

**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 Gheel Autism Services
Centre ID:	OSV-0002022
Centre county:	Dublin 7
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Gheel Autism Services
Provider Nominee:	Peter Byrne
Lead inspector:	Anna Doyle
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	9
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
15 March 2016 09:30	15 March 2016 19:00
16 March 2016 09:00	16 March 2016 14:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was the first inspection of this centre. The inspection was announced and formed part of the assessment of the application for registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs and fire safety procedures.

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

register were found to be satisfactory with the exception of the A2 form which needed to be amended to reflect the actual number of residents residing in the centre.

The centre is operated by Gheel Autism services and comprises of two semi-detached community residential homes located in North Dublin. There is a seomra (a prefabricated building) at the end of the garden that provides two additional recreational rooms for residents. The centre primarily supports nine residents with Autism and supports both male and female residents. One resident is in the process of transitioning to another centre belonging to the service. This person was not present on the day of the inspection.

Six residents' questionnaires were received by the Authority. These had been completed by staff in consultation with residents. Two family members were spoken to over the course of the inspection and six family questionnaires were received from family members by the Authority. The opinions expressed through the residents questionnaires found that residents were broadly satisfied with the services and facilities provided. Residents stated that they felt safe and liked living in the centre. Some residents did not wish to meet with the inspector in a formal way and this was respected. However, the inspector did meet with four residents over the course of the inspection.

Family members spoken to expressed their complete satisfaction with the centre and stated that they knew who to raise a concern with if they needed to. Family members also confirmed that they attended a family forum each year organised by the centre.

The person in charge was present throughout the inspection as was the location manager who is also a person participating in management for the centre. The provider nominee, along with a service manager for this centre attended both the opening meeting and the feedback session.

Overall the inspector found that residents healthcare and social care needs were met. The centre was homely, clean and well maintained. It was accessible to the local community and transport links. However some improvements were required in health and safety, safeguarding, medication management and the records maintained in the centre. In addition improvements were required in the contracts of care, residents' finances, the record of complaints and the notification of incidents to the Authority.

The action plan at the end of this report identifies those areas where improvements were required in order to comply with the Regulations and the Authority's Standards.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

The inspector found that residents' rights and dignity were maintained and there were opportunities for residents to contribute to how the centre was run. However improvements were required in relation to the management of residents' finances and the complaints records.

There was a policy in place for residents' finances, personal property, personal finances and possessions and the inspector found that residents had newly developed finance support plans in place. However residents did not have direct access to their own finances in that all residents' monies were located in the head office of the organisation. The inspector found one example of where this system could impact on resident's rights. This was discussed at the feedback meeting and the provider assured the inspector that this practice was being reviewed. Two residents' financial records were reviewed by the inspector who were satisfied that there were systems in place to safeguard residents' monies, however not all balance checks were countersigned by two staff in line with the service policy.

The centre was managed in a way that maximised resident's capacity to exercise choice in their daily lives. Residents were consulted on the day to day running of the centre. Weekly residents meetings were held where issues discussed included finances and goals for the year. Residents choose their menu plan on a daily basis in the centre.

The centre had policies and procedures for the management of complaints. The procedures were publicly displayed and written in an accessible format. For example there was an advocacy notice board in the centre that provided details on who to make

a complaint to and the contact details for advocacy services. Relatives who completed the Authority's questionnaire stated that they would know who to complain to if they had a concern. One family member stated that they would like more information on their family members' finances. Two residents' family members were spoken to on the first day of the inspection. They expressed their satisfaction with the centre and stated that they felt they could raise concerns with any member of staff.

The residents' questionnaire distributed by the Authority prior to inspection had been amended by the provider into a user friendly format for residents. Six residents had completed this with support from staff. All residents spoken to stated that they knew who to make a complaint to. Some residents stated that they would like to do more activities and would like to have the opportunity to manage their own medication. There was one complaint logged in the centre on the day of the inspection that had been followed up on, however it did not contain details of whether the complainant was satisfied with the outcome of the complaint.

The inspector observed residents being treated by staff in a respectful and dignified manner and residents were encouraged to maintain their own privacy and choices over the course of the inspection. For example all residents were consulted with before speaking to the inspector. The inspector was given information on the specific communication needs of residents prior to meeting with them so as to ensure their dignity. All residents had intimate care plans, however some required more detail to guide staff practice.

