Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Lorrequer House
Centre ID:	ORG-0011673
Centre county:	Dublin 14
Email address:	lyn.mcdermott@gmail.com
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Lorrequer House
Provider Nominee:	Clair Walsh
Person in charge:	Lyn McDermott
Lead inspector:	Linda Moore
Support inspector(s):	Deirdre Byrne
Type of inspection	Announced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 March 2014 11:00	18 March 2014 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
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

This was an announced inspection to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. It comprises one six bedded community house where five residents currently live.

Inspectors met with management, residents and staff members over the inspection. Inspectors observed practice and reviewed documentation such as personal care plans, health plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files. As many of the residents at the centre are out during the day, part of the inspection took place in to the evening, when residents had returned from their day activities.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. There were regular meetings for residents, and residents' communication support needs were met very effectively. The centre was clean and had a warm, hospitable atmosphere and inspectors found that the residents were comfortable and confident in telling the inspectors about their home. Residents were actively involved in the development of their personal plans.

While evidence of good practice was found, a considerable number of areas of non-compliance with the Regulations were identified.

Areas for improvement included medication management, risk management practices, governance arrangements and access to training. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors reviewed only one component of this outcome in relation to residents' personal possessions.

Inspectors found that at the time of inspection the provider had developed a policy to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. However, this required improvement. While the provider and person in charge had put arrangements in place to protect the property and the finances of residents, these were not sufficient to ensure residents' finances were adequately protected and that there was transparency in relation to the use of residents' monies. Residents' families made a contribution from the residents' disability allowance to the everyday costs of running the service. The amount was not set out in an agreement with the residents and the consent of the person was not obtained. Residents did not have their own bank accounts and instead accessed money from the centre's bank account.

The person in charge showed the inspector how some residents were using the balance of their disability allowance each week. The inspector reviewed a number of these and noted transactions were being signed by a staff member but were not being countersigned by the resident or another staff member.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
In general, inspectors found that residents were supported to be involved in the development of their personal plans. However, some improvements were required to ensure personal plans were outcome focussed rather than solely activity based.

Each resident had a personal plan and inspectors reviewed three of the plans with a staff member. They were based on the individual support needs of the resident. However, while it was apparent during the day that many of the goals for 2013 were achieved, there was no documentary evidence of regular reviews and the participation of residents in the development of their plans was not documented. While residents had not signed their plans, they discussed these in detail with inspectors. In addition, one resident also had an accessible version of goals displayed in their bedroom.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. Residents' assessments were not fully inclusive of resident's specific social, emotional, participation needs, preferences and preferred routines. There was no evidence of individualised risk assessments in place to ensure continued safety of residents. These had not been completed for residents at risk of falls, epilepsy or swallowing difficulty. See Outcome 11.

Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Two residents had part time jobs which they enjoyed and others were facilitated to attend courses outside of their day services if they wished. Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

Inspectors met with one relative who was a board member visiting a family member and evidenced good rapport and communication between family members and staff. Residents told the inspector that family members and friends could visit at any time and some residents said that they visited their family home regularly.

The person in charge and staff were committed to promoting the rights of residents. Residents told inspectors about their rights in the centre and this was displayed on a poster in the centre. They explained to the inspector that the staff understood their needs and treated them with respect at all times.

Residents gave numerous examples of how they were involved in the running of the centre for example, preparing meals and doing laundry duties and assisting to keep their bedrooms clean. There were regular house meetings where residents made decisions and asked staff for support.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. Staff were observed interacting with residents in a respectful manner, consulting with them and seeking their views.

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors generally found that the provider had put some risk management measures in place however they did not meet the requirements of the Regulations and Standards. The areas requiring attention included the risks associated with residents at risk of choking, fire safety, and emergency planning, and, the systems for the identification, assessment, management, recording and investigation of risk.

