Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Peamount Healthcare ID Community Based Service
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	20 August 2019
Centre ID:	OSV-0003504
Fieldwork ID:	MON-0024390

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre is comprised of two separate apartment type buildings in suburban areas of West County Dublin. It provides 24 hour residential support services to persons with intellectual disabilities. The centre accommodates residents in a variety of units which range from single residency to three persons sharing a unit. The staff team is comprised of a person in charge, a clinical nurse manager, a social care leader, a social care worker, staff nurses and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
20 August 2019	09:45hrs to 18:20hrs	Thomas Hogan	Lead

What residents told us and what inspectors observed

The inspector met with a number of residents who were availing of the services of the centre and observed care and support being delivered by staff members. Residents appeared satisfied with the care and supports that they were receiving and during conversations expressed to the inspector that they were happy and felt safe residing in the centre.

Capacity and capability

Overall, the inspector found that this centre presented with very mixed findings across the regulations inspected against. While residents experienced a reasonably good quality of life and positive outcomes, there were a number of areas which required improvement in order to achieve regulatory compliance. The inspector found that while there had been some efforts made to address these matters since the time of the last inspection, effective management systems had not been fully developed or implemented by the time of this inspection.

The inspector met with the person in charge as part of the inspection and found that they were very knowledgeable in the areas of relevant legislation, regulations and national policy. The person in charge had recently been appointed to the centre and had developed a comprehensive awareness of the individual needs of residents availing of the services of the centre. The inspector found that the person in charge met the requirements outlined in the regulations relating to academic qualifications and management experience.

A review of staffing arrangements found that identified minimum staffing levels were not maintained on occasions in the centre. Through discussions held with staff members, the inspector identified a number of dates were minimum staffing levels were not maintained in the centre with outcomes which resulted in direct impact on residents. On one such occasion, a resident was not administered insulin as prescribed which resulted in the involvement of medical and out-patient services.

As a result of poor record keeping, staff duty rosters maintained in the centre did not reflect occasions when staff members were redeployed to other areas or designated centres operated by the registered provider. The inspector found that 'actual' rosters were not maintained in the centre as required by the regulations. In addition, the inspector found that the skill mix amongst the staff team was not appropriate to meet the identified needs of residents. The registered provider had not ensured that the appropriate grades of staff with the necessary experience and competencies had been deployed in the centre.

The inspector reviewed staff training records and found that there were some minimal deficits in three mandatory training areas. Staff were found to have completed and were up-to-date with all seven remaining mandatory training areas. The person in charge had put a training plan in place to address the identified deficits.

The governance and management arrangements of the centre were reviewed by the inspector as part of the inspection. While the governance structures had been strengthened since the time of the last inspection through the recruitment of a new person in charge, the inspector found overall that the centre was not effectively managed to ensure effective and consistent care was provided to residents in a safe environment. In addition, there was a need for further improvement in oversight and monitoring of the care and support being delivered in the centre. Annual reviews and six-monthly unannounced visits were found to have been completed; however, these internal tools failed in a number of instances to self-identify areas which were not in compliance with the regulations or required improvements. For example, in the most recent annual review and six-monthly visit reports, areas of concern which were found at the time of this inspection which included fire safety, medication management and risk management had not been identified by the registered provider.

The inspector reviewed a sample of incident, accident and near miss records maintained in the centre and held discussions with the management team and found that notifications were appropriately made to the Office of the Chief Inspector as required by the regulations.

A review of the centre's complaints policy and procedures was completed by the inspector along with a review of the centre's complaints register. The inspector found that there were appropriate arrangements in place for managing complaints received and residents were encouraged to raise concerns where appropriate. There was evidence to demonstrate that complaints were promptly investigated and responded to.

Regulation 14: Persons in charge

The inspector found that the centre was managed by a suitable skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

The identified minimum staffing levels were not maintained in the centre on occasions which resulted in negative outcomes for residents. Staff duty rosters

maintained were not reflective, on occasions, of the actual staff deployed in the centre. The inspector found that the skill mix of the staff team did not meet the assessed needs of residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There were some minor deficits in three mandatory training areas. For example, two staff members had not completed training or refresher training in basic life support and the use of an automated external defibrillator.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that effective management systems were not in place in the centre to ensure that services provided were consistent and effectively monitored. The registered provider had failed to self-identify areas of non-compliance with the regulations or areas which required improvement.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that notifications were appropriately made to the Office of the Chief Inspector as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector found that there were appropriate arrangements in place for the management of complaints.

