

**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 Health Service Executive
Centre ID:	ORG-0011256
Centre county:	Kerry
Email address:	maryg.omahony@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Ann Sheehan
Person in charge:	Yvonne Mulvihill
Lead inspector:	John Greaney
Support inspector(s):	Cathleen Callanan;
Type of inspection	Announced
Number of residents on the date of inspection:	28
Number of vacancies on the date of inspection:	2

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:
18 June 2014 09:35	18 June 2014 18:00
19 June 2014 09:00	19 June 2014 14:15

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This was a monitoring inspection of a Health Service Executive (HSE) centre for adults with disabilities. The inspection was announced and took place over two days. As part of the inspection process inspectors met with residents, the person in charge, the provider, and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, policies and procedures, and staff files.

The centre first opened in 2001 following the transfer of residents with an intellectual disability from the nearby psychiatric hospital. Accommodation was provided to residents in two buildings each comprising three five-bedded units. On the days of the inspection there were 28 residents living in the centre, of whom 23 were male

and five were female.

Care was provided by registered psychiatric nurses from mental health services under the direction of a consultant psychiatrist. The centre was in transition from mental health services to disability services and a new governance structure had been put in place to oversee the transition.

Based on discussions with staff and observations of inspectors, staff members were knowledgeable of individual resident's needs and their immediate care requirements. Staff met the physical and medical needs of residents to a good standard, and it was evident that they had good personal relationships with the residents. However, improvements were required in relation to supporting residents through a person-centred approach to care planning. For example, many of the residents had limited access to education and vocational training throughout their lives and there was little evidence that they had been supported to achieve their potential. Care practices and care planning were designed to address the physical and medical needs of residents rather than supporting residents become more independent. Additionally, a number of residents had significant communication needs, however, there was inadequate evidence of training of residents or staff to address communication needs.

Care was provided by nursing staff based on the medical model with an absence of any staff skill mix incorporating social care and other related backgrounds with training, knowledge and experience of supporting residents with an intellectual disability.

Required improvements included:

- contract of care
- health and safety and risk management
- fire safety training
- training on protection from abuse
- medication management
- statement of purpose

The action plan at the end of the report includes the immediate action plan issued to the provider and identifies additional improvements required 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 2013.

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:

This was the centre's first inspection by the Authority.

Findings:

There was a policy on the management of complaints dated September 2011, however, it was not comprehensive as it did not adequately outline the complaints process, the independent appeals process or the person responsible for overseeing the complaints process. There was a notice on display in the visitors room in one of the units identifying the complaints officer and the independent appeals process, however, it was not on prominent display throughout the centre and was not in an accessible format. Inspectors found that there were two complaints processes in operation. One was based on the display notice that identified the complaints officer who was based off-site. The complaints log associated with this process was not available in the centre on the days of the inspection. The second complaints process had recently commenced and involved recording complaints in a complaints log held in each unit, however, there was no policy governing the process to be followed in managing these complaints. Inspectors viewed two complaint logs that identified the complaint, the action in response to the complaint and the outcome of the complaints process.

There was an advocate identified to support residents make a complaint and contact details were provided on the complaints notice. However, based on the degree of disability of the residents in the centre, inspectors were not satisfied that the advocacy service was sufficiently proactive in supporting residents to make a complaint.

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents' meetings or resident/relative surveys. Inspectors were informed of plans to introduce a residents' forum, however, this had not commenced prior to the inspection and there was no other

systematic process to consult with residents and their relatives on an ongoing basis about how the centre was planned and run.

Based on the observations of inspectors on the days of the inspection, residents were treated with dignity and respect. There was a visitors' room in each building to facilitate residents meet with visitors in private and care practices respected residents' privacy and dignity. Inspectors were informed that religious service was available for residents off-site, but based on discussions with staff, residents were not routinely consulted regarding whether or not they would like to attend.

Most residents had single bedrooms, however, eight residents shared four twin bedrooms. One of the residents presented with significant challenging behaviour, often resulting in destruction of property in the bedroom. This resident shared a room with another resident that had significant communication deficits, both expressive and receptive, however, there was no evidence to demonstrate that it had been determined that both residents were happy to share the room with each other.