Inspectors read the Health and Safety Statement for 2014. This included some risk assessments of the environment and work practices in the centre. The person in charge and staff explained how they took responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. However, inspectors were not entirely satisfied that staff took a proactive role in the management of all risk in the centre.

There was a risk management policy in place however many of the requirements of the risk management policy as set out in the Regulations were not contained within the policy. The policy did not include the specific risks required by the Regulations including self harm, aggression and violence and the arrangements for identification, recording, investigation and learning from serious incidents. A small number of accident, incidents and near misses for 2013 were being recorded in detail and these were reviewed by the person in charge. However, inspectors were of the understanding that not all incidents had been recorded. There was evidence that incidents were discussed at the staff management meetings and the board meeting with a view to learning from them and reducing the risk of recurrence. However, this process was not robust or clearly defined in the policy.

Residents commented that they felt the centre was safe and secure as there was a staff member in the centre at all times.

Inspectors found that while there was an emergency policy in place, and alternative accommodation arrangements were discussed with inspectors, these were not set out in the policy.

Fire safety was well managed apart from fire safety training and learning from drills. There was evidence of regular fire drills and both staff and residents participated. The records of fire drills were detailed and included learning outcomes. However, while the learning was regularly documented, there was no evidence that these issues were addressed. Residents and staff were able to tell the inspector about what they would do if the fire alarm went off. Records reviewed by inspectors indicated that fire training had not been provided to all staff and fire training was only delivered two yearly to other staff. Fire equipment was serviced regularly, as were fire alarms. Inspectors found that all fire exits were unobstructed on the days of inspection. inspectors noted that there was no emergency lighting in the centre, while the director explained the arrangements in place, there was no risk assessment completed to identify if emergency lighting was necessary and if the control measures were adequate.

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found that there were arrangements in place to safeguard residents and protect them from the risk of abuse. There were areas for improvement in relation to staff training and the management of resident's finances. See Outcome 1.

Staff were generally knowledgeable about what constituted abuse and how they would respond to any suspicions of abuse. However, not all staff had received training on the protection of vulnerable adults. There were no records maintained, for example, sign in sheets or certificates to demonstrate training delivered to staff. There were no plans to address this deficit in training.

There was a policy in place which provided guidance to staff on how to respond to suspicions of abuse and was in accordance with the Regulations. There were no records of incidents or allegations logged. However, the person in charge was familiar with the content of the policy and it would guide practice. Inspectors found that safeguarding was regularly discussed with staff.

Throughout the inspection, the inspector noted that staff interacted with residents in a kind, caring, respectful and patient manner.

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

There were no restrictive practices in use in the centre, the person in charge said they do not provide care for residents with behaviours that challenge, as outlined in the statement of purpose. However, staff had not been provided with training in this area should residents' conditions change. Residents had access to psychology services, however there was no up-to-date report for two residents to guide their care.

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

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found that there were appropriate arrangements in place to support residents' healthcare issues as they arose. Inspectors reviewed the care plans for residents and found that they had access to a general practitioner (GP), including an out-of-hours service. There was evidence that residents accessed other health professionals such as the physiotherapy, dietician and speech and language therapist services if required.

Health assessments were in place for all residents and provided some valuable information for staff in the care of residents. However, these assessments did not include all aspects of the care required and there were no assessment or plans in place to address the areas such as a resident at high risk of falls and no care plan to guide care. This was similar for residents with epilepsy, those at risk of choking and dementia.

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff. However, the management of modified consistency diets required improvement.

Inspectors joined residents for lunch. There was a central dining room which was decorated to a high standard. Inspectors observed that the meal was well presented.

Inspectors found that one resident had difficulty swallowing and was at risk of choking when having their meals. This resident had been reviewed by the Speech and Language Therapist (SALT) and recommendations made relating to their consistency of diet, however the recommendations of the SALT were not being implemented and so this resident was placed at risk. A care plan for this resident was sent to the Authority following the inspection and it was satisfactory.