There were no CCTV systems in place in the centre.

Judgment:
Substantially Compliant

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):

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

Findings:

Overall, the inspector found that residents' communication needs were being met and that the centre was part of the local community.

Staff were very knowledgeable about the communication needs of residents and there was a comprehensive user friendly personal plan for residents that were individual to their needs. The inspector saw where individual goals for residents had been developed

using photographs to guide the resident on the steps required to achieve this goal. In addition communication plans were contained in personal plans to guide staff practice. For example one plan contained photographs of Lamh signs that one resident used to communicate.

The inspector found good evidence of information that had been developed into a user friendly format for residents including the centres complaints form, the resident's questionnaire distributed from the Authority, residents meetings, staff rosters, weekly schedules and financial plans.

Residents had access to televisions, radios and the internet and one resident liked to use a computer and another used an iphone.

There was a notice board in the centre that displayed local activities in the community and the inspector saw evidence that residents were part of the local community. For example one resident volunteered at a local charity shop, while another volunteered at the local church. In addition residents availed of other local amenities including hairdressers/barbers, grocery shops and local support groups.

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

Findings:
Overall the inspector found that residents were supported to develop and maintain personal relationships and links with the wider community.

The questionnaires completed by residents and family members showed evidence that families were actively involved in the residents lives. Residents had regular visits home and family members were invited to attend residents' annual review meetings. Relatives spoken to felt that they could visit the centre anytime, and one relative described the centre as 'a home from home'. In addition relatives told the inspector that they were always informed of their family member's wellbeing and that family forums were held in the service annually.

There were no restrictions on visitors to the centre unless requested by residents. Five residents had their own bedrooms and four residents shared bedrooms. There was adequate communal space for residents to receive visitors with the addition of the seomra at the rear of the building providing more privacy should residents require it.

Residents were supported to maintain links with their wider community based on their individual choices. One resident had a goal in place to start visiting the local barbers independently.

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):

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

Findings:

Overall the inspector found that there were procedures in place for the admission and discharge of residents to the centre and each resident had a written agreement contained in their personal plan. However improvements were required in this area.

There was an admission policy in place that was reflected in the statement of purpose. One resident was transitioning to another area in the service. This centre had recently been inspected by the Authority where the transition plan had been viewed by the inspector. It was found to include the wishes of the resident and was been implemented on a phased basis to ensure that the resident was happy with the decision. In addition this resident shared a bedroom and the provider informed the inspector that they did not intend on using this vacant bed in the future. The intention was to reduce the capacity of the centre to eight residents.

Each resident had a written contract of care and as an action from previous inspections to other centres in this service, an addendum had been added to the contract that detailed all of the fees to be charged, however this addendum was not signed by all representatives.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

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

Findings:

Overall the inspector found that residents had opportunities to participate in meaningful activities in line with their personal preferences.

Each resident had a personal plan, aspects of which were developed into a user friendly format for residents. There was evidence of family involvement in personal plans and family members spoken to were very aware of the goals that had been developed for residents. In addition an annual review had been completed, that involved participation of residents, family members and allied health professionals where appropriate. Residents who chose not to attend their annual review had this information recorded on the review form and the inspector saw where goals had been discussed with those residents.

The inspector reviewed a sample of social activities for residents and found them to be varied. For example residents were involved in dance classes, Special Olympics and using local community facilities. There were provisions in place in the centre for residents to have one to one social activities with staff during the week. In addition residents were developing new skills to promote independence. For example one resident was learning to cook and another was increasing independence in personal care.

One resident was being supported to move between services. This had been at the request of the resident. The inspector had reviewed the transition plan for this resident at a previous inspection in this service and found it to be in line with the residents wishes.

Judgment:

Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

Overall the inspector found that the location, design and the layout of the centre was suitable to meet the needs of the residents.

