Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	ORG-0011215
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mary Warde
Person in charge:	Ann Burns
Lead inspector:	Marian Delaney Hynes
Support inspector(s):	Nan Savage
Type of inspection	Announced
Number of residents on the date of inspection:	97
Number of vacancies on the date of inspection:	7

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 following receipt of unsolicited information. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 February 2014 10:30	25 February 2014 17:30
26 February 2014 09:10	26 February 2014 19:00

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

Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 08: Safeguarding and Safety

Summary of findings from this inspection

The inspection was triggered as a result of unsolicited information received by the Authority.

As part of the inspection, inspectors met with residents, the provider, person in charge and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, medication records and policies and procedures. Inspectors visited all nine residential units within the centre.

Inspectors covered three outcomes with a specific focus on the areas of nutrition and the use of restrictive procedures. Inspectors were concerned that practice in both areas required significant improvement to ensure the health and well being of residents and in order to comply with the requirements of the Regulations and the Standards.

The issues identified during the inspection were discussed with the provider, person in charge and members of the management team who made a commitment to addressing the issues as a priority.

The non-compliances are discussed in the body of the report and actions required included in the Action Plan at the end of this report.

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

Theme:
Health and Development

Judgement:
Non Compliant - Major

Findings:
While inspectors observed some good practice, they were concerned that residents' experience at mealtime was unsatisfactory and did not promote dignity, choice, respect or promote independence. Inspectors found that the overall approach to mealtimes was not person-centred.

The policy on nutrition was in draft format and was not dated. The person in charge told inspectors that it was the intention to implement the policy in the very near future with the support of the dietician as soon as this person was appointed.

There was evidence that 11 residents had recent nutritional reviews however, the recommendations had not been fully implemented into the residents' personal support plans.

Inspectors noted that residents' weights were monitored on a regular basis however, some residents weights were under the recommended measurement. There was evidence that these residents had been recently referred to the dietetic services for review. The CNM told inspectors that a new dietician was due to commence employment in early March 2014.

At the time of inspection there was no standardised nutritional assessment tool in use. The person in charge told inspectors that the newly appointed dietician would train the staff in the implementation of a recognised assessment tool.

On both days of the inspection, inspectors found that mealtimes were not a pleasant experience nor a social occasion as the following was observed:

1. The meal time was a hurried occasion for some residents particularly those who required assistance. Inspectors observed some residents being offered spoonfuls of food in quick succession by some staff members before the residents had swallowed and enjoy the previous spoonful. One staff member stood over a resident whilst assisting with their meal.

2. On day one of the inspection, some residents were not offered any drink for the duration of the meal.
3. On day one of the inspection, some meals sampled by an inspector were served cold as they had been left on an unheated trolley and uncovered for between 20 and 25 minutes.
4. Inspectors observed that some residents had not been appropriately positioned either before, during or after their meal which posed a risk to residents.
5. Some staff were not attentive to the dignity of residents. Inspectors heard staff using inappropriate descriptions when referring to residents during the meal time and rushing residents by repeatedly asking "are you ready" between spoonfuls of food.
6. There was a lack of awareness by some staff as to the ability of residents, with assistance being given to some residents who were subsequently observed by inspectors eating their meal independently.
7. Some of the staff did not use the mealtime opportunity to speak to or communicate with the residents as some residents were assisted in silence.
8. Inspectors did not observe any residents being offered second helpings.
9. Gravy was poured over some meals without any consultation with residents about their preference.
10. Most of the meals were served in a modified format. Inspectors observed staff mixing the food up and pouring gravy over it prior to assisting residents with the meal. This practice limited the resident choice of food.
11. Inspectors observed one staff member assisting a resident in a very undignified manner.
12. While there were two main course lunch options daily, food choice for residents was limited as they had to decide their choice of meal a week in advance. Inspectors were told that this was to facilitate menu planning.

Inspectors were very concerned about the long fasting times between the last meal of the day and the first meal the following day which extended up to 15 hours for some residents. These arrangements were not based on the needs of individual residents but facilitated staff duty arrangements. For example, staff told inspectors that residents would be offered supper between 7:00 pm and 7:30 pm and breakfast would not be served until 10:00 am and 10:30 am the following morning. Staff explained to inspectors that this was the routine practice because all residents' personal and hygiene care needs were attended to first, before breakfast was served. The person in charge said that she was aware of this practice and that it would be reviewed without delay.

Inspectors found that some residents who were underweight were prescribed supplements and high calorie diets by the dietician however, there was no evidence in the daily record sheets that residents were receiving this fortified diet.

Staff were not familiar with the appropriate grade of liquid thickeners for residents with swallowing difficulties. For example, one care plan reviewed described fluids as "slightly thickened". The CNM was unable to define what the specific thickness of the fluids should be.

Because inspectors were so concerned about meals and the mealtime experience they requested the person in charge to carry out an observation of the lunch time experience on the second day of inspection. She described the experience as enlightening, difficult

and distressing.

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

Judgement:
Non Compliant - Major

Findings:
Ann Burns was the person in charge and she was supported in her role by the Assistant Programme Director and Clinical Nurse Managers (CNM). The person in charge was full-time and had the required qualifications, experience and support necessary to manage the designated centre having regard to its size and layout.

