

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Sunbeam House Services Ltd
Centre ID:	ORG-0007943
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Sunbeam House Services Ltd
Provider Nominee:	John Hannigan
Person in charge:	Michele Geoghegan
Lead inspector:	Deirdre Byrne
Support inspector(s):	Helen Lindsey
Type of inspection	Announced
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 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 2 day(s).

The inspection took place over the following dates and times

From:	To:
02 April 2014 11:30	02 April 2014 19:30
03 April 2014 08:30	03 April 2014 10:00

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

This was the first monitoring inspection of this designated centre for adults with an intellectual disability the Health Information and Quality Authority's Regulation Directorate (the Authority). The purpose of the inspection was to assess 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. The designated centre is part of Sunbeam House Services Limited, and as part of this inspection process prior to this inspection, two inspectors met the nominated person on behalf of the provider (the provider) as well as other members of the management team at the Sunbeam House Services Head Offices. At this inspection, the inspectors met with residents and staff members, the person nominated on behalf of the provider and the management team.

Sunbeam House Services Limited is governed by a board of directors consisting of 9 members, with John Hannigan as CEO. Mr Hannigan is also the person nominated on behalf of the provider and will be referred to as provider throughout the report. Mr Hannigan is supported in his role by the senior management team which is made up of seven managers with a variety of roles and responsibilities. During discussions, the provider and senior management team demonstrated a commitment to providing a good quality service with clear reporting systems in place. At this inspection improvements were found around the corporate policies being implemented at local level were in process for example, the local risk registers for the designated centres

had been drafted and would be implemented in June 2014.

The designated centre consists of one house in an urban area, which is in close proximity to the local community, city centre, shops and good access to public transport. Overall, inspectors found that residents received a good quality of service in the centre. The centre can accommodate up to five residents, and inspectors met all residents during the inspection. Staff supported residents in making decisions and choices about their lives. The centre had a warm atmosphere and inspectors found that residents were comfortable and confident in telling inspectors about their home. The house was warm and nicely decorated.

Inspectors found evidence of good practices across all seven outcomes monitored. Residents were familiar with the staff, and were supported to make choices in accordance with their needs, interests and capabilities. The staff were familiar with the residents needs and were observed to speak to them in a respectful and dignified manner. There were suitable fire safety procedures in place with regular fire drills in the centre.

However, inspectors found areas of non compliance over the seven outcomes also. These related to residents social care needs being assessed and reviewed by a multidisciplinary team; also the systems in place for safeguarding residents and the management of behaviors that challenge required review. There were improvements required in aspects of medication management. The arrangements in place for agency staff to have access information and contingency measures required improvement.

These 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 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:

Inspectors found the residents were involved in the development of their personal plans. There was a personal plan in respect of each resident. Inspectors reviewed four residents personal plans, and these were discussed with both the person in charge and staff on duty. The personal plans read by inspectors were based on the individual support needs of the resident.

The personal plans of the residents reviewed were detailed and provided much information around the social care needs of the residents. They included general and intimate information about the resident such as their family, likes, interests and photos of loved ones. The inspectors found personal plans included a detailed account of each residents goal for the year. There was a record of the residents weekly activities such as the day service or work they attended. Inspectors observed residents were very involved and familiar with their personal plans. For example, some residents spoke about their personal plan and went through it with inspectors. There was evidence on each residents personal plan that they were involved in their documentation and regular review.

The person in charge explained that personal plans were drawn up each year, and reviews were carried out every six months or more frequently where required. Inspectors saw records that plans were regularly reviewed. Each resident had a key worker who was responsible for drawing up the personal plans and for completing each review. However, residents' wellbeing and welfare was not supported by an evidence-based system of assessment and review in accordance with requirements of the

regulations. For example, personal plans were based on an assessment by the staff in the centres, but there was no evidence of a multidisciplinary assessment initially or ongoing. Additionally, information regarding residents most up-to-date identified needs was not available to guide staff as this was held at head office. There was frequent review of residents personal plans however, an area of improvement was identified as the reviews were not multidisciplinary. For example, there was no evidence of other health or social care professional involvement.

Inspectors noted that a recent internal audit carried out in the designated centre made reference to residents having to move to another designated centre on bank holidays. There was no reference or rationale for the resident moving centres at bank holidays documented or whether it was suitable to meet the residents assessed needs. Inspectors discussed this with the person in charge and management, they acknowledged on some occasions residents have been moved a bank holiday but only if it was within their wishes.

There was evidence that where either residents needs or preferences changed plans had yet to be made to support a move to more suitable or preferred environment, in some instances more independent living or individual living arrangements and this is discussed in more detail in outcome 8.

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 - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Inspectors found the provider had a proactive approach in ensuring the health and safety of residents, staff and visitors to Sunbeam House Services and the designated centre was promoted and protected. However, an area of improvement was identified in relation to the management and monitoring of risk.