Judgment: Compliant

Quality and safety

A review of the general welfare and development of residents found that individuals experienced a good quality of life while availing of the services of the centre. Residents were observed to live active lives and self-direct the care and support they received. Independence was promoted and there were numerous examples of the development of skills amongst residents to allow for integrated living. The inspector found that residents were also supported to attend a number of community based activities including knitting, bowling and social inclusion groups, and one resident had been supported to obtain part-time paid employment in the local area.

The inspector completed a full walk through of the premises of the centre in the company of the person in charge. The centre was comprised of 11 units across two separate settings which collectively provided 26 individual bedrooms. Overall, the inspector found that the premises of the centre were designed and laid out to meet the needs of residents; however, some issues relating to general maintenance were identified. In one area, the inspector found that a number of the units required painting and decoration. In addition, there was a need identified for the removal of damaged items and broken furniture from an outdoor space in this area. In the second setting (an apartment block), the inspector found that flooring throughout many of the individual apartments required replacement and storage arrangements required review in a number of apartments.

A review of arrangements in place for the management of risk found that the registered provider had failed to identify, assess and address some risks which had presented. For example, a scenario which involved staff being instructed to leave a resident in a building without fire doors in the event of a fire and their non-compliance with the evacuation procedures had not been identified as a risk. While there was a local risk register present, the risks outlined on this document were found to be limited to resident related risks and as previously mentioned did not include all presenting risks. The inspector was informed that there was an additional organisational risk register in place; however, staff members and the local management team did not have access to this document and as a result were not aware of control measures outlined to control risks. The centre's risk policy (dated July 2018) was reviewed by the inspector and was found not to contain a number of areas outlined as being required by the regulations.

The inspector reviewed the fire precaution arrangements in place in the centre. There was a fire alarm and detection system installed throughout. While there was emergency lighting fitted in most of the required areas, the inspector found that in one apartment there was none present. In one setting (which included four units and accommodated 10 residents) the inspector found that there were no fire doors fitted with the exception of one in an office area. In a second setting (an apartment block) the inspector found that while there were internal fire doors fitted, these did not have self-closing mechanisms in place as required. A review of a

sample of five personal emergency evacuation plans found that information provided was contradictory in one case and ambiguous in other instances and overall did not clearly outline the supports required by residents in the event of a fire or similar emergency. Due to limited and poor recording practices in the maintenance of fire drill records, the inspector found that there was an absence of evidence available to demonstrate that staff and residents were aware of the procedure to be followed in the event of a fire and that all persons could be evacuated in a safe manner.

A review of practices relating to the management of medication was completed by the inspector. It was found that individual capacity assessments had been completed for residents relating to the self-administration of medication and there was appropriate storage arrangements in place in resident bedrooms. The inspector noted; however, that keys for a central medication cabinet in one setting were not stored in a safe manner. In this area, the inspector found that there were a number of PRN medication (medication only taken as the need arises) which did not have expiry dates listed. A review of medication administration records for a sample of four residents found that in all cases prescribed medications had not been administered as prescribed and included anti-epilepsy, analgesic, statin and anti-inflammatory medications.

The inspector reviewed incident, accident and near miss records and found that the centre satisfactorily protected residents from experiencing abuse. Residents spoken with by the inspector communicated that they felt safe while availing of its services and were knowledgeable on how to raise concerns should any arise in the future. Staff members met with were aware of the different types of abuse and the actions required if a safeguarding concern was ever suspected or witnessed.

Regulation 13: General welfare and development

The inspector found that residents were supported and encouraged to develop natural support networks in their local communities.

Judgment: Compliant

Regulation 17: Premises

A number of areas of the centre required painting and decorating. In one setting there was a need for removal of damaged and broken items from the area identified. In another area, several apartments required flooring to be replaced throughout.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre's risk management policy did not outline a number of areas identified as being required by the regulations. In addition, the inspector found that some presenting risks had not been identified, assessed of managed by the registered provider.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had failed to ensure that there were effective fire safety arrangements in place. For example, emergency lighting was not fitted in all required areas of the centre, fire doors were not in place in all required areas, and self-closing mechanism were not fitted to fire doors. In addition, personal emergency evacuation plans did not clearly outline supports required by residents and there was an absence of evidence available to demonstrate that all persons could be evacuated from the centre in a safe manner in the event of a fire .