The person in charge demonstrated an understanding of the Regulations and Standards and had continued to maintain her professional development through her attendance at courses and study days relevant to her role.

Inspectors however, were concerned that the person in charge had not ensured that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored in areas such as mealtimes, nutrition and the use of restrictive practices. These matters are further discussed under Outcomes 8 and 11.

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

Judgement:
Non Compliant - Major

Findings:
Inspectors reviewed the arrangements to protect residents from abuse. That there was a policy in place which provided good guidance to staff and management. The policy on protection was approved on 9 January 2014. Inspectors found that staff and management were knowledgeable about what to do should there be an allegation or suspicion of abuse. However, not all staff had received training in this area, as required by the Regulations.

Throughout the inspection, inspectors noted that most staff interacted with residents in a kind, caring, respectful and patient manner, however, as discussed under outcome 11 inspectors were concerned about the level of dignity and respect displayed by some staff at mealtimes.

Inspectors met with residents who confirmed that they felt safe and described the staff as being very kind and were able to tell the inspector about a number of staff whom they could talk to if they had a concern.

Inspectors found that restrictive arrangements had been put in place, which did not comply with the centre's policy and did not reflect the individual personal plan. Inspectors reviewed the arrangements for the use of seclusion as a means to respond to the behavioural issues. Records showed a bedroom has been used for seclusion on five occasions in the past 14 months for varying periods of time.

Inspectors reviewed the centre's policy, which had an approval date of the 19 September 2013. The policy detailed roles and responsibilities, definition of seclusion, criteria for use, criteria of the room, and the procedure to be followed when seclusion is in use. Inspectors were concerned that the policy had not been fully implemented. For example, it stated that the room was not to be used for the purpose of controlling behaviour although the person in charge and the CNM told inspectors that this was the primary purpose for using the room during behavioural incidents. The policy further stated that the room be checked thoroughly to ensure there was no access to hazardous objects. However, inspectors were informed that the room had not been checked and therefore was unsafe as a resident had full access to a scissors whilst in seclusion.

Inspectors found that the room had not been risk assessed prior to its use during any episode of seclusion. The policy further stated that a written record must be entered into the seclusion log. Inspectors found that there was no such record available for inspection.

Although there was a multidisciplinary personal care plan around the management of seclusion it had not been fully implemented.

The CNM had identified a number of possible triggers to behaviours that challenge in the resident's file and these included constipation. However, appropriate records had not been maintained from three to fifteen days prior to behavioural episodes. The CNM told inspectors that she could not rely on the accuracy of these records and this information could not be used to ensure that the behaviour trigger was being adequately monitored and managed to reduce the risk of incidents occurring. This resident was on a large quantity of medication to assist personal routines and the CNM told inspectors that an

alternative was also available as a measure. However, when inspectors requested to see the alternative there was none available.

Inspectors reviewed the medication prescription chart for this resident and found that he had been administered a PRN (as required) medication which was not within the timelines of the prescription. The CNM told inspectors that she would bring this matter to the attention of the relevant medical personnel.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	ORG-0011215
Date of Inspection:	25 February 2014
Date of response:	25 March 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 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient assessment and care planning in place regarding nutrition.

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:
Policy on Nutrition has been dated – Developed December 2013. It remains in draft form as there is a consultation process in place with staff. The draft policy will be used to guide practice until final sign of by the Nutrition Committee by 30th April 2014.

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

A policy on protected meal times is been drawn up. This will be in draft for circulation / consultation on 11th April 2014 with sign off and full implementation by 05th May.

The Care Plans of the 11 residents who underwent Nutritional assessments have been updated to include the recommendation of Dietician – recommendations are being implemented.

Dietitian commenced duty on 03rd March 2014 and is currently providing a 4 day service to the Designated Centre.
There is no recognised screening tool validated for use in an adult population with ID. The newly appointed Dietician is working with staff and other ID services to modify a current universal screening tool (MUST) to meet local needs. This will be piloted and the required training provided in two areas of the complex with residents of varying dependency levels. The two areas identified include residents who are identified as been underweight. Pilot to commence on Monday 28th April 2014. By Monday 30th June the pilot data will be compiled. On 14th July data will be presented to inform how we will proceed. In parallel to the pilot, ongoing referrals to Dietician within the Designated Centre will continue to be dealt with by the newly appointed Dietician.

Speech and Language Therapy commenced on 06th March 2014 and providing a 2.5 day service to Designated Centre. They have commenced reviews of a number of residents. Basic training on swallowing, positioning and grades of thickness has been carried out on 20th, 27th and 28th March 2014 for all staff. Further training and workshops will be provided for staff directly involved in caring for residents with swallowing difficulties, once appropriate assessments have been completed.

Contact has been made with the Centre for Nurse and Midwifery Education on identifying training needs of nursing and support staff. A training plan including training on documentation; scope of practice; attitudes in assisting meal times; and care planning will have commenced by 07th May 2014.

Proposed Timescale: 14/07/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents were not offered any drink for the duration of the meal.

