

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Mobhi Road
Centre ID:	OSV-0001525
Centre county:	Dublin 9
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Peter Bradley Foundation Company Limited by Guarantee
Lead inspector:	Thomas Hogan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 07 September 2017 09:30 To: 07 September 2017 17:55

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to inspection

This unannounced inspection was carried out to monitor ongoing regulatory compliance in the designated centre. This was the third inspection of this designated centre and it took place over one day. Seven outcomes were inspected against which included follow up on actions from the previous inspection.

Description of the service

The designated centre is operated by Acquired Brain Injury Ireland and made up of a large semi-detached house in north Dublin. The ground floor of the designated centre comprises of an entrance hallway, living room, dining room, large kitchen area, staff office, one bedroom and a bathroom. On the first floor there are four bedrooms all with en suite bathroom facilities. On the third floor of the designated centre there is a staff office and sleep over room with separate bathroom facilities.

How we gathered our evidence

The inspector met and spoke with residents, staff members, person in charge, and team leader of the designated centre during the inspection. Practices were observed and documentation such as statement of purpose, residents' guide, complaints register, resident meetings minutes, financial records, completed audit records, and care plans. Some additional documents were forwarded to the inspector by the person in charge following the inspection and these were reviewed as a desktop

exercise.

Overall judgment of our findings

Overall it was found that designated centre was in substantial compliance with four outcomes, moderate non-compliance with a further two outcomes, and in major non-compliance with one outcome. Further detail on these findings can be found in the main body of this report.

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 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):

No actions were required from the previous inspection.

Findings:

Overall, the inspector found that residents' wellbeing and welfare was maintained and promoted within the designated centre and opportunities to participate in meaningful activities was provided and supported. There were some areas of improvement identified, however, and these were brought to the attention of the person in charge and team leader at the feedback meeting.

Comprehensive assessments were not completed in the areas of personal and social care for residents of the designated centre. An 'initial assessment summary' completed at time of admission focused on the areas of brain injury, physical, sensory, cognitive, character, behavioural, emotional and independence issues. The inspector found that a comprehensive health assessment was available on file for all residents. For assessments that were completed there was evidence available which confirmed that residents and their representatives were actively involved in the process. The team leader and person in charge outlined that there was multidisciplinary input into the assessment process with psychology, social work, person in charge, team leader, and service manager input available.

The inspector was informed that goal planning for residents was completed in the 'individual rehabilitation plan' document. In the case of one resident this documents focused on physiotherapy, incontinence, social goals, fitness, and cooking goals. Overall, it was found that there was good awareness of residents' individual goals and there was ongoing review of these at several forums. Goals were listed on daily log books, discussed at monthly staff meetings and resident meetings, and were reviewed by the 'clinical team' (multidisciplinary) at meetings held every three months. These reviews,

known as 'progress reports', were made available to the inspector and it was found that they were constructive in nature with suggestions being made on how to achieve goals. In addition, annual reviews of the individual rehabilitation plan took place with family input where available.

Daily schedules and weekly timetables were in place for residents which reflected the goals contained in the individual rehabilitation plan. In the case of one resident, an accessible easy read version of this was made available which had improved communication and aided in the development of personal skills. Despite other residents not having plans available in accessible format, residents spoken with were knowledgeable on their individualised goals.

Overall, activity records for the designated centre were reviewed by the inspector and it was found that there were appropriate opportunities for residents to engage in meaningful activities which included a variety of day services tailored to residents' needs, supported employment, trips to the cinema, visits to restaurants, shopping, day trips, and befriending clubs.

Residents spoken with during the inspection confirmed that they were consulted with prior to any admissions to the designated centre. The team leader outlined the process undertaken involving the recent discharge of a resident from the centre and the inspector found that this took place in a planned and safe manner.

Judgment:
Substantially 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):

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

Findings:

The inspector found that overall the health and safety of residents, visitors and staff was promoted and protected within the designated centre. There were some minor areas for improvement identified during the inspection and these were brought to the attention of the person in charge and team leader.

The designated centre had a risk management and assessment policy in place (reviewed in May 2017) and included guidance on types of risks to assess, general approach to risk assessments for residents, review process and timeframes of risk assessments, serious incidents and adverse events involving residents, management of risk in the event of an emergency, management of risk associated with transportation of residents,

management of risk associated with smoking, related documents and policies. It was found that while some guidance was provided on the areas mentioned, the risk management and assessment policy did not clearly include the requirements as per the Regulations. The following areas were identified as requiring inclusion:

- general hazard identification, other than those relating to residents
- measures and actions in place to control risks identified
- measures and actions in place to control the unexpected absence of a resident, accidental injury to residents, visitors or staff, aggression and violence, and self-harm; arrangements
- arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents
- arrangements to ensure that risk control measures are proportional to the risks identified, and that any adverse impact such measures might have on residents' quality of life have been considered

The designated centre had a health and safety statement in place (dated February 2015), which contained a policy statement, responsibilities of staff, and health and safety arrangements.