The design and layout of the centre was in line with the statement of purpose for the centre. The centre was clean and suitably decorated. Five of the residents had their own bedrooms and four residents shared two bedrooms. Bedrooms were found to be spacious, personalised, suitably furnished and had adequate storage space for personal belongings. There were adequate toilets, bathrooms and showers to meet the needs of the residents. The kitchens had enough cooking facilities and the dining areas were spacious. There was adequate communal space for residents to spend time or meet visitors. In addition there was a utility room in both houses where residents could launder their own clothes if they chose to.

Upstairs there was a door that led from one house to the other. This door was locked at all times so as to ensure residents dignity and respect. The inspector was informed that it was only used for fire evacuations in the centre and therefore the inspector found that it was not impacting on any residents.

The garden areas were well maintained and there was outside seating facilities for residents. At the end of the garden there was a seomra that consisted of two additional recreation areas for residents.

Residents had access to appropriate equipment to promote independence and comfort. For example handrails were in place in shower areas and outside the back doors.

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

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

Overall, the inspector found that there were systems in place to protect the health and safety of residents in the centre. However some areas of improvement were required in relation to fire safety and the risk management.

The centre had a health and safety statement in place that outlined the responsibilities of various staff within the organisation and referenced a wide range of policies and procedures to guide staff in their work practices. Staff carried out monthly health and safety checks as part of their responsibilities in this statement.

There were adequate fire safety precautions in place. A fire evacuation plan was displayed in a prominent area of each house in the centre. However the fire procedures were not detailed enough to guide staff and did not outline their roles and responsibilities in the event of an evacuation. In addition it did not outline the control measures in place for residents who were at risk of absconding during a fire evacuation.

Suitable fire fighting equipment was provided throughout the centre and there was evidence that they had been serviced appropriately. Fire escapes and exits were marked clearly and were not obstructed. A visitor's book was also maintained in the hall of each house to show who was in the building in the event of an emergency.

An emergency response pack was available in the centre and the emergency procedures contained information on where residents should be evacuated to in the event of an emergency. The inspector reviewed a sample of the personal emergency egress plans (PEEPs) for residents and found them to be concise and informative. The PEEPs included information on mobility, awareness and supports needed.

The centre held monthly fire drills and reports showed that the fire drills occurred at different times. The drill records recorded the time taken to evacuate and issues identified. However, it did not record the names of staff and residents involved in the fire drill and did not consistently record the details of the fire drill if there were 'no issues identified'.

There were procedures in place for the prevention and control of infection. A colour coded cleaning system was in place for mops, chopping boards and towels and equipment was stored appropriately. There were adequate hand-washing facilities and sanitising hand gels were available in key areas throughout the centre. Pictorial signage was also on display to promote good hand hygiene practices. Personal protective equipment was available. There were arrangements in place to dispose of clinical waste

generated in the centre. Daily, weekly and monthly cleaning schedules were in place.

The centre had an organisational risk management policy in place and maintained three risk registers including a corporate, centre specific and service and care register. Individual risk management plans were in place for all residents, however one residents risk management plan did not detail all potential risks. This was discussed at the feedback meeting

All incidents were recorded on a computer generated form and collated on a monthly basis and reviewed by the person in charge. However it was not evident that incidents were reviewed with staff so as to identify learning and guide future practice.

The inspector found that the vehicles used by staff was appropriately taxed, insured and had a national car testing certificate.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe Services

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

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

Findings:

Overall the inspector found that there were measures in place to safeguard and protect residents from abuse, however improvements were required in intimate care plans and safeguarding measures to protect residents.

There was a policy on safeguarding in the centre. All staff spoken to were knowledgeable about what constitutes abuse and what to do in the event of an allegation of abuse. There was a designated person in the centre and all staff knew who they were. Residents spoken to stated that they felt safe in the centre. However it was not clear if incidents relating to one resident, whose behaviour was impacting another resident, had been appropriately reviewed. This was discussed at the feedback meeting and the provider was asked to submit the number of incidents relating to this resident to the Authority. The inspector subsequently reviewed this information and found that while incidents of this behaviour had been reviewed for the resident, there was no

evidence of how the impact of this behaviour on another resident had been reviewed.

There was a policy in place for the provision of behavioural support. A psychologist was available in the centre. The inspector reviewed a sample of behaviour support plans. They had been developed with the support of a psychologist and were detailed enough to guide practice.

Restrictive practices were used in the centre and the inspector saw evidence of how these had been reviewed to reduce their use in the centre.

