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**A designated centre for people with disabilities
operated by Stewarts Care Ltd, Dublin 20**

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**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 Stewarts Care Ltd
Centre ID:	OSV-0003897
Centre county:	Dublin 20
Email address:	Deirdre.Brady@stewartscare.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stewarts Care Ltd
Provider Nominee:	Gerry Mulholland
Lead inspector:	Noelene Dowling
Support inspector(s):	Helen Lindsey;
Type of inspection	Announced
Number of residents on the date of inspection:	21
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 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:
28 July 2014 10:00	28 July 2014 20:00
29 July 2014 08:00	29 July 2014 04:00

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

This was the third inspection and first registration inspection of this centre which forms part of Stewarts Care Ltd. The entire campus service was the subject of an inspection in February 2014. Since that inspection the campus referred to as the residential service had been reconfigured into six separate centres for the purpose of registration. Designated centre 1 is designed specially to provide care for residents of severe to profound intellectual disability with challenging behaviors.

This inspection was announced and took place over two days. All 18 of the outcomes required to demonstrate compliance with the legislation and regulations were inspected against. As part of the monitoring inspection the inspector met with

residents and staff members. Inspectors spoke with relatives and received two completed questionnaires in respect of the service and some questionnaires completed by staff on behalf of service users. Inspectors observed practices and reviewed the documentation including personal plans, medical records, accident and incident reports, policies procedures and staff files.

The inspection also reviewed the progress taken by the provider in addressing the actions required following the inspection report of February 2014. In total 33 actions were issued to the provider at that time. The provider's response was timely, satisfactory and detailed. As the previous report was a compilation of the findings of all of the residential houses a number of actions did not specifically relate to the houses now configured as designated centre 1. However, the findings indicate that the provider has made considerable progress and had commenced actions in all cases.

Actions satisfactory resolved were: health care assessment and monitoring, governance structures and adequate monitoring systems, Complaint procedures; end of life care policy; system for the protection of residents.

Issue where actions remain outstanding for completion included: Mandatory training including fire training for staff, use of methods of restrictive practices and cohesive management of behaviour support plan; risk management procedures; intimate care procedures; medication management; staffing levels and meaningful activities for residents. However, actions in all areas could be seen to have commenced. The overall outcome is however significantly influenced by staffing levels which impact on the quality and ultimately the safety of care.

The application for registration includes a house which is currently used to accommodate residents whose assessed needs differ from the majority of residents in designated centre 1. Plans have been made to provide suitable placements in the community houses in the very near future for these residents and the house will then be renovated to accommodate two residents.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities)

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 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):

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

Findings:

There was evidence from documentation and from information received from relatives that they, and, where possible residents, were consulted with regard to their care needs and could attend at multidisciplinary meetings. It was apparent that residents had choice in basic daily routines such as getting up or whether they wished to attend at day service or not and staff knew their individual preferences for example the food they prefer very well. Staff were observed asking residents what they wanted and giving them choice.

A resident's council meeting takes place monthly. However no resident from designated centre 1 participates in this forum primarily due to the extent of the residents intellectual disabilities. The provider has made progress in sourcing an advocacy service and is in the process of formalising this arrangement. How this service will be made available and relevant to the residents in this centre has not as yet been decided upon. Staff do advocate on resident's behalf for example representations have been made in regard to suitability of placements, alterations to the various premises and access to activities. The manner in which residents were addressed by staff was seen to be appropriate and respectful. All bedrooms were single and they were personalised taking identified safety issues into account. There was evidence that staff tried to maintain resident's dignity and respect when carrying out personal care with doors closed and were seen to be watchful of any inadvertent behaviours residents engaged in which impacted on their dignity. As required the policy on intimate care has been revised and directions in personal plans were clear. In some instances however suitable locking mechanisms on bathroom doors were not in place which meant that other residents could interrupt the procedures.

In one of the houses a female resident resides with an all male resident and staff group. Staff articulated how they support this resident and in these circumstances attempt to ensure that her care and dignity needs are met sensitively. However it was unclear whether, in line with the policy on personal care her wishes had been ascertained and adhered to where at all possible. This situation has been in place for a number of months due to staff leave and impacts on the resident's right to choice in care givers and overall respect for the resident's dignity.