A comprehensive risk register was in place in the designated centre, however, the risks associated with the use of an open fire in the living room area, and the risks associated with the front door step of the building - raised by staff members - were not considered in this document or in any risk management context.

A review of incidents and accidents which occurred in the designated centre was completed by the inspector. This found that there were a total of three incidents in 2017 to the date of inspection. All three related to seizure activity secondary to a diagnosis of epilepsy and one of these incidents also involved a resident falling.

Training records made available to the inspector were reviewed and it was found that all staff members had completed fire training. Four staff were found to have had either no training completed in the area moving and handling of residents, or did not complete refresher training completed in the timeframe required by the designated centre.

The inspector found that there was suitable fire equipment in place in the designated centre. Since the time of the last inspection fire containment had been installed on all three levels of the building. The actions from the previous inspection relating to Outcome 7 - Health and Safety and Risk Management were found to be satisfactorily implemented.

Records were available which confirmed the fire alarm system was serviced and maintained on a quarterly basis. Emergency lighting was also serviced and maintained on a quarterly basis with records in place. Daily fire safety checks were completed in the designated centre which considered areas such as fire doors, obstructions, and egress plans for residents. Monthly health and safety checklists were also completed and actions listed following the July 2017 checklist being carried out were found to be fully completed. Monthly vehicle safety checks were also completed which confirmed the road worthiness of the service vehicle in use within the designated centre.

Individual personal emergency egress plans (PEEP) were in place for each resident and outlined the supports required during an emergency evacuation. The plans accounted for the mobility and cognitive understanding of residents.

Fire drill records were reviewed by the inspector and it was found that drills were completed monthly. Evacuations were completed in a timely manner. One fire drill highlighted that a resident refused to evacuate the centre on one occasion, however, this risk was not considered on the PEEP or any risk assessment document. The team leader for the centre updated the PEEP during the inspection to highlight that additional supports may be required.

Residents and staff members spoken with were knowledgeable on what actions to take in the event of a fire. In addition, procedures for safe evacuation of residents were prominently displayed in the designated centre.

While two carbon monoxide alarms were found to be in place in the building, no checks were conducted on these to ensure that they were in working order.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

Overall, it was found that measures were in place to protect residents from harm or suffering abuse within the designated centre and appropriate actions were taken in response to allegations, disclosures or suspected abuse, however, improvements were required in the area of staff knowledge and awareness regarding types of abuse and the actions required in the event of witnessing or suspecting abuse.

A review of incident records indicated that there had been no abusive concerns reported since the time of the last inspection. The inspector spoke with two residents regarding abuse and both stated that they felt safe in the designated centre and knew who to

Speak to if they ever felt unsafe.

Three staff members were spoken with by the inspector regarding the types of abuse and the actions to take if abuse was witnessed or suspected. Two of the three staff members spoken with did not demonstrate sufficient knowledge in these areas. This was brought to the attention of those present at the feedback meeting.

A policy on safeguarding vulnerable persons at risk of abuse was in place in the designated centre (reviewed in 2016). The document outlined the designated centre's position through an initial statement, definitions, special considerations, prevention, risk management, principles, key considerations in recognising abuse, complaints, responding to concerns or allegations of abuse of vulnerable people, the role of the designated officer, the role of the safeguarding and protection committee, roles and responsibilities, and the safeguarding plan.

An intimate care policy was found not to be in place in the designated centre at the time of inspection.

The person in charge confirmed that the designated centre required staff to complete training in safeguarding every two years. A review of staff training records made available to the inspector found that two staff members had completed the training in the previous two years, seven staff members had not completed the training in the past two years, and a further two staff members had never completed the training.

A policy titled 'Challenging Behaviour' was found to be in place for the provision of behavioural support and had been reviewed in June 2015. This document provided limited guidance on the provision of behavioural support under the headings of: definitions, intent statement, why challenging behaviour arises, common approaches, awareness of behaviour, how to respond in general, strategies for dealing with challenging behaviour, specific concerns about a person, and staff support and debriefing.