There was a comprehensive risk management policy read by the inspectors and it was found to meet the requirements of the Regulations. A new version of the policy had been recently drafted and it made reference to the specific risks outlined within the regulation. However, the policy was not fully implemented in practice to ensure ongoing monitoring and assessment of risks. For example, where risks had been identified such as crossing the road, there was no documented evidence of what measures and action was to be taken to prevent these risks from occurring. There was no evidence of meetings or discussion in the designated centre around risks and their ongoing

management.

Inspectors reviewed a corporate risk register for the organisation. A draft version of a local risk register recently drawn up for the designated centre was read by inspectors. However, it was not yet implemented. The management informed inspectors that it was anticipated to be fully implemented by June 2014.

A health and safety statement dated August 2013 was read by inspectors. It outlined the procedures for the prevention and the management of infection. Inspectors saw and read an emergency evacuation plan, which included the transport arrangements and alternative accommodation options. Inspectors spoke to staff who were familiar with the plan what they would do in the event of an emergency.

There was a policy on the management and prevention of fire. Inspectors saw fire exits were unobstructed and read daily checks that were completed by staff. There were monthly fire drills and both staff and residents participated. Inspectors saw records were maintained for drills and they included the findings and any learning required. Residents and staff were able to tell inspectors what they would do if the fire alarm went off. Inspectors saw documented evidence that fire equipment was serviced regularly such as fire extinguishers, fire alarms and emergency lighting. Fire evacuation plans were displayed throughout the centre. Records reviewed by inspectors indicated that all staff had participated in fire training within the past three years.

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:

Overall, inspectors found that there were measures in place to safeguard residents and protect them from abuse however, improvements were required.

Residents spoken with during the inspection said they knew who to contact if something happened to them, and in the personal plans of care individuals had written that they felt safe. Inspectors observed staff and residents getting on well. Staff spoken with were

knowledgeable about what constituted abuse, and what to do if they witnessed abuse or it was reported to them. Inspectors read training records which confirmed most staff had received some training on identifying and responding to different types of abuse. However, for some staff this remained outstanding. A plan for future training was seen to be in place for a revised protection and safeguarding course, which would be mandatory for all staff.

An allegation of abuse had been notified to the Authority prior to this inspection. Inspectors were satisfied it had been adequately investigated, and appropriate measures were put in place to safeguard the residents. A report of the investigation was submitted to the Authority. Allegation of abuse were reported in incident forms, they were completed in the designated centres and submitted to the head office of the service provider for review by senior management. Inspectors also read residents files and daily records which records any incidents that had occurred in the centre affecting the residents.

There was a policy and procedures for the prevention, detection and response to allegations of adult abuse in place that gave direction to staff. However, it was not comprehensive enough to fully guide practice. For example, while it described physical and sexual abuse, it did not set out any other types of abuse that may occur. A draft of a new policy to be implemented in the future was seen to be more comprehensive.

A policy relating to positive behaviour support was read by the inspectors, and seen to be operating in practice. Where there were plans in place they identified the underlying causes of behaviour, and had been developed with the resident and specialists. There were updates recorded on a regular basis. Residents told the inspector of the support they received in developing new skills while managing any identified risks. Documents that explained this were seen on their personal file. However, in reading the personal files it was evident that not all identified behaviours had behaviour support plans in place, to guide care planning and practice. This presented a risk that needed to be managed by the person in charge. For example, the management of behaviours around specific sexual behaviours and in relation to staffing issues. Additionally, some personal plans contained up to four types of behaviours that challenged and did not provide sufficient guidance to staff on the management of each of the individual behaviours. These matters were brought to the attention of the person in charge who undertook to address them.

There were processes in place to protect the rights of residents around restrictive practices. There was a rights restrictions committee in place to review all restrictions made. It was made up of both people from the organisation and external people to ensure an independent perspective. Although the areas covered in the designated centre were seen to be comprehensive, an area of improvement was identified. For example, one area of restriction had not been assessed, along with documentation of the alternatives to its use and there was no evidence of monitoring or review.

During the inspection there were tensions between the residents who lived in the house. The staff and the person in charge confirmed that this was often the case. One person told an inspector that they did not want to live in the house anymore. Inspectors observed that the lack of places for people to engage in leisure activities added to the

tensions between individuals. Behaviour support plans did identify the behaviours that residents may exhibit however, this information was not complete for all areas of behaviour that challenges identified throughout the personal plan. It was acknowledged that plans were in place for individuals to achieve their personal goals, some of which were around changes in accommodation.

Residents personal finances were not reviewed at this time. This area will be reviewed at the next inspection.

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 - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Inspectors found the provider had systems in place to ensure residents health care needs were met and there was evidence of overall compliance with the Regulations. However, some improvements were required in the records regarding health care assessment and management.