Residents were not asked if they had sufficient food or if it was sufficiently hot.

Action Required:
Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
Meal time experience has improved. Issue re cold food resolved. No meal taken from the Bain-Marie until it is been served, drinks offered during meals. Meal times are

supervised by Clinical Nurse Managers or Nurse in Charge.

Daily diet record sheets are been maintained and residents are receiving appropriate modified diet.

Catering Manager is more actively involved in service and visits units and communicates with the Clinical Nurse Managers on a daily basis. Catering Manager and Catering Staff will be receiving the training necessary to ensure they meet the required standards, including managing menu cycles and the preparation of modified diets. This will be provided directly by the Catering Company and engagement on this commenced Tuesday 25th March 2014 in consultation with the Dietician.

Food ordering system and stock control in each area reviewed and changed to ensure adequate stocks of food available for residents at any time during the day.

Proposed Timescale: 25/03/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not offered assistance in an appropriate and dignified manner.

Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
Dignity and respect is being upheld at meal times. Clinical Nurse Managers and Nurse in Charge reinforce and monitor this. All other dignity issues identified on inspection have been addressed. Training will have commenced on Values by 06th June 2014. This training consists of appropriate values, actual practice and what motivates staff, inspires dignity, respect, equality, privacy person centeredness and how values impact on our practice
With reference to observation of a staff member standing over residents while assisting with meal. There is a care plan in place based on this resident's personal preference with regard to this practice. It has been reviewed by SALT and has been deemed appropriate in this case. Communication with all residents during meal time is been encouraged and promoted. All managers in the service have been mandated to complete an E-Learning programme on communication with persons who have an Intellectual Disability. This will be completed by 18th April and a certificate of completion will be submitted to Person in Charge. Following this phase, this learning will be cascaded throughout the organisation. Refer to www.hseland.ie

Proposed Timescale: 06/06/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents had long fast periods between the last meal of the day and the first meal the following day.

Action Required:
Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

Please state the actions you have taken or are planning to take:
As a result of significant training provided to all staff, there is a greater understanding of the importance of nutritional needs being meet on a continual basis.

Meal times have been changed from 24th March 2014:
a. Breakfast will commence at 9.30 a.m.
b. Lunch will commence at 14.00
c. Tea will commence at 17.30
d. Supper will commence at 21.30

Proposed Timescale: 24/03/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents had limited daily choice regarding meals as they had to choose meals two weeks in advance.

Action Required:
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

Please state the actions you have taken or are planning to take:
Residents are now offered a minimum of two choices of daily meals and change of mind with regard to choice is also facilitated. A wide variety and choice of healthy snacks are freely available throughout the day.
Two week menu cycle introduced on 12/05/2014
Four week menu cycle to be introduced on 01/09/2014

Proposed Timescale: 01/09/2014

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place were insufficient and did not provide for consistent and effective monitoring of care being provided.

Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1. The registered provider has appointed a person in charge of the designated centre as per regulation 14.(1) , please refer to NF30.

2. There is an identified person in charge over 24 hour period in the Designated Centre. Training for persons participating in management of service will be delivered in May 2014. Training for CNM's in roles and responsibilities will commence in May 2014.

3. All Clinical Nurse Managers have been met with by Provider and Area Manager to reinforce requirement of effective and consistent monitoring and supervisions of practice within the Designated Centre. Person in Charge is meeting with all managers weekly on their role in the monitoring and supervision of practice.

4. Person in Charge is more actively monitoring practice in Designated Centre. A document to record this will be signed off and implemented by 04th April 2014. This will be in use as a mechanism through all grades of Managers in the system, feeding into the Provider.

5. Project team set up first meeting 28th March to support management team in strengthening the overall governance of service.

Proposed Timescale: 04/04/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practices around the use of seclusion were unsatisfactory and did not ensure the wellbeing and safety of the resident.

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

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

1. The seclusion policy with regard to the named service user is currently been reviewed and will be completed by 02nd May 2014. At no time is seclusion used to manage behaviour it is used as an emergency plan when the named service user loses control, i.e. is a threat to himself and others, all staff who work with this individual are aware of this rationale.

2. Room has been risk assessed and recommendations around potential hazards are been considered by Multidisciplinary Team. Observation sheet for use while seclusion is active, is been researched and will be introduced by Friday 11th April 2014.

3. A request has been made for review by a specialist with regard to the management of challenging behaviour for a number of named residents. Date for this review will be confirmed 11th April 2014.

4. Care plan on constipation updated and is been implemented. Bowel activity is been recorded as part of care plan. Prune juice on the day of the visit was in the fridge as it had been opened and is stored in fridge once opened as opposed to cupboard where staff member looked.

5. The PRN medication prescription was been administered within the correct timelines the way the prescription was written was open to interpretation, this has been corrected. A PRN Protocol is been drawn up by Consultant Psychiatrist with Special Interest in Intellectual Disability. This will be completed by 04th April 2014.

Proposed Timescale: 02/05/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended training in the protection and safeguarding of residents from all forms of abuse.

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:
Training on Vulnerable Adult for staff is on Tuesday 01st April and Wednesday 02nd April 2014.

Proposed Timescale: 02/04/2014