There was good contact with families and this was encouraged. Due regard to safeguarding issues was taken into account by staff in relation to visits and access.

Valuables held for safe keeping were recorded and the signatures of both staff were evident. Residents clothing is laundered on the premises and there was no current evidence that clothing was not being returned. There was ample space in each bedroom to hold clothing and other personal belongings.

A complaints policy, including an appeals process had been introduced and on this inspection the procedures in the houses were found to be consistent with the policy. Any issues raised were initially resolved at local level and this was documented, the complainant was responded to and their views on the outcome sought. Records indicated that complaints received were managed in accordance with the policy. This process was currently being overseen by the provider to ensure compliance with the policy. The policy, in easy read format is posted in each of the houses.

Activities take account of the residents stated or known preferences. In some instances there is considerable opportunity to participate in interesting activities and outings. For some of the residents however this is impacted upon by safety issues and staffing levels. This is actioned and outlined further in outcome 8 Safeguarding and Safety and Outcome 17 Staffing.

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):

Findings:

Systems and supports were in place to help residents communicate and staff understand the resident's communication and meaning were evident in most areas of the centre.

Pictorial images and communication books and cards were evident and used to good effect. Multidisciplinary services including speech and language therapy had been sourced to help identify the specific communication needs. These included diagrams of food, drinks, feelings and the meaning of specific. These and the communication cards were seen to be incorporated into the daily routines of the residents. Families were consulted regarding this and their knowledge of the residents was incorporated into these interventions. Residents had access to televisions and staff were aware of, for example, their favourite programmes or music. Staff were seen to be familiar with the resident's non-verbal cues and responded appropriately. The personal plans also included these communication systems.

A pictorial resident guide and rights charter was also available. In most but not all of the houses the personal plans were synopsised in pictorial format for the residents and this process is ongoing.

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:

There was evidence from records reviewed and questionnaires forwarded to the Authority and speaking with those residents who could communicate with the inspectors, that family relationships were supported and encouraged. There was an open visiting policy and visits home were also supported by staff. Family members and next of kin were identified and invited to attend the multidisciplinary meetings. Where it was feasible taking the residents needs into account friends can visit and there is access via day-services to companionship outside of the centre.

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:

The policy on admission was detailed. Although no new admissions have taken place for a significant period of time, referrals are routed via the HSE services or social work services. These are then reviewed by the admissions committee which is multidisciplinary and lead by the head of adult services. By virtue of their care needs and assessment the current residents with the exception of those in the house which is been re-designated meet the criteria for admission defined in the statement of purpose. There was evidence of transitionary plans including life skills training taking place to support a number of residents to move from this accommodation to community based houses.

Currently there is no contract available for residents but some additional costs, for example holidays have been included in the pictorial residents guide. The provider is currently in the process of developing a policy on accessing resident's funds for additional costs. The process in use includes an assessment of the capacity to consent for the release of such funds. However, the current arrangements are unclear in terms of what charges can or are being levied for which may or may not be outside of the charges for long term care.

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):

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

Findings:

As required by the action plan from the previous inspection the provider had commenced the process of revising the methodology and implementation of personal care plans and consultation with resident or relatives in regard to them. The changeover to computerised care/personal planning and recording systems had been completed. This facilitates the sharing of a range of up-to-date information between pertinent individuals and clinicians. There was evidence of appropriate multidisciplinary involvement in resident's personal plans which were guided by the clinicians' assessment of need, staff knowledge and the residents stated preferences, behaviours and assessed risk factors. The personal plans were reviewed annually and contained individual sections on a range of needs including health care, social care, family contacts, dietary requirements and restrictive practices. Individualised supports such as communication cards, daily activities and personal care needs were identified in the plans.

The plans demonstrated that the resident's preferences were understood and the goals were meaningful, including good family contact, enjoyable activities and support to develop life skills where this was relevant. The process of outlining these personal plans in an easy read or pictorial format for residents had also commenced. In some instances pictures of activities undertaken were included as mementos for residents. The outcomes of the plans were not easily identified however and this was acknowledged.