Inspectors reviewed records that confirmed residents had access to a general practitioner (G.P.) who was based in the locality. Primarily residents attended their G.P. at the surgery unless out-of-hours care was required in the houses. Records and interviews demonstrated that there was regular access to medical practitioners and staff were observant and responsive to any changes in the health care status of the residents. There was evidence of referral and regular consultation with allied services as required by the residents. There was evidence of regular access to ophthalmic services, dentistry, dietetic, and chiropody services available. A comprehensive psychological service for behavioural management and support for residents were available externally as dictated by the residents needs. Interventions were documented and there was evidence that these were adhered to. There was evidence that where a resident refused treatment or intervention this was documented but also that every support was afforded.

An annual health and wellbeing plan was undertaken. The staff document this review. However, not all residents health care needs were identified or recorded in the plan or its review. For example, dementia, epilepsy and attention deficit hyperactivity disorder (ADHD). Additionally, there was no composite health assessment and status documentation available and therefore the records did not provide full information on

residents overall health status or underlying conditions which is pertinent to the care provision. The action in relation to this is detailed under Outcome 5 Social Care Needs.

The designated centre was observed by inspectors to be fully equipped with cooking and catering facilities in a homely environment. Residents can, as they wish and according to their capacity do their own shopping with or without staff and are involved in preparing meals. Inspectors were told by some residents that they preferred to cook their own meals, others preferred to have their meals made by staff. Dietary requirements are supported and where relevant residents are supported with weight dietary advice or special dietary requirements. Residents confirmed this with inspectors. Food observed was nutritious and varied.

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:

Inspectors found that the provider and person in charge had arrangements were in place to protect the residents in relation to medication management. However, improvements were required in the review of residents medications and training for staff.

Inspectors met the staff employed in the centre who were all registered general nurses. Staff spoken to were familiar with the procedures and policies on the administration of medication. However, there was no evidence that staff received up-to-date training in medication management.

There was a comprehensive medication management policy. It included procedures on the management of medicines that required strict controls (MDAs). However, these were not fully implemented in the designated centre. For example, small number of residents were prescribed and administered MDAs but local guidelines on their use had not been developed. This was discussed with the person in charge.

Medications were dispensed from the pharmacy in blister packs to promote the correct administration. Inspectors reviewed two residents prescription and administration sheets and found evidence of good practices in the administration of medications. A small number of residents self medicated and the person in charge had ensured a risk assessments of the residents capacity had been completed, along with details of

supports in place and regular reviews.

Inspectors observed residents were prescribed a range of medications and these included a number of "as required" (PRN) medications. However, there was no records of formal regular review of the medications, whether the dose or amount of medications had been reduced since initially prescribed to the residents. This was discussed with the person in charge and management at head office who acknowledged it was an area where improvement was required.

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:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The designated centre is part of a larger organisation with a clearly defined management structure which identifies the lines of authority and accountability in the centre. Overall, inspectors found that governance arrangements were satisfactory with some improvements required.

The person in charge of the designated was suitably experienced. Inspectors acknowledged that the role of person in charge is relatively new for the whole organisation and takes time for process to be developed around this. The staff rosters reviewed indicated the days the person in charge was present in the centred. The person in charge also oversees the management of another designated centre in the organisation and is not required to undertake staff duties in any of the centres. Inspectors noted that the while the residents were familiar with the person in charge and they had an easy rapport with each other, as the person in charge was covering two designated centres this may impact on their ability to be manage issues around the residents health and social care needs. This was discussed with the person in charge who acknowledged she was relatively new to the role and covering another designated centre which may impact on this.

The nominee of the provider is engaged full-time as the managing director of the organisation and is also suitably qualified and experienced. He was known to the

residents and the staff and was seen to be very involved in the direction of care practices.

A number of processes are used to monitor and oversee the safety and quality of care. These included the undertaking annual audits in the designated centre from which actions were identified and monitored for compliance. They were carried out both internally and externally for a range of areas. The audits included matters such as health and safety, medication management, resident's records and the environment. The last audit was undertaken in February 2014. Staff and residents were clear on the management structure, reporting systems and areas of responsibility.

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 - Minor

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The provider had ensured that there were robust recruitment processes in place and that staff employed in the centre were suitable to work with vulnerable adults. However, some improvements were identified to meet the requirements of the Regulations.

Inspectors reviewed the records relating to staffing and found that they contained most of the information outlined in Schedule 2 of the regulations however, an area of improvements was required to ensure compliance. For example, a history where gaps in employment existed. A number of agency staff were used to cover staff leave. While there was a service level agreement with them, there was no evidence of any other recruitment checks carried out by the provider.

Training records were reviewed by inspectors for staff of the designated centre. The records were stored on the organisation intranet system and inspectors reviewed these in detail. However, some improvements were identified. For, example some staff members had not had adult protection (safeguarding) training.