Records available in designated centre demonstrated that there were few incidents relating to behaviours which challenge. There were concise behaviour support plans on file for residents who required same. The plans provided clear guidance for staff members and were prepared by a member of the psychology team. While all staff members were found to have completed training in the area of behavioural supports, this had not been completed within the previous two years as required. Staff spoken with were found to have satisfactory awareness of the content of the behaviour support plans and confirmed that practice was guided through their use.

A Restraint policy was in place in the designated centre (reviewed in June 2015) which outlined the designated centre's position on the matter. Areas included in this document included: the law, professional standards and advice, ethical principles, consent, definitions, general policy, and beyond restrictive practices. The inspector found that there were no restrictive practices in place in the designated centre at the time of inspection.

The inspector found that there were no restrictive practices in use in the designated

centre at the time of inspection.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

The inspector found that residents were supported on an individualised basis to achieve and enjoy the best possible health.

Residents' health care needs were met through timely access to health care services and appropriate treatment and therapies. While comprehensive health assessments were completed and available on file, there was an overall absence of health care plans in place for identified health needs. Only one resident had health care plans completed and on file. Medical needs such as epilepsy, hypertension, myopia, and mental health conditions were not captured in the care planning process.

Evidence was available to demonstrate that residents had access to allied health care services which reflected the diverse care needs of the designated centre. These services were largely accessed through community services and the person in charge indicated that access to such services was generally in a timely manner. In addition, it was found that residents had access to a medical practitioner of their choice.

The inspector observed a meal being prepared for residents. There was full involvement of residents in this process with appropriate supports in place. There was evidence of choice of meals and this was planned at a weekly resident meeting. All foods were found to be labeled in storage and in refrigerated areas and expiry dates were available for same. Staff supported residents with grocery shopping, making healthy choices, maintaining hygiene, and providing easy read instructions for preparing foods. Staff members informed the inspector that everyone sat and ate meals together in the centre and that it was a sociable event.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

Overall, the inspector found that each resident was protected by the designated centre's policies and procedures for medication management. Some areas of improvement were identified during the inspection and brought to the attention of the person in charge.

There was a medication policy in place (dated October 2016) which provided clarity on the areas of prescribing, ordering, collection, storage and administration of medication. In addition, the following areas were contained within the policy document: training and competency, self-administration of medication, controlled medication, refusal, covert administration, as required medication, allergies, over the counter medication, withholding of medication, day service arrangements, medication errors, procedures for holidays and outings, self-administration of medication, out of date medication, complementary medication, management of sharps, and emergency medications.

The inspector found that while individualised medication plans were in place for each resident; these were not dated or included in any review process. A review of the prescription sheet for one resident found that the route, frequency, start date, and prescriber's signature was not completed. This was brought to the attention of the person in charge and team leader by the inspector.

A staff member was observed administering medication to one resident and was found to overall adhere to appropriate medication management processes. The staff member did not, however, wash their hands prior to administering the medication to the resident.

Appropriate procedures were found to be in place in the designated centre for the handling and disposal of unused and out of date medications. A weekly returns system to the local pharmacy was in place in the designated centre. A system was in place for reviewing and monitoring safe medication management practices in the designated centre. Regular audits were completed on medication management and records of these were made available to the inspector.

A review of a self-administration of medication assessments completed for residents found that the outcome of the assessment process was not clear. Three options for the levels of support required were listed, however, in the case of all assessments no level of support was selected. There were no completed risk assessments available relating to the self-administration of medication by residents.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

The inspector found that while the quality of care and experience of residents was monitored on an ongoing basis, this process required further development and review.

An annual review of the quality and safety of care in the designated centre was completed for 2016; however, no date of completion was included on this document. The person in charge confirmed that it was completed in December 2016. Areas examined as part of the review included: occupancy, admissions, environmental improvements, quality, training, accidents and incidents, complaints, staffing, staff survey, individualised rehabilitation plan audits, medication management, food and dining, catering, finances, resident survey, family survey, and quality improvement plan. The document was not satisfactorily completed, however, with the 'action plan' arising from the review process stating "...this is a summary of actions you will take during 2017...".

Reports were made available to the inspector from unannounced visits to the centre by the provider or persons on their behalf. These were completed in May 2016, November 2016 and May 2017. Evidence of follow up on actions contained in previous reports of unannounced visits was not clear, and updates on the status of incomplete actions was not contained in the most recent version of action plans. The person in charge provided a verbal update to the inspector which indicated that actions from the most recent unannounced visit had been completed.

