

**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 Nua Healthcare Services
Centre ID:	OSV-0005180
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Nua Healthcare Services
Provider Nominee:	Noel Dunne
Lead inspector:	Louisa Power
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- 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 wellbeing 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. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:

08 March 2016 09:25

To:

08 March 2016 16:30

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

Outcome 01: Medication Management

Summary of findings from this inspection

The inspection was an unannounced inspection to monitor compliance in relation to medicines management. The inspection was triggered following a desktop review of notifications submitted by the person charge in line with Regulation 31(1)(d). This was the second inspection of the centre; the first inspection had taken place prior to the registration of the centre and the centre was unoccupied at the time. As part of the single outcome inspection, the inspector met with the person in charge, residents and staff members. The inspector reviewed medication management practices and documentation such as prescription charts, medication administration records, training records, policies and procedures and records of residents' meetings.

The centre was located in a rural location near a small village. The centre comprised a large residential house and a smaller cottage. At the time of the inspection, all residents were accommodated in the large residential house. The centre provided 24 hour care to adults with intellectual disabilities and mental health needs.

Good practice was observed in relation to the ordering, receipt, disposal and monitoring of medicines management in the centre. An assessment of each resident's needs in relation to support with medicines management had been completed and an individualised medicines management plan had been developed.

Improvements were required in relation to the storage of medicines that require refrigeration and to ensure that medicines are administered as prescribed to residents at all times. Management plans in relation to positive behaviour support required review to guide staff effectively. These findings are discussed throughout the report and in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, 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: Medication Management

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. There was a medicines management policy which detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines.

Medicines to be kept at room temperature were stored securely. Staff confirmed that medicines requiring additional storage and documentation controls were not in use at the time of the inspection. However, medicines requiring refrigeration were stored in a refrigerator that could not be locked and a system was not in place to monitor the reliability of the refrigerator used to store medicines.

Compliance aids were used by staff to administer medicines to residents. Resources were available to the nurse staff to confirm prescribed medication in the compliance aid with identifiable drug information.

The inspector observed medicines administration practices and found that the staff did adhere to many aspects of the centre's policy, legislative requirements and professional guidance. However, the inspector noted that a staff member signed the medication administration record to indicate that a medicine had been administered to a resident prior to administering medicine instead of following the event to ensure an accurate and contemporaneous record was maintained.

A sample of medication prescription and administration records was reviewed. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However, it was noted that medicines were not administered as prescribed. A resident was prescribed a medicine to be administered on alternate days but the medication administration record indicated that it had been administered daily for three days on one occasion and on two consecutive days on another occasion within a ten day period.

Another resident was prescribed buccal midazolam to be administered in the event of a 'tonic clonic seizure' but records indicated that buccal midazolam had been administered to the resident during an absence seizure on five occasions in January/February 2016. In addition, gaps were noted in medication administration records at times when medicines were due to be administered on one occasion for one resident.

A comprehensive and individualised assessment had been completed for each resident which took into account cognition, communication, reception and dexterity. Four levels of support were outlined in relation to medicines management. At the time of the inspection, all residents required full support with medicines management (level 3). A personalised medicines management plan had been developed for each resident which outlined the resident's individual preferences in relation to medicines administration and the level of support to be provided in relation to medicines management.

There was a system in place for the reviewing and monitoring of safe medicines management practices. Staff with whom the inspector spoke confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the medication prescription records. A weekly check was undertaken of the stock levels and expiry dates of 'as required' medicines. There was a weekly audit of medicines management practice which examined a number of areas related to medicines management, receipt, storage, disposal, staff training and administration.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

A sample of medication incident forms were reviewed and the inspector saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented.

The inspector observed that resources relating to medication management were available to staff. Training had been facilitated in medicines management for all staff.

A number of residents required support to manage behaviours that challenge and the inspector reviewed a sample of care plans for residents who were prescribed 'as required' psychotropic medicines for the management of challenging behaviour. A management plan that outlined a proactive approach to behaviour that challenges including the identification of specific triggers and the use of reassurance and distraction techniques was in place for all residents as appropriate.

However, the management plan did not include 'as required' psychotropic medicines and did not give guidance in relation to the appropriate and time administration of these medicines. In addition, where a resident was prescribed more than one 'as required' psychotropic medicine, the management plan did not give guidance in relation to the most appropriate agent to be administered as first line.

The inspector observed an incident whereby a resident required such a medicine but staff were unclear as to which agent to administer as two 'as required' psychotropic medicines were prescribed.

Where chemical restraint was used, a clear assessment was completed prior to the administration. Documentation reviewed indicated that potential episodes of restrictive procedures were considered only if the potential benefit of restrictive procedures to the resident, and the risk involved if restrictive procedure was not used, outweighed the possible negative effects on the resident subject to restrictive procedures. Where possible, the underlying cause of the challenging behaviour had been identified and alleviated. Records clearly reflect that residents were monitored during any episode of chemical restraint. Adverse events resulting from chemical restraint were documented. It was clear that all alternative interventions were considered prior to the use of chemical restraint.

A sample of health care plans was reviewed and plans were developed in line with each resident's assessed needs. The health care plans were augmented by management plans which were developed with 'rescue' treatment that may be required. The information contained in the plans was evidence based. However, the information was not tailored to the individual resident. For example, general triggers for seizures were outlined in all epilepsy management plans reviewed even though some residents had very specific triggers detailed elsewhere in their health care records. In addition, the specific brands of insulin prescribed for a resident were not outlined in the management plan or care plan. Furthermore, personalised information in relation to this resident's diabetes care was limited in relation to follow up by the multidisciplinary team.

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:

Louisa Power
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 Nua Healthcare Services
Centre ID:	OSV-0005180
Date of Inspection:	8 March 2016
Date of response:	1 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: Medication Management

Theme: Health and Development

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

Personal plans relating to healthcare were not personalised.

1. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects

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

the resident's assessed needs.

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

Specific Health Management plans for seizure activity has been updated and tailored to individual residents needs within this designated centre.

Proposed Timescale: 08/04/2016

Theme: Health and Development

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

Management plans did not include 'as required' psychotropic medicines and did not give guidance in relation to the appropriate and time administration of these medicines

2. Action Required:

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

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

The person in charge will complete a full review of all the management plans surrounding the use of psychotropic medication to ensure that clear guidance is provided through all Management plans.

Proposed Timescale: 22/04/2016

Theme: Health and Development

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

A staff member signed the medication administration record to indicate that a medicine had been administered to a resident prior to administering medicine.

3. 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:

The Staff member was re-trained in line with the Designated Centres Policy on the safe administration of medication.

Proposed Timescale: 08/04/2016

Theme: Health and Development

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

Medicines were not always administered as prescribed

4. 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:

All Medication Errors are processed in line with the Designated Centre's Policy on the Safe Administration of Medication. Further Training is being completed by the staff nurse at the team meeting.

Proposed Timescale: 15/04/2016

Theme: Health and Development

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

Medicines requiring refrigeration were stored in a refrigerator that could not be locked and a system was not in place to monitor the reliability of the refrigerator used to store medicines.

5. Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

A refrigerator which can be locked has been acquired and a system will be implemented to monitor the temperature of the refrigerator.

Proposed Timescale: 15/04/2016