There was a policy on the management of residents' personal property and possessions. Residents were provided with adequate storage for personal property and possessions in each of their bedrooms. However, some residents did not always have access to their bedrooms during the day as they were locked to prevent other residents entering and damaging their property.

A range of activities was available and many of these were facilitated in an Activation Centre, which is on the grounds of the centre. Some residents attended a day centre from Monday to Friday each week.

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

A number of residents had significant communication needs and some residents were non-verbal. Staff members spoken with by inspectors were knowledgeable of the communication needs of residents and informed inspectors of the various non-verbal cues used by residents to express their needs. One resident had recently commenced LAMH (a manual sign system used by persons with intellectual disability and communication needs) training as part of the preparation programme for moving to the

community, however, there was insufficient evidence of ongoing assessment and review of all residents in relation to their communication needs, for example by a speech and language therapist. There was no evidence of the use of assistive devices to support communication and information was not routinely provided in a format accessible by residents based on their communication requirements. Staff had not received adequate training in communicating with residents that required support, such as using LAMH signs.

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

Many residents were advancing in age and had lived in institutional setting for much of their lives and either had very few family members living or had little contact with family, while other residents had excellent support and ongoing relationships with their family. Based on discussions with staff and a review of records, relationships with families were facilitated and supported and families were kept informed of resident's well-being.

A process of consultation with family members had commenced, whereby group meetings were held with families on a regular basis in order to discuss plans for moving residents to community settings. One to one meetings had been held with a number of families and it was planned that, where relevant, these would be held with the relatives of all residents.

Many residents had not been supported to develop contacts or relationships outside of the centre, however inspectors acknowledge that a process of change is under way and that some residents are being supported to develop skills to assist them to reside outside of an institutional setting.

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was a draft admissions and discharge policy, however it was not yet approved for implementation. The centre does not accept new admissions and there was a process in place to support residents to move from the centre to the community in a planned manner.

Based on a sample of records viewed, and confirmed by the provider, residents do not have a contract of care.

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:

This was the centre's first inspection by the Authority.

Findings:

On the days of the inspection the centre was in a period of transition, moving from the remit of mental health services to disability services. The transition process included developing personal plans based on a person-centred model rather than the pre-existing medical model and, because the process was not complete at the time of inspection,

each resident had two care plans, the pre-existing medical model care plan, which did not address the social care needs of the residents, and the new social care model personal plan that was not yet implemented. As a result, residents did not have a comprehensive operational personal support plan. The personal plans were being developed by staff from the Health Service Executive (HSE) and from external agencies with the support of staff employed in the centre. There was evidence of consultation with residents and their relatives in relation to the development of the plans through family meetings as discussed in Outcome 3.

Records indicated that a significant amount of planning had taken place in preparation for transferring the care of residents from mental health services to disability services and for moving residents to the community at a future date. However, some improvements were required as there was limited/no involvement of other members of a multidisciplinary team, such as speech and language therapy and occupational therapy.

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

The centre comprised two separate buildings on large, well maintained grounds on the outskirts of a town. Each building was subdivided into three smaller self-contained units with bedroom accommodation for five residents in each and also contained a small kitchenette, a sitting room and a dining room that opened out into a small secure garden. Sanitary facilities comprised one toilet and one assisted shower in each of the six units, however one of the shower rooms also contained a standard bath. In total, there were 22 single bedrooms and four twin bedrooms. Bedrooms were adequate in size and had adequate wardrobe space in each for residents to store clothing and personal possessions, however many of the bedrooms did not contain a bedside locker.

The centre was bright and spacious and appeared to be clean throughout. While acknowledging that maintaining the centre in a good state of repair presented a challenge due to the challenging behaviour of a number of residents, frequently resulting in damage to fixtures and fittings, the centre was in need of redecoration due to damaged wardrobes and chipped paintwork.

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:

This was the centre's first inspection by the Authority.