A clearly defined management structure was found to be in place in the designated centre. The person in charge was responsible for two designated centres with a considerable geographical distance between both. When spoken with, the person in charge informed the inspector that they were comfortable with this arrangement and spent an equal amount of time in both centres. The person in charge was supported in their role by team leaders in both centres, and local practice ensured that either the

person in charge and/or the team leader was on duty in the centre each day.

The person in charge demonstrated sufficient knowledge of the legislation and their statutory responsibilities. Residents in the designated centre spoke with could identify the person in charge.

Judgment:

Substantially 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):

No actions were required from the previous inspection.

Findings:

Overall, it was found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Staffing levels took into account the statement of purpose and size and layout of the designated centre.

There were planned and actual staff rosters in place in the centre. Residents were observed receiving assistance, interventions and care in as respectful, timely and safe manner.

The training records of staff were reviewed by the inspector and it was found that there were failures across all mandatory training requirements to ensure that all staff received prescribed training and refresher training. Deficits in the areas of fire training and manual handling training, and safeguarding have previously been outlined under Outcome 7 Health and Safety and Risk Management, and Outcome 8 Safeguarding and Safety. A requirement to complete safe administration of medication training every two years was not completed by eight staff members. Similarly, documentation training was not completed by eight staff in the two year window required. Training identified as being required in the area of managing aggression was not completed by any staff in the designated centre.

Both the person in charge and team leader outlined that formal supervision was completed with staff on a quarterly basis. This process involved a one-to-one meeting with each staff member. A review of supervision records, however, indicated that supervision meetings were not taking place on a regular basis with some staff member

having not received any supervision since 2014. In other cases supervision meetings were not completed in the timeframe outlined by the person in charge.

A review of volunteers and student placements within the designated centre highlighted that appropriate vetting was not in place for students. The most recent placement of this nature in the designated centre was in August 2017. The person in charge confirmed that no records of vetting were available for these individuals.

Staff files were not available in the designated centre at the time of inspection and therefore were not reviewed by the inspector.

Judgment:

Non Compliant - Major

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:

Thomas Hogan
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 Peter Bradley Foundation Company Limited by Guarantee
Centre ID:	OSV-0001525
Date of Inspection:	07 September 2017
Date of response:	10 November 2017

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 05: Social Care Needs

Theme: Effective Services

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

Comprehensive assessments were not completed for the personal and social care needs of each resident in the designated centre.

1. Action Required:

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

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The health, personal and social care needs of each resident will be reviewed by the PIC and Team Leader, in conjunction with the keyworker and resident, with quarterly Clinical Team Reviews to ensure that all support needs are accurately reflected in the individualised documentation and reviewed annually, or sooner, as required. All residents will be requested to attend their GP at least annually for health screening.

Proposed Timescale: 30/11/2017

Theme: Effective Services

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

Personal plans were not made available to all residents in accessible formats.

2. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The accessibility of the format of personal plans will be reviewed with each resident by their keyworker and team leader, to ensure these plans are as accessible as possible to each individual. Where relevant, speech and language and any other recommendations regarding communication and information processing will be reviewed at the quarterly review to ensure recommendations reflected in the accessibility of the plans.

Findings of each review between keyworker, team leader and resident to be presented to PIC and recommendations to increase accessibility implemented.

Proposed Timescale: 15/12/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management policy in place did not include hazard identification and assessment of risks throughout the designated centre.

3. Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risk management policy in place did not include the measures and actions in place to control the risks identified.

4. Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risk management policy in place did not include the measures and actions in place to control the unexpected absence of any resident.

5. Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risk management policy in place did not include the measures and actions in place to control the accidental injury to residents, visitors or staff.

6. Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risk management policy in place did not include the measures and actions in place to control aggression and violence.

7. Action Required:

Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

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

The action submitted by the provider for this action did not satisfactorily address the failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risk management policy in place did not include the measures and actions in place to control self-harm.

8. Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

The action submitted by the provider for this action did not satisfactorily address the

failings identified.

Proposed Timescale:

Theme: Effective Services

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

The risks of an open fire in the living room and front door step of the designated centre were not assessed.

9. 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:

Risk assessments relating to the open fire and front door step will be completed and reviewed in line with identified risk rating.

Proposed Timescale: 31/10/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Two members of staff did not demonstrate sufficient knowledge in the areas of types of abuse and the actions to take in the event of witnessing or suspecting abuse towards a resident.

10. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

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

Safeguarding Training has been scheduled for all members of staff on 6th December 2017.

Regular staff meetings will include Safeguarding as a standing agenda item to ensure all staff are aware of safeguarding, types of abuse and actions required to be taken.

Proposed Timescale: 06/12/2017

Theme: Safe Services

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

An intimate care policy was found not to be in place in the designated centre at the time of inspection.