In some instances the content of the personal plans indicated that further training was needed to fully implement the concept based on the complexity of the resident needs. For example, in one instance the social plan simply stated the need to identify activities for the resident rather than implement a focused programme based on the resident's needs and preferences. The training process for staff had commenced. Residents who could communicate stated that the plans were carried out.

However, outcomes of the plans are impacted upon by staffing levels and the security of care that is required. Day to day activities, stimulation and change of scenery form a significant part of the residents lives given their assessed needs and dependency levels. Some of the residents have access to the day care service but a significant number are unit based. An activities staff member is assigned to a number of the units and their tasks include planning and taking residents on individual trips to places such as the zoo, shopping, or day trips away or simple for drives. All activities whether on campus or outside external require significant staffing resources due to the support needs of the residents. There was evidence that activities such as drives, outings or swimming have had to be cancelled due to lack of staffing. In some instances allowing a resident access to the garden has to be supported by two staff and the remainder of the residents must also be supported during this period. In cases where two staff are required the ability to undertake such activities and also continue daily activation or care for the residents in the units is severely limited. On four occasions in one instance a drive for a resident with significant challenging behaviours has had to be cancelled due to staff shortages. Activities which staff may have been able to undertake in the units were also impacted upon. The impact of this is discussed in Outcome 8 Safeguarding and Safety.

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):

No actions were required from the previous inspection.

Findings:

Designated Centre 1 is comprised of five separate houses accommodating between one and eight residents. Four of the houses are located within the Stewart Care campus and one just outside, with two story and three single story buildings. The actions required from the previous inspection did not specifically refer to this centre.

All of the houses have single bedrooms, living and dining areas with some having a small additional sitting room for relaxation or quiet time. There are a sufficient number of suitably adapted bathrooms and showers for residents use. Suitable furnishings were provided and rooms were decorated with personal items. Overall the premises were clean and well maintained with flooring, lighting and heating in the houses satisfactory. All laundry and catering with the exception of light meals snacks and breakfast is undertaken in a central and suitably equipped location.

The houses all have a small enclosed garden area outside with flowers and shrubs and in two cases a swing and basketball hoop. Minimum assistive equipment was required for mobility and records demonstrated that maintenance issues were promptly identified and reported. Vehicles used had evidence of road worthiness.

One of the houses is sub-divided into four separate but interconnected apartments, two downstairs and two upstairs. There is a significant safety emphasis required in this house which to some extent dictates the environment. One of the apartments upstairs is shared by two residents who also share the kitchen and bathroom facilities with a resident in a single apartment. In reality however, the kitchen is not available to two residents due to risk of contact and subsequent injury. There is a kitchen space in the two bedded apartment but this only contains a table, chairs and presses. It is not equipped to heat, prepare or store any food or drink. Therefore these residents do not have access to a kitchen facility. The bathroom is also shared between both apartments and this places additional safety and monitoring requirements on staff and restrictions on some 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:

Progress had been made to address the actions required for this outcome identified in the previous inspection with some improvements still required. There was a current and signed health and safety statement available. Systems for review of safety and risk were evident. A detailed safety audit of the premises and work practices had been undertaken. The risk management policy has as required been amended to comply with the regulations including the process for learning from and review of untoward events. As stated in his response to the previous action plan a risk manager had been appointed to support the development of strategies to minimise risk and respond to incidents. Individual risk assessments in the houses had commenced and a health and safety audit for the houses was to be undertaken in September 2014. The risk management policy was further supported by relevant policies including an emergency plan. The missing persons policy was proactive, emphasising the need to initially identify a resident who may be at risk of unauthorised absence and then taking preventative measures. To this end strategies such as placing restrictors on windows has been implemented.

The emergency plan was detailed and it contained all of the required information including arrangements for the interim accommodation of residents should this be required. An integrated generator was available for use and emergency phone numbers were readily available to staff. A system of emergency response to events such as aggression, violence or the unauthorised absence of a resident had been instigated. Specific staff in nominated houses were identified to respond immediately. Staff had been issued with emergency alarms and were seen to be wearing these where appropriate.

