

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Boroimhe
Centre ID:	OSV-0002390
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Maureen Hefferon
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
06 April 2016 10:00	06 April 2016 20:00
07 April 2016 09:00	07 April 2016 14:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
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 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:

This was an announced 18 outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision. A previous inspection had been carried out in this centre in September 2014. The inspector reviewed the actions the provider had undertaken since this inspection and found that for the most part the actions had been completed; however one action relating to safe and suitable premises had not been completed.

As part of the application for registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA). All documents submitted by the provider for the purpose of application to register were found to be satisfactory.

Description of the service:

The centre is a seven bedroom community home operated by St Michaels House. It is situated in north County Dublin and supports both male and female residents. It is located near public transport, shops and local amenities.

How we gathered evidence.

Two family questionnaires and six residents' questionnaires were received by the inspector on the first day of the inspection. The views outlined in these are included in this report. As part of this inspection, the inspector met with residents and staff members. Practices were observed and the documentation reviewed included care plans, accident logs and residents meetings. While the person in charge had been interviewed at the last inspection, over the course of the inspection they were found to be knowledgeable of the resident needs, responsive to any issues identified and demonstrated good leadership skills. The person in charge, provider nominee and the service manager attended the feedback meeting.

Overall judgment of our findings:

Overall the inspector found that the residents had a good quality of life in the centre and that staff were knowledgeable to support residents' needs. However, one outcome was found major non-compliant under safeguarding. The inspector was not assured that appropriate procedures were followed after a safeguarding issue was reported to staff in the centre. These along with other non-compliances are discussed throughout the body of the report. The action plan at the end of this report outlines the changes required.

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 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that residents' rights and dignity were maintained. However, improvements were required in relation to the implementation of the finance policy in the centre.

It was evident from speaking to residents and reviewing documentation that residents were consulted on how the centre was run. For example, residents told the inspector about residents meetings that were held every Monday in the centre. The inspector reviewed the minutes of these meetings, and found that issues discussed included menu planning, fire safety, activities and laundering clothes in the centre.

There was a complaints policy in place and it was displayed in a user friendly format in the centre. Residents spoken to stated that they knew who to make a complaint to should the need arise. This was also confirmed through the information contained in the residents and family questionnaires received by the inspector.

There was one complaint on file on the day of the inspection. The inspector found that this issue had been addressed at the time it was made. However, through the review of documentation and in speaking to the complainant, the inspector found that the nature of this complaint was still an ongoing issue and as such the complainant was not satisfied with the outcome of the complaint.

Staff spoken to were very knowledgeable about the residents needs and were observed to treat residents with dignity and respect. Residents were seen to be facilitated to exercise their rights in the centre. For example, the inspector saw pictures of some of

the residents preparing to vote in a recent election. In addition residents were enabled to take risks within their day to day lives. For example many of the residents travelled independently on public transport and stayed in the centre on their own for periods during the day.

Intimate care plans were in place where appropriate, however some were not detailed enough to guide staff practice so as to ensure that residents dignity was maintained. This was discussed with the person in charge.

There was a finance policy in place; however the inspector found that aspects of this were not implemented into practice. For example, residents did not have financial passports in place to guide staff practice. The inspector viewed a sample of residents' financial records and found that there was an effective system in place to safeguard residents' finances. The person in charge audited financial records as did the person completing the unannounced quality audit of the centre.

There were no CCTV cameras in operation in the centre.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that residents' communication needs were being met and residents had opportunities to participate in the local community in line with their individual preferences.

The inspector viewed two communication plans for residents and found them to be effective enough to guide staff practice. For example, one communication plan stated that a resident required pictures to understand and assist them in making choices. The inspector found good evidence of information that had been developed into a user friendly format for residents including: a stay safe programme, the statement of purpose, staff rosters, weekly schedules and pictorial menus.

Residents had access to television and radio. A laptop had recently been purchased that provided internet access for residents. The inspector saw one resident researching a venue on the internet for an upcoming celebration. In addition, one of the residents

informed the inspector that they liked to get a newspaper in the local shops at weekends and during the week.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:

Overall the inspector found that positive relationships between family members and residents were supported and families were actively encouraged to visit the centre and be involved in the residents' lives.

There were no restrictions on visitors to the centre in line with residents own wishes. There was a local visitor's policy in place confirming this. Residents had their own bedrooms and had access to areas in the centre where they could meet visitors in private.