Residents had intimate care plans in place and staff were observed to treat residents with dignity and respect throughout the inspection. However the plans were not detailed enough to guide practice. For example there was no information contained in the plans where residents shared rooms to ensure residents dignity was maintained.

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):

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

Findings:

Overall the inspector found that a record of all incidents occurring in the centre was maintained, however improvements were required in notifying the Authority of all incidents.

The inspector found two presses that were locked in the centre, that were not notified as restrictive practices.

Judgment:

Substantially 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.

<p>Theme: Health and Development</p>
<p>Outstanding requirement(s) from previous inspection(s): This was the centre's first inspection by the Authority.</p> <p>Findings: Overall the inspector found that residents were supported to access new experiences and opportunities while respecting residents' needs and wishes.</p> <p>Residents were engaged in varied social activities both inside and outside of the centre and the inspector saw evidence of residents learning new skills to promote independence. For example: learning how to put items of clothes on, cooking a meal or going to the barber shop independently. One resident liked gardening and a section of the garden had been developed for them to grow plants. Another resident was involved in the Special Olympics and told the inspector of the many medals they had won in their chosen sport. In addition some of the residents attended a dance therapy group held in the centre.</p> <p>While there was limited evidence of formal educational opportunities for residents outside of the centre, the inspector acknowledges that this is based on the residents' complex needs and individual choices.</p>
<p>Judgment: Compliant</p>

<p>Outcome 11. Healthcare Needs <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i></p>
<p>Theme: Health and Development</p>
<p>Outstanding requirement(s) from previous inspection(s): This was the centre's first inspection by the Authority.</p> <p>Findings: Overall the inspector found that each resident was supported to achieve good health outcomes, however improvements were required in the review of personal plans and the implementation of agreed supports from allied health professionals.</p> <p>The inspector reviewed a sample of personal plans and found that residents had an assessment of need in place. Residents had access to allied healthcare professionals where required. However the inspector found that the recommendations from an allied health professional had not been implemented. For example an occupational therapist</p>

had made recommendations for supports required for one resident to deal with sensory issues. There was no evidence contained in the personal plan that this had been actioned. In addition the changing needs and review of personal plans was not always contained in the personal plans. For example residents' supports were reviewed at staff meetings in the centre, however the information agreed at these meetings was not reflected in the personal plans.

The food available to residents was varied and nutritious and residents were involved in choosing their menu on a daily basis, in line with their preferences. Residents were involved in buying food in the centre and also involved in preparing meals. The advice of dieticians was contained within the personal plans and some residents were attending local community groups around healthy eating.

Judgment:
Substantially Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

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

Findings:

Overall the inspector found that there were policies and procedures for the safe administration of medication in the centre, however improvements were required in a number of areas.

Medications were supplied by a retail pharmacy business in individual 'pouches' where appropriate and all medications were stored in a locked press. There were procedures in place relating to the ordering, prescribing, storing and administration of medication. The medications were checked by a nurse prior to being delivered to the centre to ensure that medications delivered were correct. There was a system in place to audit the amount of PRN (as required medication) medications stored in the premises, however some medications stored in the premises that were not supplied in blister packs did not have the accurate balances recorded. In addition one medication was not been stored in line with the manufacturers' recommendations. Unused or discontinued medication was stored separately and documents showed that these medications were returned to the pharmacy.

A sample of prescription sheets and medication administration sheets were viewed by the inspector and the following areas required improvement:

- Indications for use for one prescribed medication was illegible

- Eye drops prescribed for one resident did not indicate whether both eyes or one eye were affected.

A monthly medication audit was completed by the location manager or the person in charge. Any issues raised from these had been addressed. There was a system in place to record medication errors in the centre. The inspector reviewed these and found that they had been followed up on appropriately.

All staff were trained in the safe administration of medication. However the inspector found that one practice in the centre was not in line with best practice. This involved staff members re dispensing medications into containers when residents were going home for holidays or weekend breaks. In addition it was not clear in one PRN protocol why medication was administered prior to going home for visits.

None of the residents within the centre self administered medication, however there was evidence in each residents plan that an assessment had been carried out on the self administration of medication to explore this.