11. 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:

The Intimate and Personal Care Plans of all residents who require support with personal care will be reviewed by the PIC, Team Leader and Keyworker in line with ABI Ireland's Intimate and Personal Care Policy.

These individualised plans will be reviewed at minimum annually.

Proposed Timescale: 10/11/2017

Theme: Safe Services

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

Seven staff members had not completed safeguarding training in the previous two years as required by the designated centre. In addition, two staff members had never completed this training.

12. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Safeguarding Training has been scheduled for all staff on 6th December 2017. Safeguarding policy will be reviewed at the next staff meeting on 8th November 2017.

Regular staff meetings will include Safeguarding as a standing agenda item to ensure all staff are aware of safeguarding, types of abuse and actions required to be taken.

Proposed Timescale: 06/12/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:

Four residents in the designated centre did not have health care plans in place despite having identified health care needs.

13. 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:

The individualised health care plans for each resident will be reviewed by the PIC, Team Leader, keyworker, Clinical Team and resident to ensure accurate reflection of all their health needs. Involvement of medical personnel will be sought where necessary.

This individualised documentation will be reviewed annually, at a minimum or when individual circumstances change.

Proposed Timescale: 10/11/2017

Outcome 12. Medication Management

Theme: Health and Development

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

1. A medication for one resident was found on the prescription sheet not to have the route, frequency, start date, and prescriber's signature listed.
2. A staff member was observed administering medications to a resident without having washed their hands.
3. Medication plans in place were not dated or subject to review.

14. 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. Prescription Sheet has been corrected and the prescriber's signature listed
2. Infection control training has been scheduled for all staff on 30th November 2017.
3. All medication plans have been reviewed and will be reviewed on an ongoing basis as circumstances change.

Proposed Timescale: 1 & 3 Completed Nov 2nd '17. 30th November '17 for No. 2

Proposed Timescale: 30/11/2017

Theme: Health and Development

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

Assessments for self administration of medication were not satisfactorily completed. Risk assessments relating to the self administration of medication were not completed for any resident.

15. Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

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

Assessment of all residents in relation to their medication support have been reviewed and completed. Risk assessments will be completed for those who are actively engaging in self administration of medication and reviewed quarterly.

Proposed Timescale: 02/11/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The annual review of the quality and safety of care and support in the designated centre was not completed to a satisfactory standard.

16. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

The annual review for completion on 12th December 2017 will be clearly dated and signed and will provide a comprehensive summary of the recommendations for 2018 and the actions to be completed, with clear dates for completion.

Proposed Timescale: 12/12/2017

Theme: Leadership, Governance and Management

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

The status of actions relating to the plans from previously completed unannounced visits to the designated centre were not available or reviewed at follow up unannounced visits.

17. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

Notification will be sent to those conducting Regulation 23 inspections by the Provider Nominee, that the status of actions relating to the plans from previously completed unannounced Reg 23 visits to the designated centre, be reviewed at the next unannounced Reg 23 visit.

Proposed Timescale: 10/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were not available for students on placement in the designated centre.

18. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

Garda Vetting will be completed with all staff and student placements

Proposed Timescale: 31/10/2017

Theme: Responsive Workforce

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

Staff were not trained as per the designated centre's mandatory training requirements.

19. Action Required:

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

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

Mandatory training has been scheduled for staff:

12th September First Aid Training (EO'S)

13th September MAPA Training (SR & CR)

14th September MAPA Training (SR&CR)

1ST November Client Risk Assessments, Goal Writing, IRPs, Keyworker Role, Lone Working & Relationship and Sexuality Training (EOS, LF, SR, PvL)

14th November First Aid (SR)

15th November MAPA (PvL & DC)

16th November MAPA (PvL & DC)

21st November Client Risk Assessments, Goal Writing, IRPs, Keyworker Role, Lone Working & Relationship and Sexuality Training (DC&NH)

6th December Safeguarding & Prevention of Abuse (All Staff)

19th December SAMS Training (AK)

Proposed Timescale: Gaps in any Mandatory training has been identified and has commenced for any appropriate staff. Will be completed by Dec 19th 2017

Proposed Timescale: 19/12/2017

Theme: Responsive Workforce

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

Supervision was not completed for all staff in the designated centre.

20. Action Required:

Under Regulation 16 (1) (c) you are required to: Ensure staff are informed of the Act and any regulations and standards made under it.

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

A supervision schedule for the Team Leaders has been drawn up and implemented to ensure all staff receive supervision as per organisational policy.

Proposed Timescale: 31/10/2017