The questionnaires completed by residents and family members, indicated that families were actively involved in the residents lives. Family members were invited to attend residents' annual review meetings. Two residents who met with the inspector spoke about family visits home. On the day of the inspection, one of the residents was going out with a family member for the evening.

It was evident from talking to residents that they were involved in the local community, one resident spoke about their neighbours and some residents had part time jobs in their local community. Over the course of the inspection the inspector observed residents attending a variety of activities and it was evident that residents had a full and varied social life in the community.

Judgment:
Compliant

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there was an admission policy in place and each resident had a contract of care. However, improvements were required in residents' contracts of care and the transition process for one resident.

There was an admission policy in place in the centre. One resident had been admitted to the centre last year. The inspector found evidence of a clear transition plan that had been reviewed to assess its effectiveness. The resident's family had indicated on their questionnaire that they had been included in the process and had an opportunity to visit the centre prior to the resident's admission to the centre. However, one allied health professional involved in the care of the resident had not been involved in the transition process. This was recorded in the minutes of the review meeting held, where it was stated, that the resident's transition may have been supported in a different way if the allied health professional had been involved in the transition process for the resident.

Residents in the centre had been consulted about the new admission to the centre and support had been given to residents around concerns they had prior to this resident being admitted to the centre. The inspector saw evidence where one resident was finding it difficult to adjust to a new person moving into the centre. While it is acknowledged that this resident had received a lot of support from the psychologist and the staff in the centre around this, it was difficult to assess the real impact this support was having for the resident it was still an issue highlighted by the resident. This was discussed at the feedback meeting.

Each resident had a contract of care, which had been signed by the resident; however, not all contracts where appropriate had been signed by a representative of the resident. While the inspector was informed that residents could read or were able to understand information when something was read to them; the inspector was not satisfied that this had been fully assessed. For example, the inspector spoke to one resident about their contract of care and it was not clear whether they fully understood the information contained in the contract.

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that residents had opportunities to participate in meaningful activities that were appropriate to their interests and preferences.

Each resident had a personal plan and the inspector found that aspects of the plan in relation to social care goals had been developed into a user friendly format. The annual review reports viewed, showed that residents and family members were involved in this process. Residents were involved in who attended these reviews. For example one resident who did not wish family members to attend the review had this choice respected.

Residents spoken to were able to tell the inspector about their goals for the year and this was verified in the personal plans. Examples of social care goals included going on holidays, going to a concert and going greyhound racing.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Overall the inspector found that the location and layout of the centre was suitable for its stated purpose. However, an action from the previous inspection had not been completed, as an additional showering facility had not been installed as required to meet residents' needs.

At the last inspection, it was identified that residents had only access to one shower room upstairs in the centre and that this was not adequate to meet the needs of the residents. The action plan submitted to the HIQA, included plans to install a second shower facility in the centre. However, this had not been completed.

The inspector spoke to the person in charge and the provider nominee about the outstanding action in relation to shower facilities. While the inspector saw evidence of discussions around plans to try and find a solution to this problem, there was no evidence of a clear plan to address the issue. The inspector found on speaking to staff, that this issue was impacting on one resident in the centre in the morning times, when sometimes their needs could not be appropriately met due to another resident using the shower.

In addition the inspector found that residents did not have access to a second shower room upstairs in the centre. The residents also informed the inspector that they would like to have additional showering facilities and were aware of the providers' plans to try and address this issue.

Each resident had their own bedroom. There were adequate communal areas for residents to meet friends/visitors in private. There was a large kitchen dining area with adequate cooking and storage facilities. Residents had access to a utility room and had the opportunity to launder their clothes on certain days if they wished.

There was a garden to the rear of the property that was well maintained. The inspector was informed that new garden furniture was to be purchased for the summer and residents had access to a barbeque.

There were systems in place for the disposal of clinical and general waste in the centre.

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there were policies and procedures in place for risk management and emergency planning. However, improvements were required in individual risk management plans, fire safety and the management of infection control in the centre.

There were emergency evacuation procedures in place that outlined the measures to be taken in the event of an emergency. An emergency pack was available in the centre. Each resident had a personal emergency evacuation plan (PEEP) contained in their personal plans. Some residents stayed in the centre for short periods during the day on their own. One resident spoken to was able to tell the inspector, what they would do in the event of a fire. However, the fire records did not show evidence of fire drills being completed when residents were on their own in the centre.

Suitable fire safety equipment was provided and there was an adequate means of escape, including emergency lighting. Fire exits were unobstructed. All staff had completed training in fire safety with the exception of one staff. Fire records were kept which included details of fire drills, fire alarm tests and the maintenance of fire fighting equipment. However, the fire drill records did not record the names of staff and residents involved in the fire drill.