The policy on infection control was detailed and staff articulated good practice in relation to this. Staff were observed taking appropriate precautions and protective equipment including gloves, aprons and sanitizers were evident.

Inspectors reviewed the fire safety register and saw that fire drills had been carried out in each of the individual houses twice yearly, some unannounced and residents were included in these drills. Fire safety management equipment including the fire alarms, emergency lighting and extinguishers had been serviced quarterly and annually as required. Staff were able to articulate the procedures to undertake in the event of fire. In one instance a fire transport mat had been provided for use due to the resident's physical incapacity. Fire training however was not up to date with 20 staff not having

had this training. The provider has set dates for October 2014 but this time frame is not suitable given the needs of the resident and staffing levels. Evacuation plans had been compiled for each resident. In two houses fire doors did not have magnetic holders and were held open with wedges. While the reasons for this action were valid in terms of resident's behaviour this negated their value as fire doors. Some of the exit doors locking mechanisms had been reviewed for ease of access in regard to keys but not all had been replaced.

There was a risk assessment and management plan for residents available which was found on this inspection to be more specific and pertinent to the risks presented to or by the residents. The majority of risks in this centre were in relation to self harm or inadvertent harm to others. There was evidence that the procedures used to manage these concerns in particular the use of locked doors and single occupancy were discussed, clinically prescribed and a clinical rationale was available. However there was also evidence of direct impact on the quality of life of residents. This included inability to access levels of socialisation and activity primarily due to staffing issues.

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):

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

Findings:

The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory and included a designated person to oversee any allegations of this nature. The provider also uses the HSE "Trust in Care" policy to guide practice. Records demonstrated that all current staff have received training in the prevention of and response to abuse between 2012 and 2013. Primarily this was undertaken by the organisations social work service. Staff were able to articulate their understanding and responsibilities in relation to this and there was a designated line of accountability identified which was readily available and known by staff.

Since the inspections of December 2013 and February 2014 the provider received the final report of the independent investigation into allegations made concerning the service provision. In response to this report the provider initiated a detailed action plan which took account of the issues raised regardless of whether the concern was founded or not. The procedures introduced included monitoring systems, supervision arrangements, audits of systems and care practises.

A review of a sample of the records pertaining to resident monies being withdrawn from the property accounts indicated that the systems for recording this money and its usage have improved. All monies given for residents use were dated and the expenditure was recorded and receipted for the financial office. Money paid in on behalf of residents in fee payments are recorded via a unique identifier and records were transparent. However the arrangements for residents for whom the provider acts as agent are not currently compliant as the required documentation and procedure had not been implemented in relation to this. However, the records seen do not indicate that there should be any concern in relation to this. This was discussed with the financial controller who agreed to remedy this in accordance with the requirements.

There were up-to-date policies on the management of behaviour that is challenging and on the use of restrictive procedures. A number of systems are in place to direct/oversee and manage behaviours. There are two psychiatrists assigned to the centre and a behavioural support specialist. As indicated in his action plan response the provider has appointed a behaviour support nurse. The function of this role is twofold: to provide individual assessment and intervention plans for residents in conjunction with the psychologist and to provide ongoing training and support for staff. Records, observation and interviews indicated that challenging or self harming behaviours are a significant feature of in this centre. There were detailed behavioural support plans available which outlined triggers, potential risk factors and symptoms which indicated stress. They provided guidance to staff on the most effective way of supporting the resident and maintaining the safety of all people.

Records of incidents were also maintained and the clinicians could see changes or improvements. These were fully discussed at the multidisciplinary meetings. Staff were knowledgeable on these factors and were seen to act and filter such behaviours. While some Pro-re nata (PRN) medication was prescribed for episodes of behaviour in these circumstances. From a review of a sample of the administration records of this medication inspectors did not find evidence that it was used in excess. A system of clinical debriefing following any incidents of challenging behaviours was also in the process of being implemented in order to further identify good management strategies.