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The arrangements for the storage of medication keys in one area of the centre was found not to be satisfactory. A number of PRN medications were found not to have expiry dates listed. The records of four residents were reviewed by the inspector and in all cases it was found that there were a number of prescribed regular medications which were not recorded as having been administered.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that residents were adequately protected from experiencing abuse while availing of the services of the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Peamount Healthcare ID Community Based Service OSV-0003504

Inspection ID: MON-0024390

Date of inspection: 20/08/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC will ensure that the minimum staffing will be in place at all times to meet resident's needs. The actual roster will be updated to reflect any changes, as they occur and this will be monitored by the ADON of the service. All staff have access to the actual roster and is printed and available as changes occur. There are 2 social care workers employed in the centre and they will contribute to identifying and meeting the social care needs of the residents. They will guide the team through staff meetings and internal education sessions on a bi monthly basis. A number of the Healthcare assistants have a social care qualification and are employed in the centre. The PIC will ensure that there is daily guidance and support given to the staff teams to ensure the delivery of social care best practice. There will be an identified team leader in each unit in the absence of the PIC.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A training plan had been implemented prior to inspection and the 2 staff members that are currently out of date will have completed/refresher and mandatory training by 30/9/19.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Annual Review process will be reviewed and education and feedback will be provided by the Registered Provider to the nominated reviewers.
The reviewers will follow the guidance document on Regulation 23 when completing the reviews. This will ensure that all areas are monitored and identified during this process.

Any issues from previous inspections both internally and from HIQA will be incorporated into the reviews.
Medication administration records will be checked at each handover to ensure that all medications have been administered. The PIC will do a daily check for the records in both units when on duty.
Ongoing monitoring audits are undertaken by the PIC in both locations including RMOF, Risk Register, Care Plans, and Residents' Finances.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider will liase with the Housing Committee of Peamount Healthcare to ensure that the painting and decorating requirement for the centre will be included in the programme for 2020.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk Management policy currently under review and will be signed off on 30th September 2019
All the PEEPS have now been reviewed and reflect the supports required in the event of a fire.
A fire drill will be scheduled for both units by the Health and Safety Officer. The reports

will be detailed enough to provide staff and residents with the guidance required for safe evacuation in the event of Fire or any Emergency.

The Risk register will include environmental and location specific risks which will be kept in the office in each location.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Resident risk assessment relating to PEEP completed on day of audit.
A fire drill will be scheduled for both units by the Health and Safety Officer. The reports will be detailed enough to provide staff and residents with the guidance required for safe evacuation in the event of Fire or any Emergency. Fire drill reports to include names of all present.

Costed plan for the installation of fire doors and door closures will to be submitted to HSE for approval.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Pharmacy has provided assurance documentation confirming all blister pack medication is in date and will write expiry dates on all PRN medication. The staff receiving the medication will check the expiry dates during receipt of medication on a weekly basis.
A staff member will be identified on each shift to check Kardex files to ensure that all medication has been administered at the end of each shift as part of handover. Clinical Facilitator is running refresher training to all staff on SAMMS.
The key to the medication cupboard is kept in a key safe in staff office.
PIC and CNM1 to undertake weekly audit of Kardex files in both units.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	02/01/2020
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	21/08/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	30/09/2019

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/10/2019
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the	Not Compliant	Orange	30/09/2019

	following specified risks: the unexpected absence of any resident.			
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Not Compliant	Orange	30/09/2019
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	31/10/2019
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified	Not Compliant	Orange	31/10/2019

	risks: self-harm.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/09/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/10/2019
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of	Not Compliant	Orange	31/10/2019

	risk, including a system for responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	21/08/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	21/08/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Orange	31/10/2019

	followed in the case of fire.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	21/08/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	21/08/2019
Regulation 29(4)(c)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating	Not Compliant	Orange	21/08/2019

	to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant national legislation or guidance.			