There was evidence of learning from previous fire drills that had been updated in residents PEEP's however, it was not reflected in the fire evacuation procedures in order to guide practice. In addition, the same control measures had been implemented for two residents. For example the fire drills showed that two residents responded well to fire drills when they were allocated some responsibility. Both residents were now being asked to carry the emergency pack during fire drills, however there was only one emergency pack available in the centre.

There were risk management procedures in place and the inspector saw risk assessments related to the centre. Residents had individual risk management plans in place, however one risk assessment for the management of violence and aggression required more detail.

Incidents were recorded on an e-form and copies were maintained on residents personal plans. There had only been a small number of incidents in the centre in the last year and the inspector saw evidence of how the person in charge had reviewed these at staff meetings.

There was an infection control policy available in the centre; however there was no evidence in one resident's plan of infection control measures in place to minimise the risk of cross contamination.

There was no bus available in the centre. Staff used their cars to transport residents as required. The person in charge maintained insurance certificates for staff cars and was aware of their responsibility to ensure that certificates of the road worthiness of staff cars were on file where appropriate.

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there were measures in place to protect residents from being harmed or suffering abuse. However, improvements were required in relation to a safeguarding issue that had been reported to staff in the centre. In addition improvements were required in behaviour support plans.

There was a policy on, and procedures in place for, the prevention, detection and response to abuse. All staff with the exception of one had completed safeguarding training. The residents spoken to and information from residents' questionnaires found that residents stated they felt safe in the centre. Staff spoken to were knowledgeable about what constitutes abuse and were aware of the reporting procedures in place, however the inspector did not see evidence of this in practice in relation to one safeguarding issue that had been reported to staff in the centre by a resident. This safeguarding issue had not occurred in the designated centre.

Prior to the inspection, HIQA had been notified of a safeguarding issue. As part of this inspection, the inspector reviewed procedures that had been followed in relation to this incident. In addition the inspector was shown a copy of the preliminary screening report that had been completed by the designated liaison officer. The inspector found a number of failings pertaining to this allegation that included:

- The incident had not been reported to a senior manager as per the service policy.
- The e-form had not been completed until 15 days after the allegation was made. The inspector viewed this form and the report that had been recorded by the staff on the day of the allegation and found that the information was inconsistent in both reports.
- The preliminary screening report viewed by the inspector found inconsistencies. For example the report stated that the designated liaison officer had discussed the incident with the person who received the allegation initially. This was not correct, as confirmed by the person who received the allegation.
- The person who made the allegation was not interviewed by a competent person external to the centre.

- The relevant authorities had not been notified of the allegation.
- The policies and procedures did not guide practice for staff in relation to reporting incidents of abuse.
- The preliminary screening process did not take into account the views of the person making the allegation. In addition, the inspector found that the preliminary screening process was not robust enough and that the designated liaison officer was the only person involved in the investigation team as outlined in the report.

As a result of these findings the inspector asked to meet with the provider nominee to outline the above concerns. The inspector requested the provider to fully review the information pertaining to this allegation and make recommendations based on these findings.

There was one restrictive procedure in the centre. This had been referred to the positive monitoring approaches group as per service policy; however there was no clear evidence of this practice being reviewed. The inspector did see evidence at a residents meeting where this restrictive practice had been discussed with other residents and the residents were in agreement with it.

There was a policy on positive behaviour support in the centre. One behaviour support plan was viewed by the inspector. It was found to be detailed to guide practice; however it did not highlight the guidelines in place regarding possible escalation of behaviour. The resident had access to a psychologist who had just recently reviewed the support plan.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:
Safe Services

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

Findings:
Overall the inspector found that a record of all incidents occurring in the designated centre were maintained and, where required, notified to the Authority.

Judgment:
Compliant

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that residents were supported to avail of activities internal and external to the centre that was in line with the residents' personal preferences.

Most of the residents availed of day services provided by SMH. One resident had recently decided not to avail of this service and this had been accommodated by the provider. The person in charge informed the inspector that this resident was been referred to other day service option. In addition, some of the residents were in supported employment. For example, one resident worked in a local sports shop. The inspector reviewed a sample of activity schedules for residents and found that residents had access to varied social activities on a regular basis.