A significant number of restrictive procedures are utilised, including body suits, locked internal and external doors, half-doors. In some instances residents live separately within a suite of rooms with security measures such as locked doors to ensure other residents and staff safety. Staff have received training in an approved method of managing behaviour and if necessary in using physical interventions when this is deemed absolutely necessary. All such procedures are clearly documented and prescribed. On this inspection staff were clear and consistent on the specific techniques to be used if any such intervention was undertaken. These are also documented in an incident report.

A multidisciplinary restraint review group meets regularly to discuss the use of restrictive measures for each resident and clinicians also review episodes of challenging behaviours and devise guidelines for staff. All restrictive procedures are documented and discussed. They are then prescribed for by the consultant psychiatrist and any medications used for these purposes are regularly reviewed and monitored. Clinical assessment, clear rationale and protective factors apparent for their use were evident. There was an improvement noted in the clarity of the rationales and evidence of alternative methods and removal of restrictions implemented. While some records indicated that consolation had taken place with relatives this process was not consistently evident from the pertinent documentation. However, from the questionnaires forwarded to the authority and speaking with some relatives this consultation was confirmed.

The procedures used such as the all-in-one suits were seen to be managed in a way that protected resident's dignity so that during the daytime it was not obvious that such clothing was being used. A swing had been placed in a safe garden section for a resident which was a very important aspect of removal of the space restriction and provided therapeutic time for the resident. However, the impact of the restrictive systems used on the resident's quality of life or on other residents had not been entirely considered. For example as observed by the inspector, locked internal and external doors in one unit and the need for high level of staff monitoring had a significant impact on the remaining residents quality of life an ability to relax in the unit. Implementation of such systems and consistent behaviour management supports although very thorough and detailed require consistency of practice and staffing levels. Robust systems are required to ameliorate the restrictions and to manage the impact of these on the residents involved and on other residents. In some instances severe limits are placed on freedom of movement and access to other residents. Staffing levels are not consistently adequate to ensure that periods of needed activity, change of environment or access out of the restrictive environments are consistently available for residents. Decisions regarding the procedures have not taken account of the low staffing levels in order to ensure quality of life and care can be maintained within the structure and within reasonable time frames.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

A review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated compliance with the obligation to forward the required notifications to the Authority. There was also evidence that any incidents or accidents were reviewed for development and learning.

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:

.Where appropriate to the residents' capacity and needs there was evidence of life skill development and opportunities to participate in activities either individually or in groups. Assessments have been undertaken to ascertain the resident's capacity and decisions for interventions are made based on this assessment. Basic self-care skills and social skill development was supported by staff and residents were supported to in this. Some residents attend day care and they said they enjoyed this. There were communication systems evident between the various services involved and evidence that staff encouraged residents to participate according to their capacities. The staff could be seen to make efforts to ensure there was social participation for residents, for example going to shopping centres or for meals out according to their abilities. The outcome is impacted upon by, for example one house where a resident who it is recognised could have more life skill development cannot do as the accommodation does not allow this currently. This is actioned under Outcome 6 Safe and suitable premises.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The action required from the previous inspection had been satisfactorily addressed in this centre. A local general practitioner (GP) service is responsible for the health care of residents and is available on the campus five days per week. Overall the records reviewed demonstrated that there was regular access to this service and out-of-hours service is available. There was evidence from documents, interviews and observation that a range of allied health services is available and accessed. This included occupational therapy, dietician services, physiotherapy, psychiatric and psychological services a number of which are integral to the organisation which is suitable to the diverse needs of the resident population. Treatment and interventions were detailed and staff were aware of these. Such interventions were revised annually as required. On this occasion there was a more cohesive approach to the monitoring of health care, evidence of timely response and correlation between the annual health check and the supporting documentation completed by staff. The documentation was also more detailed and indicated that all aspects of the resident's health care and complexity of need was noted and considered. Where appropriate assessment tools including skin integrity were utilised and plans demonstrated adherence to treatments strategies. External specialists such as wound care clinicians or neurologists were also sourced.

A policy on end of life care has been developed. There was no resident who required this at the time of this inspection although the process allows for advanced planning and nursing staff are available.