There were regular supervision arrangements in place such as staff meetings which were held every six weeks, and a more formal system of one to one supervision between the person in charge and staff members has recently been initiated. Many staff

have been working in the centre for a long period of time, and had an in depth knowledge of the residents, staff were observed supporting and engaging with residents in a person centred, professional and friendly manner. Staff also discussed residents in a very respectful and positive way, and were very knowledgeable in relation to individual needs of the residents.

A number of agency staff provided cover for staff on leave and an arrangement was in place for an agency to provide nursing cover. However, improvements were required to ensure these staff were familiar with the reporting systems in place when on duty. For example, it was identified in an internal audit that had been completed in the service that two agency staff working in the centre did not know who was in charge. While there was no evidence of this on the day of the inspection the matter was discussed with the person in charge and management. The audit also noted that agency staff would not be able to access via a computer to online policies or other key documents. These matters were brought to the attention of the person in charge.

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:

Deirdre Byrne
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 Sunbeam House Services Ltd
Centre ID:	ORG-0007943
Date of Inspection:	02 April 2014
Date of response:	30 May 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 05: Social Care Needs

Theme: Effective Services

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

Residents' personal plans and reviews were not based on a multidisciplinary assessment or input.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

All plans will be reviewed by 30/07/2014 with input from all related professional staff as required. Plans will be reviewed monthly by keyworker to determine effectiveness.

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

Proposed Timescale: 30/07/2014

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:

Where areas of risk were identified as outlined in the inspection report there was no evidence of the measures in place or actions taken to prevent them from occurring.

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:

Individual risk forms will be up-dated in line with SHS policy. Each identified risk will include measures and actions to manage and control the risk.

Proposed Timescale: 31/07/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Where restrictive procedures have been implemented, there was no evidence of a risk assessment, alternatives used or monitoring of their use.

Individual plans to have not been developed to manage some behaviours.

Some care interventions developed to manage certain behaviours were not comprehensive enough to provide guidance.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

Comprehensive Behavioural Intervention Plans will identify all behaviours and management of individual behaviours with the detail required to direct working practice. Staff who do not work with clients regularly in the centre will have a guideline on the immediate actions required to manage specific behaviours and will be directed to view the Behavioural Plans on site.

Alarms on bedroom doors for two clients will be reviewed with Clinical Psychologist

input which will direct local practice. Staff guideline will be developed following review.

Proposed Timescale: 31/07/2014

Theme: Safe Services

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

The policy on and procedures on the prevention, detection and response to abuse was not comprehensive enough to guide practice.

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:

New Organisational Policy on abuse will be implemented by 31/07/2014

Will be discussed with all staff at team meetings by 30/09/2014

Proposed Timescale: 30/09/2014

Theme: Safe Services

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

Not all staff had completed training in the understanding and prevention of 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:

Training for all current staff is taking place and untrained staff will have completed their training by

Proposed Timescale: 31/07/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Individual residents health care needs were not consistently assessed and planned for.

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:

Healthcare plans will be developed for specific health issues.

Proposed Timescale: 31/07/2014

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:

There was no evidence that staff had training in medication management.

The policy on the management of medication was not fully implemented in practice in relation to the management of MDA medication.

There was no evidence of regular review of residents medications.

Action Required:

Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

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

All current staff will have completed HSE land e learning on medication management by August 31st 2014.

Local policy on MDA Schedule 2 medication will be drawn up by staff team.

Visit to Medical Practitioner Form amended to identify review of PRN medication is carried out at clinical reviews.

Proposed Timescale: 30/08/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not all documentation was in place in respect of all staff as per Schedule 2 of the Regulations.

There was no evidence of additional recruitment procedures in place for agency staff.

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:

In respect of schedule 2, a history where gaps in employment existed – Inspector was advised that for staff who were employed in the 1980-1990s the recruitment procedure at that time was to go through gaps on CV at interview stage the reasons/ explanations at that time were not recorded or wrote down, however it was part of the recruitment process at the time to go through these at interview stage with the candidate.

There was no evidence of additional recruitment procedures in place for agency staff. SHS communicate with both NOC and 24 Hour care. Both agencies have provided letters from 2013 to confirm that they undertake these checks required under scheduled two as per letters from both agencies attached
SHS validate and check in with both agencies every 6 months

Proposed Timescale: 30/09/2014

Theme: Responsive Workforce

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

Agency staff were not provided with access to online policies and procedures.

Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

Request sent to IT Department to train all regular agency staff to access online policies and procedures and to input data into client database.

Proposed Timescale: 30/08/2014

Theme: Responsive Workforce

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

Some staff have not received mandatory training in safeguarding and safety of vulnerable adults.

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:

All staff will be trained in Safeguarding and Safety of Vulnerable Adults

Proposed Timescale: 30/09/2014