Inspectors found that there was an ample supply of fresh and frozen food, and residents could make themselves a snack at any time. Photographs of foods for prompting were kept in the kitchen for residents to use to assist them in deciding what they wanted for dinner. The inspector saw residents using these to express their likes and dislikes at meal time.

The person in charge and staff had arranged weekly meetings for residents in the centre as another way of supporting residents to communicate their views. Inspectors reviewed the minutes and notes of some of these meetings and residents also told the inspector that they used the meetings to make decisions on what they wanted to eat during the week.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Although Inspectors found that the provider had put arrangements in place to support the person in charge in protecting residents in relation to medication management inspectors were concerned about some aspects of medication management including the safe administration of medication, and the competency of staff administration medication.

The person in charge had developed a policy on the management of medication. This policy did not guide practice, for example, the administration of medication, crushing, PRN (as required medication), over the phone prescribing and the use of anti coagulant therapy. Inspectors found that staff had not received medication management training and the practices in place may have placed residents at risk.

There was no up to date medication prescription for all residents and staff referred to a typed list of medications when administering medications. There was no current prescription for a resident receiving anti coagulant therapy. The signage of the administration of medication required improvement. For example, there was no signature list of the staff administering medication and the medication administration record did not include the dose of the medication. Staff said they administered over the counter medication as required without a prescription and there was no record that this was prescribed or administered. There was no photographic identification in place for any resident.

There was no system in place for reviewing and monitoring safe medication management practices. While one dispensing medication error had been responded to in December 2013, Inspectors noted that there was a medication error on the week prior to the inspection and the person in charge was not aware of this.

There was no medication management protocol in place for residents who may experience status epilepticus.

Staff and residents had access to pharmacists, who provided support to staff on the new medication if required.

When these issues were raised with the person in charge, she informed inspectors she was going to arrange medication management for all staff immediately following the inspection.

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The provider had established a suitable management structure, and the roles of managers and staff were clearly set out and understood. This was outlined in the statement of purpose.

The person in charge was supported by the provider who reports to Board of Directors to assist her to deliver a good quality service. The board met monthly for eleven months of the year. The minutes were reviewed by inspectors.

The person in charge also holds bi weekly staff meetings with all staff to discuss any issues that arise. The provider attends this meeting and reports to the board. The provider and person were in contact regularly and the provider had been actively involved in the centre.

The person in charge was appropriately qualified and had continued her professional development. She had sufficient experience in supervision and management of the service. She told inspectors she had read the requirements of the Regulations and Standards and was actively trying to update her knowledge. She had very clear knowledge about the needs of each resident. She had completed a management course. However inspectors found that the person in charge role was not full time, she was rostered as part of the staff and while she was provided with up to thirty hours per month for administration she did not have the opportunity to engage in the governance of the centre on a consistent basis. The person in charge did not have the opportunity to engage in auditing, review of personal plans, review of medication practices or to complete supervision with staff, these issues are discussed throughout this report. There were no deputising arrangements in place for the person in charge.

Inspectors observed that the person in charge had a person-centred approach with residents and staff through her open and friendly interaction with them. She demonstrated strong leadership and good communication with her team. She was frequently observed meeting with residents and staff and ensured good support to all

staff.

There is no system in place to review the quality and safety of care in the designated centre.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found that there were appropriate levels of staff on the day of inspection to meet residents' needs and the layout of the premises in that the person in charge was rostered as the second staff member on duty. However, staffing levels need to be reviewed in light of the findings in Outcome 14. Additional staffing were in place on days when planned activities were scheduled.

Staff files were reviewed and they did not contain all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, staff members did not have sufficient evidence of two written references. There was no evidence of the person's identity, including a recent photograph on staff files.

There were some informal staff supervision arrangements in place. However, the records showed that these meetings had not taken place since 2013 and they were not used to improve practice and accountability. Inspectors read the individual performance reviews of staff last dated 2008. The person in charge said she planned to commence these performance reviews again in 2014.