One resident showed the inspector certificates of courses they had completed through their day services. Another resident had attended a baking class on the first day of the inspection and had brought home cakes from their class to share with other residents.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that residents' healthcare needs were being met, however improvements were required in the assessment of need and health action plans to guide practice.

Residents had an assessment of need in place; however it did not reflect all of the residents support needs. In addition, some of the information contained in the assessment was inconsistent. For example one resident's assessment around the consistency of food required was recorded differently within different sections of the personal plan. The inspector acknowledges that this centre was in the process of updating all assessments for residents through a new format that had been introduced in the service.

Some residents health action plans were not detailed enough to guide staff practice. For example one resident who had diabetes did not have the supports in place listed in their support plan. In addition there were no health action plans in place for some identified needs.

Residents had access to allied health professionals, including psychology, psychiatry and physiotherapy.

Residents chose their meals at weekly meetings and the inspector observed a wide variety of nutritious food available in the centre. The inspector did not observe any meals in the centre where all residents were present, however they did observe some residents having breakfast or coffee breaks and found that they were a positive and social event.

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that each resident was protected by the designated centres policies and procedures for medication management.

There was a written operational policy in place which outlined the procedures for ordering, prescribing, storing and administration of medication. The inspector reviewed a sample of prescription and administration records and found that they contained the appropriate information.

Medications were securely and appropriately stored in a locked press. Out of date or unused medications were stored separately from regular medications in a secure

medication disposal bin.

There were arrangements in place for the audit of medication management practices. For example, medication stock takes were completed weekly. Records of medication errors were stored in the centre and there was evidence that advice was sought from a nurse manager on call when a medication error occurred.

All staff had up to date training in the safe administration of medication, with the exception of one staff member who had just returned from leave. However the person in charge had identified a date for this staff to complete refresher training in this area.

There were no controlled medications used in the centre. There were no residents who self administered medication in the centre and there was evidence to support that this choice had been discussed with residents. However one resident spoken to stated that they would like to self medicate. The person in charge intended to follow this up with the resident.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that a written statement of purpose was available that broadly reflected the services provided in the centre. On review it was found that the document contained all of the information required in Schedule 1 of the Regulations

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that effective management systems were in place to support and promote the delivery of a safe, quality care service.

There were clearly defined management structures in place that identified the lines of authority and accountability in the centre. The person in charge reported to the service manager, who is a person participating in management (PPIM). This PPIM reported to the provider nominee. The person in charge was also supported by another PPIM in the centre. The person in charge was interviewed over the course of the inspection. They were found to be suitably qualified and had the necessary skills to carry out their role. They had a very good knowledge of the residents needs in the centre and were very responsive to any issues that were raised over the course of the inspection.

Regular staff meetings were held in the centre. The inspector reviewed a sample of these and found that the actions identified had been addressed. The person in charge met with the service manager every six weeks.

The provider had nominated a person to complete unannounced safety and quality audits in the centre. A sample were reviewed by the inspector and found that a corrective action plan had been developed from the most recent audit.

An annual review had taken place in the centre and the report was available for the inspector.

Judgment:

Compliant

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

<p>Theme: Leadership, Governance and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The inspector was satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements in place to cover any absences of the person in charge.</p> <p>The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent.</p>
<p>Judgment: Compliant</p>

<p>Outcome 16: Use of Resources <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i></p>
<p>Theme: Use of Resources</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Overall the inspector found that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.</p> <p>The inspector found that sufficient staff were available to meet the assessed needs of the residents. In addition measures had been taken by the person in charge to increase supports for one resident at weekends in line with their needs.</p>
<p>Judgment: Compliant</p>

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):

No actions were required from the previous inspection.

Findings:

Overall the inspector found that there was a skilled mix of staff to meet the residents' needs in the centre.

The inspector found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents. Staff spoken to felt that the centre was adequately resourced to meet the needs of the residents and felt very supported in their role. There was access to nursing input as required from a nurse manager on call. The inspector was informed that only regular relief staff who knew the residents were employed within the designated centre in order to ensure consistency for residents. The staffing levels were reviewed where appropriate to meet residents' needs. For example the inspector saw where staffing levels were increased at weekends to support one resident. Staff were observed to have a very good knowledge of the residents and their needs, and responded to residents in a timely, respectful and dignified manner.

The person in charge had supervision meetings with staff. The inspector viewed a number of these and staff had discussed future training needs. There was no formal appraisal in place for staff. This was discussed at the feedback meeting and the inspector was satisfied that the provider had taken reasonable steps to try and address this issue.