Residents meals are prepared in the catering department and delivered chilled to the units each day to be heated prior to serving. The diverse needs of the residents were addressed in the dietary supports available. There was documentary evidence of advice from dieticians and speech and language therapist available and staff were knowledgeable on the residents' dietary needs. There were also aware of resident's preferences. Choices were available and inspector saw additional foods such as fruit, cheese, salad eggs available snacks and various fruit juices at other times. Meals including pureed meals were served appropriately and served appropriately to residents. Resident's weights were monitored regularly and more frequently if a concern was evident. In one instance a significant dietary plan had been implemented following robust clinical investigation and was carried through by staff. This action was taken in recognition of the impact of the underlying condition on the residents social activities and was a proactive intervention on staffs behalf, guided by the dietician to eliminate this. While all kitchens had kitchenettes which were equipped with food storage equipment, heaters, kettles. Currently the residents did not prepare food. In three of the five houses the kitchens were locked as they were sources of danger for the residents and information available deemed this action to be appropriate.

Judgment:

Compliant

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

Theme:
Health and Development

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

Findings:
The provider had made suitable changes to the medication dispensing arrangements to ensure that the medication was identified for the resident for whom it was intended and a Pro-re Nata (PRN) protocol had been implemented .Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory. There are appropriate documented procedures for the handling, disposal of and return of medication. Medication was reviewed regularly by both the residents GP and the prescribing psychiatric service. No residents were assessed as being suitable for self administration of medication at the time of this inspection.

However, in some instances inspectors observed that Pro-re-nata(PRN) medication and the maximum dosage to be administered was not clearly outlined on the prescription sheet. This was discussed with the provider who agreed to rectify this. No medication errors had been reported but a system for monitoring and review had been undertaken. A medication audit of practices had also been undertaken and there was evidence that all medication was reviewed and its impact monitored.

Judgment:
Non Compliant - Minor

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

Findings:

The statement of purpose had been forwarded to the Authority as part of the application for registration. It was found to be in compliance with the regulatory requirements. Admissions to the centre and care practices implemented were congruent with the statement as a service primarily for service users with severe and profound intellectual disabilities and challenging behaviours. The house which is located outside of the campus is to be reassigned to this category of care and therefore is included in the application for registration.

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:

Inspectors acknowledge the significant changes made and still in process in the governance structure and procedures in order to create a more cohesive and effective governance system in a complex and diverse service. The board of management headed by the CEO holds regular meetings and there was evidence of good reporting systems in place. Structures include directors of clinical care programmes and facilities. Governance is supported by a range of systems including corporate risk and development.

The person nominated to act on behalf of the registered provider undertakes unannounced visits to the centres to review specific issues and meet residents and staff. The provider meets fortnightly on a formal basis with each of the programme managers for the various services. Weekly meetings of all the persons in charge are held and these are primarily used to support implementation plans for achieving compliance across the campus. Further compliance meetings are held twice weekly. An action plan for achieving compliance with the regulations has been developed.

The most significant change is the reconfiguration of the campus into 8 different designated centres and the appointment of a person in charge for each centre under the direction of the adult services manager. The person appointed to designated centre 1 is a qualified intellectual disability nurse with extensive nursing and management

experience at CNM 111 level and expertise in the management of challenging behaviours. She has also undertaken additional training in positive behaviour management and assessment tools for persons with disabilities. Interim arrangements had been made in the appointments of persons to act in her absence and to support the person in charge and this process is ongoing with interview to be held a nurse at CNM 11 grade will be formally appointed in September. Each house also has a house manager at clinical nurse manager grade. This change to the structure can be seen to have impacted positively with increased supervision and presence in the centre, key worker and team meetings clear lines of accountability, personal and follow up on issues identified. Staff spoke positively of this greater access, overview and governance. There is an appropriate on-call system in place.

Audits and spot checks have taken place on issues such as medication management; restraint practices, meals and restrictive practices. Aside from the residents forum meetings there are however no other mechanisms evident for reviewing the quality and safety of care as required by the Regulations. The compilation of the audited data including accident and incidents will support compliance with the annual review of quality and safety of care.