The pharmacist was not known to the residents as the pharmacy supplier was located some distance from the centre. This was discussed at the feedback meeting.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

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

Findings:

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

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

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

There were clearly defined management structures in place that identified the lines of authority and accountability in the centre. The person in charge reported to the provider nominee who is also the director of services. The person in charge was also responsible for another part of the service however the centre had a location manager in place that supported the person in charge in their role. The person in charge was interviewed as part of a previous inspection in this service. They were found to be suitably qualified and had the necessary skills to carry out their role. They had a very good knowledge of the residents needs in the centre and were very responsive to any issues that were raised over the course of the inspection.

The location manager who is also a person participating in management (PPIM) for this centre was available on both days of the inspection. They were met by the inspector and found to be very aware of the residents needs in the centre and were knowledgeable about the regulations. The location manager met with the person in charge every two weeks and staff meetings were held every four weeks in each of the houses in the centre. The inspector saw evidence of the person in charge's attendance at these.

Residents spoken to knew who the person in charge was and were also very familiar with the provider nominee. Staff spoken to told the inspector that the provider nominee visits the centre regularly.

The provider had nominated a person to complete unannounced safety and quality audits in the centre. A sample were reviewed by the inspector and found that the actions identified had been addressed or were in the process of being addressed. A quality and safety officer, who had been newly appointed to the service, also produced monthly quality and safety reports on incidents and complaints in the centre.

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

Judgment: Compliant

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall the inspector was satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements in place to cover any absences of the person in charge.

The provider was aware of the requirements to notify the Authority in the event of the person in charge being absent.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Overall the inspector found that the centre was resourced to ensure the effective delivery of care and support to the residents and this was in line with the statement of purpose for the centre.

Judgment:
Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

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

Staff were observed to have a very good knowledge of the residents and their needs and responded to residents in a timely, respectful and dignified manner. Only regular relief staff who knew the residents were employed within the designated centre in order to ensure consistency for residents.

Staff spoken to felt that the centre was adequately resourced to meet the needs of the residents. There was a planned and actual roster that reflected the actual hours worked by staff. The provider was undertaking a review of rosters and staff spoken to were aware of this and informed the inspector that it would benefit residents care. The review involved the transfer of day services from other areas, with the intention of providing day service provision from the centre.

Staff spoken to felt very supported in their role. Regular staff meetings were held and staff had supervision meetings with the location manager. The inspector reviewed a sample of supervision meetings and found for the most part issues identified were addressed, however it was not always clear whether issues had been addressed. For example one staff had raised an issue regarding documentation.

There was access to nursing staff as required and staff had access to a 24hr on call service should they require additional out of hours support.

The inspector did not review personnel files at this inspection, as they were inspected by the Authority at an earlier date and found to be in compliance with the regulations.

All staff had completed training in behaviour support, manual handling, medication management and safeguarding. Staff were given the opportunity as supervision meetings to discuss future training needs.

Judgment:

Compliant

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Overall the policies and procedures outlined in Schedule 5 of the regulations were in place and residents' records were safely stored in the centre, however improvements were required in the accuracy of records maintained in the centre.

All of the policies required to be maintained under Regulation 4 and listed in Schedule 5 were available. 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 and for the most part were easily retrievable, however information of clinical reviews by allied health professionals were not contained in the residents personal plan. This was discussed at the feedback meeting.

Gaps were evident in some of the personal plans and in residents' daily records. For example some daily care records were not consistently completed and there were gaps in signatures and information in financial plans for residents. In addition one resident's daily records were not available to the inspector. The inspector was informed that the resident did not like the daily records used by the centre and used a diary that they maintained themselves in the centre. However the resident would sometimes dispose of this diary. The inspector acknowledges that the provider was complying with the residents' wishes; however this did not comply with the regulations and there were no records maintained in relation to the disposal of these documents.

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

A resident's guide was maintained which included all the required information and was displayed in an easy read version for residents.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Gheel Autism Services
Centre ID:	OSV-0002022
Date of Inspection:	15 March 2016
Date of response:	26 April 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Residents did not have direct access to their finances in the centre.

Two staff did not countersign the balance of finances as outlined in the service policy.