There was a planned and actual roster maintained within the centre. There were effective recruitment procedures in place. Staff files were reviewed at an earlier date by the Authority and found to be in line with the regulations.

All staff had completed mandatory training with the exception of one staff member who had not completed training in fire safety and safeguarding vulnerable adults. However the person in charge had arranged future training dates for this staff to attend the necessary training by the end of the inspection.

There were no volunteers in place in the centre.

Judgment:

Compliant

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

Overall the inspector found that most of the documentation required by the regulations was maintained in the centre, however improvements were required to ensure that all of the policies and procedures as per Schedule 5 of the regulations were in place and in ensuring that the records maintained are complete and up to date.

Residents' records were safely stored in the centre and were available to the inspector. However, some of the information contained in the plans was duplicated which did not guide practice.

The policies and procedures outlined in Schedule 5 of the regulations were not all available in the centre for example the policy on staff training and development.

An up to date insurance policy was in place for the centre which included cover for resident's personal property and accident and injury to residents in compliance with all the requirements.

The information required under Regulation 21 and listed in Schedule 4 were maintained in the centre.

A resident's guide and directory of residents were maintained in the centre, which included all the required information.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Anna Doyle
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:	Boroimhe
Centre ID:	OSV-0002390
Date of Inspection:	06 April 2016
Date of response:	07 June 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Some intimate care plans were not detailed enough to guide staff practice.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

On behalf of the Registered Provider the PIC will review Intimate Care Plans to include all relevant details and information needed to guide staff practice.

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

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

Residents did not have financial passports in place to guide staff practice.

2. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

On behalf of the PIC each resident's key worker will complete a financial passport in accessible format with each resident.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

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

It was not evident that one complainant was satisfied with the outcome of their complaint.

3. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

Issues surrounding the source of the complaint in 2015 have been resolved and as a result records show that satisfaction for the complainant has substantially improved.

On behalf of the Registered Provider the PIC will meet with the complainant again to review the outcome of the complaint and to ensure they have an understanding of the appeals process.

Proposed Timescale: 30/06/2016

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:

The inspector was not satisfied that residents understood the details contained in the contracts of care. These contracts were not signed by a family representative where appropriate.

4. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

All current Contracts of Care have been signed by a family representative.

The Registered Provider is undertaking a review of the Contracts of Care and an updated version will be available in January 2017.

Proposed Timescale: 13/05/2016

Theme: Effective Services

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

One allied health care professional had not been involved in the transition process for one resident.

5. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

Records examined post Inspection show that the professional referred to was informed of the consultation process but was not present at the Placement Consultation Meetings held in November and December 2014.

The Registered Provider will ensure that all future admissions will adhere to the Admissions Policy and Admission Criteria in the Statement of Purpose and that all relevant Clinicians will attend Placement Consultation Meetings.

Proposed Timescale: 01/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

There was only one shower room available for residents in the centre.

Residents did not have access to a second shower facility upstairs in the centre.

6. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

The Registered Provider has plans in place for the provision of additional downstairs bathroom facilities for the designated centre.

Implementation of these plans is contingent on planning permission being granted from Fingal County Council and funding approval from the HSE.

The second shower facility referred to upstairs is a small en suite to the office/staff bedroom. This facility is available for use by Residents.

A proposal has been developed to provide an additional shower and toilet facility upstairs. Capital funding from the HSE will be required to complete this work.

Proposed Timescale: 31/12/2016

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:

Risk assessment for the management of violence and aggression required more detail.

7. 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:

The Risk Assessment document refers to the positive behaviour support guidelines as a control measure. On behalf of the Registered Provider the PIC will ensure that these guidelines are reviewed and contain all details required including escalation techniques.

The transport profile and guidelines are reviewed annually by the PIC and relevant transport personnel.

Proposed Timescale: 30/07/2016

Theme: Effective Services

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

infection control measures were not appropriately in place to minimise cross contamination.

8. 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:

On behalf of the Registered Provider the PIC will put in place infection control measures clearly stating procedures for the prevention and control of healthcare associated infections.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

The fire records did not show evidence of fire drills being completed when residents were on their own in the centre.

The fire drill records did not record the names of staff and residents involved in the fire drill.

Learning from previous fire drills was not reflected in the fire evacuation procedures in order to guide practice.

The same control measures were in place for two residents in the centre in relation to fire drills.

9. Action Required:

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

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

On behalf of the Registered Provider the PIC has reviewed Personal Evacuation Plans and evacuation procedures have been updated to guide staff practice.