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.

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was newly appointed to the post since March 2014. Inspectors were informed that there had been no periods of leave which required notification to the Authority over and above normal annual leave periods. The provider has made interim arrangements for periods of absence of the person in charge and was aware of the responsibility to report any such extended absence to the Authority. Key personnel had been identified and a recruitment process will be undertaken. It is envisaged that the person appointed will undertake the duties and roster of the person in charge on periods of normal annual leave. This should ensure consistency of management is provided for.

Judgment:

Compliant

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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>
Theme: Use of Resources
Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.
Findings: Sufficient resources for fundamental care such as food, health care, activities maintenance of the premises and vehicles used are available and utilised. Issues in the premises had been identified and the provider was seeking resources to address these with firm plans made for one house. However, there was evidence of insufficient staff to ensure that resident's wellbeing and access to activities could be maintained on a consistent basis. A full review of staffing numbers and arrangements based on residents dependency levels had taken place and was being analysed.
Judgment: Non Compliant - Moderate

Outcome 17: Workforce <i>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.</i>
Theme: Responsive Workforce
Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings: The provider has made progress in addressing the actions outlined in the previous inspection report and a plan has been implemented to do so .However some actions remain unresolved. From examination of rosters and review of resident's schedules and interviews with staff, the inspector formed the view that the staffing levels were not adequate. This impacted on the security of residents and staff and the availability of

staff to provide activation to residents during the day. There is an actual and planned rota available in each house except in one where in effect decisions are made on day to-day basis as to who will staff the unit. In another house there was a constant shortage for certain days of the week and inspectors were informed that a third staff was nominated from another unit to work but may not be familiar with the residents. A house which has high security status was supposed to be staffed by a minimum of four people, two upstairs and two downstairs. There was evidence that on consistent occasions only three staff were available. Given that the centres primary function is to support residents with challenging behaviours some of whom, as observed by inspectors, require consistent management approaches in addition to security measures this arrangement is not satisfactory. This appears to be especially noticeable during the summer months and staff may not be consistent in some units. Nursing staff are available during the day-time in all of the houses who require this by virtue of the residents assessed needs. A night nurse is available at night to offer medical care where this is required and overall this arrangement was found to be satisfactory and staff indicated that there was sufficient and timely support available.

There was a centre-specific policy on recruitment and selection of staff. The person in charge had reviewed their practices in relation to procuring the relevant documentation for agency staff assigned to them. No volunteers were being utilised at this time. Examination of a sample of five personnel files showed that progress was being made as agreed by the provider in sourcing missing documentation previously noted and all files had been reviewed by the human resources department to progress this issue. Evidence of registration with relevant bodies was available for all staff that required this.

There are forty staff assigned to designated centre 1 with eight nurses in total. Examination of the training matrix demonstrated that all staff had completed and were in the process of updating accredited training in non violent therapeutic crisis intervention. The provider is currently in the process of training in a slight variant of the modal based on the same principals. There were deficits noted in the following mandatory training however. Twenty staff are overdue for fire safety training, 24 staff are overdue for manual handling training. Disability awareness training has not been completed up to twenty staff. Other training which had been completed and is ongoing included hand hygiene, waste management. The behaviour nurse specialist is rolling out a system of training in the management of challenging behaviours. Training has commenced on the implementation of personal support plans and the newly implemented computerised care documentation system. The provider had already undertaken a significant training gap analysis which had identified the deficits outlined above and a plan was in place to address this.

Monitoring and supervision systems have commenced with the person in charge receiving training in performance management, supervision and support. It is intended to implement this supervision process across the houses, cascading from the person in charge to nursing staff, care assistants and household staff. Key worker meetings and team meetings are held regularly and there were good communication systems in place.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

No actions were required from the previous inspection.

Findings:

The inspector found that the records required by regulation in relation to residents, including medical records, nursing and general records were up to date, easily retrieved and maintained in a manner so as to ensure completeness. All of the required policies were in place and had been revised. Documents such as the residents guide and directory of residents were also available. The inspector saw that insurance was current and in line with the regulations. Reports of other statutory bodies were also available. Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration.