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

1. Action Required:

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

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

(1) The organisation is developing a new Service User Finance Policy which will be complete by 30/04/2016. From this, the organisation will implement a new finance system as part of an ongoing education around money management which will support the residents to apply for their own ATM cards and manage their finances locally with the support from staff and the PIC.

The Financial Support Agreement will be reviewed in line with the new Service User Finance Policy and implemented along with the policy.

(2) The new policy will reflect actual practice, i.e. in lone worker areas where countersigning financial records is not always possible, the location manager will sign off on all balance checks on a weekly basis.

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

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

It was not recorded on the complaints log, whether the complainant was satisfied with the outcome of their complaint.

2. Action Required:

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

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

The complainant has been contacted and has noted that they were satisfied with the outcome of the complaint. This was formally recorded and added to the complaint log for closure of the complaint by the PIC and location manager.

Proposed Timescale: 18/03/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The addendum to the contracts of care were not all signed by a family representative.

3. 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:

Families were invited to attend a Family Meeting held on the 20/04/2016 by the PIC for the location. Here, the contract amendments were discussed and families were given the addendum for signing. The majority of addendums were signed on the night. Families who were not present for the meeting were posted a copy, along with an explanation letter of the requirement to expand on the contract content. All contracts have been requested to be returned by 20/05/2016, to facilitate families living outside the area.

Proposed Timescale: 20/05/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

There was no evidence that incidents were reviewed with staff so as to inform learning and guide future practice.

4. Action Required:

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

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

On a monthly basis, a report will be produced in relation to the incidents across the centre for the PIC and Location Manager. This will be used to guide the review of incidents at the staff team meetings and to ensure that there is a lessons learned review component which will be filled out after each monthly review. There will also be a lessons learned agenda item for each team meeting to review the ongoing presenting issues.

Proposed Timescale: 06/05/2016

Theme: Effective Services

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

One residents individual risk management plan did not outline all potential risks.

5. Action Required:

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

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

The risk management plan will be reviewed with the service user, key worker, family and staff in line with the recommendations to ensure that the risk assessment highlights all areas of risk – including adequate additional controls and review dates.

Proposed Timescale: 31/05/2016

Theme: Effective Services

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

The fire evacuation procedures were not detailed enough to guide practice.

The fire evacuation procedures did not outline the measures in place to safe guard residents who may be at risk of absconding during an evacuation of the centre.

The fire drill records did not include details of who was involved in the drill and did not consistently record whether any issues had been identified.

6. Action Required:

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

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

(1) The emergency response plan will be revised in line with the organisational learning from the registration inspections and learning from review with external safety consultations. This will ensure that there is sufficient practical detail, relevant to the house specifics for the evacuation procedure.

(2) The review of the emergency response plan will take the outlined risk into consideration and make specific arrangements clear for the safe evacuation of all residents in case of emergency.

(3) The fire drill record has been amended on the organisational document control system to ensure that there is adequate space to record the details of those involved in the drill. There is also additional guidance on the record for staff to ensure that all details of the drill are recorded for later review purposes. All staff will be reminded of changes to the record by email, and at team meetings.

Proposed Timescale: 31/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The impact of one residents behaviour on another resident had not been reviewed appropriately.

7. Action Required:

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

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

The monthly report regarding incident analysis highlighted above will ensure that trends in behaviour or patterns between residents will be recognised and responded to in a timelier fashion. There would be additional clinical support available to the team as result of any emerging trends or patterns to support the residents and staff.

Proposed Timescale: 06/05/2016

Theme: Safe Services

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

Intimate care plans were not detailed enough to guide practice.

8. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

Intimate care plans will be reviewed in line with changing needs of residents. Where additional information is required to ensure that the document is comprehensive to ensure the necessary support of the resident, this will be detailed in the guidance.

Proposed Timescale: 31/05/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

Two restrictive practices in the centre had not been notified to the Authority.

9. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

All restrictive practices will be notified to the Authority. The restrictive practice policy is due for review on the 05/05/2016 and the learning from the registration inspection will be reflected in the updated policy.

Proposed Timescale: 10/05/2016

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 no evidence on one residents personal plan that recommendations from an OT had been implemented into practice.

The review of residents support needs was not always reflected in the personal plan.