Overall education and training provided to staff to enable them to provide care in accordance with evidenced based practice required improvement. Inspectors were informed that there was no training budget. Inspectors were told and a document showed that a bullying work shop and safeguarding training were provided in 2013. Inspectors found that not all staff had received manual handling training, safeguarding and fire safety training. There were no training records apart from the fire safety training maintained by the centre. Staff had not received training on the Regulations and

National Standards, epilepsy management, falls prevention and dementia to meet the needs of their residents. See Outcome 11.

The inspector found that residents' privacy and dignity was respected by staff. The inspector observed staff knocking on the doors of occupied rooms and waiting for permission to enter. Staff interacted with residents in a courteous manner and addressing them by their preferred names. The inspector observed good interactions between staff and residents who chatted with each other in a comfortable way.

Inspectors noted that volunteers were in the process of being vetted and the roles and responsibilities were clearly defined.

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Lorrequer House
Centre ID:	ORG-0011673
Date of Inspection:	18 March 2014
Date of response:	23 April 2014

Requirements

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' finances were not managed in line with the Regulations.

Action Required:
Under Regulation 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

Please state the actions you have taken or are planning to take:
There are no circumstances where the registered provider or any member of staff pays any money belonging to any resident into an account held in a financial institution.
• The provider will establish a contract of care for each resident outlining the services, support, care and welfare to be provided and the charges to be paid from each

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

resident's disability allowance. Each resident and his/her representative/ family will be clearly informed as to what the charges will cover and their written consent sought.
• The provider will discuss with families the issue of resident's access to the balance of their disability allowance and suitable arrangements put in place to allow residents easy access to their monies.
• The existing policy in relation to the handling of resident's monies and personal belongings will be amended to ensure compliance with regulations and best practices.

Proposed Timescale: 31/08/2014

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:
The assessments were not fully inclusive of residents' specific social, emotional, participation needs, preferences and preferred routines.

Action Required:
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:
• We have begun working together with each individual Resident and their Day Service Key Worker to carry out WELL BEING assessments.
• We will use these assessments to identify the specific needs of each person.
• These will be reviewed on an annual basis or more frequently depending on the changing needs of each individual.
• In the case of one individual, whose needs are greater, a full multi-disciplinary assessment will be carried out and is currently scheduled for 29th April.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The personal plan did not fully reflect the assessed needs of residents.

Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
• Personal plans will be improved to include individual risk assessments to support the continued safety of the Residents.

• Any Risks identified in the individuals Well Being assessment will be assessed and a copy of the Risk assessment contained in the individual plan.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of a robust system to assess the effectiveness of residents' personal plans.

Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
• Personal plans and goals will be reviewed on a three monthly basis or more frequently depending on the changing needs of the individual.
• The Person in charge will meet with the Resident and the Resident's key worker for these reviews.
• A copy of the reviews will be stored in the personal plans.

Proposed Timescale: 30/06/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the identification and assessment of risks throughout the designated centre.

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:
• We will improve our Risk Register to identify and assess all risks in our centre.
• The risk management policy will be updated to include hazard identification and assessment of risks throughout the designated centre in compliance with Regulation 26 (1) (a).

Proposed Timescale: 31/10/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems for the identification, assessment, management, recording and investigation of risk required improvement.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
• The risk management policy will be updated to include arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents in compliance with Regulation 26 (1) (d).
• We will also update it to include all other items included in Regulation 26(1).
• Two Key staff members will be trained in Risk assessment in October 2014.

Proposed Timescale: 31/10/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system for responding to emergencies required improvement.

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:
• Our Emergency policy will be amended to include a plan for alternative accommodation.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire training had not been provided to all staff and fire training was only delivered two yearly to other staff.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control

techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
• All permanent and Relief Staff will be trained in Fire Safety on the 30th April 2014.
• This training will be carried out on a yearly basis thereafter.