Judgment:

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:

Noelene Dowling
Inspector of Social Services

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 Stewarts Care Ltd
Centre ID:	OSV-0003897
Date of Inspection:	28 July 2014
Date of response:	29 August 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:

Staffing did not take account of the gender of residents and their right to dignity in personal care.

Action Required:

Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

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

A process has commenced to identify appropriate staff to be rostered to the area

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

identified in the report. Two female staff will be rostered to this area by 30th September 2014

Proposed Timescale: 30/09/2014

Theme: Individualised Supports and Care

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

Residents did not have arrangements for access to advocacy services pertinent to their assessed needs.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

An introductory meeting with the National Advocacy Services took place on 30th July 2014. An information and awareness programme for all staff to on accessing this advocacy service will commence in September 2014.

Proposed Timescale: 30/09/2014

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:

Residents or their representatives did not have a written contract for the services to be provided.

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:

A written contract of care setting out the terms of the services to be provided will be issued to the parents/ guardians of the service users in this designated centre by October 31st 2014. Signed copies of the contract will be recorded to the individual service user's file on receipt of same.

Proposed Timescale: 31/10/2014

Theme: Effective Services

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

Residents or their representatives did not have details of the care support to be provided and all fees to be paid for this.

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:

The contract of care has been updated to include the details of the care support and the fees to be paid for this. This was completed on 18th August 2014

Proposed Timescale: 18/08/2014

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 residents' needs were not adequately met in terms of access to suitable recreation and meaningful activities according to their assessed need.

Action Required:

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

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

The current allocation of day activity staff to the designated centre is being reviewed to ensure adequate access to suitable recreation and meaningful activities according to their assessed needs. Review commenced following the inspection on 28th July 2014.

Proposed Timescale: 30/12/2014

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 physical design of one of the houses does not support accessibility and use for all of the residents who reside there.

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:

Plans have been drawn up to improve the physical design of the premises identified in the report to ensure accessibility and use for all service users who reside there. Plans and costing have been submitted to the CEO for funding 28/8/2014 and approved.

Proposed Timescale: 31/01/2015

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:

A significant number of staff had not had training in fire safety and management.

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 staff identified at the time of the inspection as requiring fire safety and management will have completed this training by 30th September 2014.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

Systems for the exiting premises were not consistently satisfactory, particularly in relation to the management of fire exit doors.

Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

The current systems for exiting the fire doors in the designated centre will be reviewed to ensure the safe and effective management of fire doors.

Proposed Timescale: 30/09/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Restrictive procedures used did not consistently account of staffing levels and the need for quality of life to be maintained and supported.

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 activity schedule for the service users in the house identified during the inspection will be reviewed to ensure that the quality of life of the service user for whom the restrictive procedure is prescribed is consistently supported and maintained.

Proposed Timescale: 30/09/2014

Theme: Safe Services

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

Current systems for the management of residents personal finances did not protect resident from abuse.

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 Financial Director will ensure that the arrangements for all residents for whom the provider acts as agent will be formalised by using the official documentation and procedure. This will be completed for all residents by 31st March 2015

Proposed Timescale: 31/03/2015

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:

Some prescriptions did not detail the maximum dosage to be administered.

Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

A process to review the Helix Health Prescribing software commenced in August 2014. The development of PRN protocols to ensure safe prescribing of PRN medication is included in this process. This review process will be completed by 31st 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:

The numbers of staff were insufficient to meet the needs of the residents and the care programmes required.

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 process has commenced to identify appropriate staff to be rostered to the areas identified in the report. These staff will be in place by 30/9/2014.

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

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

Continuity of care was not consistently available especially during holiday periods.

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:

A process has commenced to identify appropriate staff to be rostered to the areas identified in the report to ensure the service users receive continuity of care and support.

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

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

Mandatory training requirements and training pertinent to the needs of the residents had not been adhered to.

Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

All staff will have access to appropriate training including refresher training days by 30th November 2014.

Proposed Timescale: 30/11/2014