All residents are involved in the bi-monthly fire drills including night time drills.

The residents referred to have been assessed to stay in the centre on their own for up to a period of two hours. This occurs approximately once or twice a week. The assessment includes understanding procedures to be followed in the case of fire.

The PIC intends to arrange an additional fire drill to be completed when these residents are on their own in the centre.

The PIC has informed the IT department that the Fire Drill E-Forms, which record the bi-monthly fire drills, do not allow for names of staff or residents involved to be recorded on the forms. In the meantime the PIC and staff members will record locally the staff and residents who are present during fire drills.

The two residents referred to now have different control measures in place.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

One staff in the centre had not completed fire training.

10. Action Required:

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

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

The PIC arranged for the Relief Staff Member to receive Fire Safety Training on 20/06/16.

The PIC arranged for this staff member not to be rostered on duty on shifts alone until the training was completed.

Proposed Timescale: 30/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The behaviour support plan for one resident did not include the measures in place to deal with an escalation of behaviour.

11. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

On behalf of the Registered Provider the PIC will ensure that the relevant psychologist will review the Positive Behaviour Support Plan referred to, in consultation with the day service and residential centre and will add more detail in relation to dealing with the escalation of behaviours.

Proposed Timescale: 30/07/2016

Theme: Safe Services

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

There was no evidence that restrictive practices are reviewed in the centre.

12. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

The restriction relates to a locked fridge and food press from midnight to 7am. The PIC provided evidence of Approval from the organisations Positive Approaches Monitoring Group (PAMG).

The PAMG have issued a new referral document which now contains greater details relating to this restriction, including alternative measures considered. This restriction is reviewed annually by the PAMG.

There was evidence of review of the restriction in the minutes of the Residents Meetings.

The Inspector spoke to Residents who knew and understood the need for this restriction and said they agreed with it.

Proposed Timescale: 30/07/2016

Theme: Safe Services

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

The response to an allegation of abuse was not appropriately followed up. The details of which are outlined in this report.

13. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

The PIC has reviewed the Safeguarding Policy with the staff team and discussed the learning from the incident. The PIC will ensure that the Safeguarding Policy is implemented appropriately in the future.

The incident was initially reported by the Resident to a staff member in Day Service on 15/03/16 but it was not reported to a Senior Manager until 21/03/16 which is not in line with the organisations Policy.

The Designated Officer notified the HSE Safeguarding and Protection Team of the allegation on 11/04/16.

The psychologist attached to the Day Service initially met and discussed the allegation with the Resident.

Two Clinicians were appointed and met the Resident on 11/04/16 to discuss the allegation. Following this meeting a report was sent to the Designated Officer.

The Designated Officer, PIC and Day Service staff member met the Resident on 13/05/16 to discuss the allegation, to ensure the Residents future safety and identify the supports in place for the Resident. A Safeguarding Plan was discussed, drawn up and agreed with the Resident at this meeting.

The PIC has provided all details in relation to the allegation to the Registered Provider for review and recommendation.

All future allegations will be followed up appropriately and responded to as per the Organisations Safeguarding Policy and the Designated Officer will guide staff practice accordingly.

The Registered Provider has advised the Designated Officer to review the Organisations Safeguarding Policy to ensure that reporting procedures are clear for staff members.

Proposed Timescale: 30/09/2016

Theme: Safe Services

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

One staff had not completed safeguarding training.

14. Action Required:

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

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

The PIC arranged for the Relief Staff Member to receive Safeguarding Training on 22/06/16.

Proposed Timescale: 22/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Some residents assessment of need did not reflect all of the residents support needs.

Some of the information contained in the assessment was inconsistent.

Residents health action plans were not detailed enough to guide staff practice.

There were no health action plans in place for some identified needs of residents.

15. 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:

On behalf of the Registered Provider, the PIC will review the Residents Assessment of Need documents and will include all support needs identified.

The PIC and Key workers will check for inconsistencies and update the Assessment of Need on the new organisation format.

Prior to Inspection all Residents health care action plans were approved by the organisations Health and Medical Trainer.

The PIC will arrange a further review of the health care action plans for all needs identified. Additional details will be included in the health care action plans to guide staff practice.

Proposed Timescale: 31/10/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The policies and procedures outlined in Schedule 5 of the regulations were not all available in the centre for example the policy on admissions to the centre was in draft format.

16. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

The Registered Provider will ensure that the Policies and Procedures outlined in Schedule 5 of the Regulations are updated and in place.

Proposed Timescale: 31/12/2016