked in the service in excess of 6 months. Interviews took place in August in order to fill these temporary positions and it is envisaged that following appropriate recruitment process new staff should be in place by end of October 2016.
Proposed Timescale: 31/10/2016