10. 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:

1) Where recommendations have been made by allied health professionals, the recommendations will be highlighted to the staff for addressing. The relevant support plan will be updated by the manager/keyworker to ensure that all staff are familiar with the actions to be taken following recommendations. Where relevant, a recording chart will be established to track the staff supporting the service user to engage with the actions advised. There will also be a standing agenda item added to each team meeting called 'Clinical Intervention', which will alert all staff to any recommendations as well as reviewing and monitoring any ongoing intervention.

(2) The support plan for each service user will be reviewed at each team meeting, with the introduction of a monthly report for each keyworker to have prepared. There is also an annual review of the care and support needs of each resident, which considers the changing needs. This review can be conducted again during the course of the year, should the family/service user/ staff recognise a change in need.

Proposed Timescale: 04/07/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The pharmacist available to residents was not known by the residents and was located some distance away from the centre.

11. Action Required:

Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

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

A review of pharmacy services will be undertaken, with a choice offered to residents about the choice of pharmacy service that they wish to access.

Proposed Timescale: 27/05/2016

Theme: Health and Development

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

Indications for use for one prescribed medication was illegible.

Eye drops prescribed for one resident did not indicate whether both eyes or one eye required the drops.

Staff members were re dispensing medications into containers when residents were going home for holidays or weekend breaks.

One medication was not been stored in line with the manufacturers' recommendations.

Some medications including PRN did not have the accurate balances recorded of the medications stored in the centre.

12. 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:

(1) On rewrite of the prescription sheet, the prescriber will be requested to ensure that the indications on the prescription sheet are clearer. The staff are familiar with the process that all PRN medication indications are clarified in much greater detail and signed by the prescriber. These PRN protocols are stored in the Support Plan.

(2) The prescription sheet has been returned to the prescriber for clarification about the location for the eye drops. This has been formally recorded, and will be discussed with staff at the team meeting in May for clarification.

(3) A review of pharmacy services will be conducted across May 2016, though as an interim measure, the current pharmacy service will be contacted and have these medications dispensed as required for home visits and stays away.

(4) The medication policy will be amended to ensure that there is a more consistent approach to the storage of medication in line with manufacturers recommendations. The issue noted was addressed on day of inspection.

(5) The medication protocols for ensuring the correct balance of PRN medication in stock will be reviewed by the nursing staff in the organisation. This protocol will ensure that there is a robust balance tracking method for PRN medication.

Proposed Timescale: 06/07/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

There were gaps in some of the information contained in residents personal plans.

The records of reviews carried out by members of allied health professionals were not contained in residents personal plans.

13. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

1) There is a comprehensive analysis planned of PCPs and Support Plans by the PIC. Highlighted gaps in information will be monitored to ensure full compliance and completion. Staff will be supported by the Location Manager to ensure all information is available.

(2) All reviews will now be stored in personal plans.

Proposed Timescale: 30/06/2016

Theme: Use of Information

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

The daily records for one resident were not available to the inspector and the system in place did not comply with the regulations.

The disposal of records for one resident had not been recorded in the centre.

14. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

(1) The daily recording system has been reviewed in line with the needs of the resident. There is a new system of ensuring that daily records are recorded while also retaining the wishes of the service user.

(2) The policy in relation to the Retention and Destruction of Records will be reviewed to ensure that there is clear guidelines for staff to follow in case there is destruction of records in future.

(3) The steps taken to address the missing documents to date:

- A second recording diary was used by the service user and staff in addition to the paper book used by staff. Staff were able to secure the information from the diary and transfer into paper books. This information was not able for review on the day, as the service user wishes to keep it on their person.

- Meeting held with day service manager, location manager of house and two regional managers with respect to missing information. A new process was agreed in relation to the safe transfer of paper book between house and day service to ensure service user does not have opportunity to destruct records.

- All information is now stored in a locked filing cabinet to ensure that there was no access for destruction.

(4) The 'How to Support Me' plans have been reviewed by the support team to include specific guidance on the implementation and retention of daily records.

(5) Risk assessment has been reviewed in line with potential for this behaviour.

(6) Provisional guidelines have been developed for staff to guide practice prior to the review of the policy completion.

Proposed Timescale: 30/06/2016