Proposed Timescale: 30/04/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
One permanent staff member and 3 relief staff have to still receive Safe Guarding Service user training.
• One staff member will be trained on 22nd May.
• Training for the other three staff members will be completed by the end of June.

Proposed Timescale: 30/06/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One resident on a specialised diet did not have their specific needs met.

Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
• The referred to individual now has an up to date Choking Care Plan and an up to date SALT assessment.
• Their diet has been modified according to recommendations made by the SALT. Details have been included in their care plan.
• This will be reviewed regularly and altered depending on the persons changing needs

as assessed by the SALT.

Proposed Timescale: 19/03/2014

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:
Medication management required improvement as outlined in Outcome 12.

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:
• We have asked and received support from our local GP and Pharmacy and together we have put into operation a clearer system for the ordering, receipt, prescribing, storing, disposal and administration of medicines.
• A new system for auditing medication recording practices has been adopted.
• All medication sheets and storage containers include photo ID of the resident.
• SAMS training will be provided to all staff and we will have it completed by end of August 2014.
• Our local pharmacist has provided an educational talk on warfarin therapy to all staff 16/04/14.
• Our medication Policy will be updated to include the changes adopted.

Proposed Timescale: 31/10/2014

Outcome 14: Governance and Management

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The post of person in charge did not meet the requirements of the Regulations.

Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
• The full time designated person in charge has been given additional administrative hours (administrative hours will be 10 hours per week).
• When rostered as the second person working her role will still be as the full time designated person in charge.
• Rostering arrangements have been arranged so that she will be in attendance in the centre 5 days each week (Mon –Fri).
• Deputising arrangements for the person in charge are currently being reviewed and rostering arrangements will be set in place to ensure that at all stages a competent nominated person in charge will be present in our home.
• These arrangements will be subject to ongoing review to ensure that they do not impact on quality of resident care while ensuring sufficient time for the full time designated person in charge to complete their management/administrative responsibilities.

Proposed Timescale: 31/10/2014

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is no system in place to review the quality and safety of care in the designated centre.

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 provider will arrange for an annual review of quality and safety of care.
• The results of this audit will be documented and any issues identified dealt with as soon as possible.

Proposed Timescale: 31/10/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files did not contain all of the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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:
• All staff were informed at a staff meeting of the required documentation and it has now been supplied.
• Completed Garda Vetting forms have been returned for all staff.

Proposed Timescale: 19/04/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff supervision arrangements were not formalised and used to improve practice and accountability.

Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
• The system of appraisals will resume and each staff will receive a regular appraisal.
• Following this appraisal the Person in Charge will meet with the provider to discuss any training needs that arise.
• A copy of the appraisals will be kept in individual staff files.

Proposed Timescale: 30/06/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Education and training was not provided to staff to enable them to provide care in accordance with evidenced based practice.

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:
• Manual handling/falls prevention (3 relief staff to be trained by end July, refresher training for all other staff not due until 2015)
• Safeguarding service user training (4 staff (1 permanent and 3 relief) to be trained by end June 2014)
• SAMS training (All staff to be trained by end August 2014)
• Fire Safety training (All staff trained by 30th April 2014)
• Risk assessment (2 key staff trained by end October 2014)
• Occupational first aid (refresher training for staff by end July 2014)
• Epilepsy First Aid (A talk was given to all staff by the local pharmacist 16 April 2014)
• Supporting Wellbeing in practice: An individual approach to positive behaviour

supports training (formerly known as Challenging behaviour) (Training for one Key staff member in September 2014 with further training places in this area for other Staff members at the end of 2014 and early 2015.)
• Dementia training talk was given to all permanent staff by the Clinic Nurse Specialist from St. Michael's House on 24th April 2013 (Further training in this area to be provided by end of September 2014)
The training file will be kept up to date with a record of attendance for all training completed by staff.
Staff training requirements will be reviewed annually or more frequently depending on changing needs of our residents and a training plan put in place.

Proposed Timescale: 31/12/2014