Findings:

There was a safety statement dated March 2014, however, it was not signed. There was a risk management policy dated November 2012, however, it did not adequately address all the items outlined in Regulation 26. For example, it did not address the measures in place to mitigate against the unexplained absence of a resident, aggression and violence or self-harm. Accidents and incidents were recorded and reported through STARSweb system operated by the HSE. However there was insufficient evidence of feedback to staff for the purpose of learning and prevention of recurrence.

There was an emergency plan, however, it only addressed the evacuation of residents in the event of an emergency but did not address the safe placement of residents in the event of a prolonged evacuation or other emergencies such as loss of electricity, loss of heating, loss of water or flooding.

Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire. Fire safety equipment was not located at suitable places throughout the premises due to the challenging behaviour of a number of residents and the risks this may pose to other residents and staff. Fire extinguishers were located in locked offices making them difficult to access in the event of an emergency. The provider was requested to explore alternative means of storing fire safety equipment while also protecting residents and staff from the potential of the equipment being used for the purpose of causing injury. Records indicated that there were adequate systems in place for the maintenance of fire safety equipment and for reviewing fire safety precautions. All emergency exits were seen to be unobstructed on the days of inspection, however a small number of fire doors were held open with door wedges which was not in compliance with good fire safety practices. Training records indicated that not all staff members had received up-to-date training in fire safety.

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:

This was the centre's first inspection by the Authority.

Findings:

There was a policy in place for the protection of residents from abuse, however, it was still in draft format and had not been approved for implementation. There were no records of incidents or allegations of abuse and during inspectors' interactions with residents no cause for concern was identified.

Based on the observations of inspectors, staff interacted with residents in an appropriate and respectful manner and were knowledgeable of the appropriate means of addressing challenging behaviour for individual residents. However, records indicated, and it was confirmed by the provider and person in charge, that staff had not received training on the prevention, detection or response to abuse. Personal care plans did not adequately outline positive behavioural support to alleviate the underlying causes of behaviour that is challenging. For example, the report of a psychological review of one resident clearly identified interventions to alleviate challenging behaviour, however, this was not adequately addressed in the care plan and there was insufficient evidence to demonstrate that the interventions identified in the report were routinely implemented.

There was evidence that staff were facilitated with training on behavioural support planning but training records indicated poor attendance.

Based on records viewed by inspectors and discussions with staff there were appropriate systems in place for the management of residents' finances.

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

A review of the records of accidents and incidents that occurred in the centre indicated that appropriate notifications had been submitted to the Authority.

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

A large number of the residents in the centre had lived in institutional settings for a significant portion of their lives and many of the residents resided in mental health facilities from an early age. As stated previously in this report, a process of transition had commenced in preparation for residents moving to community settings. As part of the process a number of residents had a programmes developed based on their identified needs to support them to integrate into the community. However, on the days of the inspection the process was still in the early stages and there was insufficient evidence to demonstrate that residents had been facilitated with education and training to support them to achieve their potential.

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:

This was the centre's first inspection by the Authority.

Findings:

Residents were under the care of a consultant psychiatrist and there was evidence of regular review. Residents had access to general practitioner (GP) services, including out-

of-hours, and there was evidence of review. There was evidence of review by chiropody, however there was insufficient evidence of access to other allied health/specialist services such as speech and language therapy and dietetics. For example, a number of residents were provided with modified diets and staff confirmed that for at least one resident it was based on swallowing difficulties. However, there was no evidence of referral and review by speech and language therapy. There was evidence of referral and review by dental for residents who presented with dental problems, however, there was no evidence of a programme of referral to dental services as part of a programme of preventive care.

Staff spoken with by inspectors were knowledgeable about residents' health and social care needs. As stated previously personal support plans were in the process of being developed for each resident, to replace care plans based on the medical model, however, improvements were required. For example, evidence-based tools for the assessment of issues such as falls risk and the risk of developing pressure sores were not used. Additionally, a small number of residents had wounds but there were no wound management care plans in place demonstrating ongoing assessment of the wound or directing the care to be provided.

Meals were prepared in a central kitchen and delivered to the centre in a heated delivery trolley. There was a menu available offering a varied choice of food each day, however, based on discussions with staff it was clear that residents were not always offered choice. For example, there was only one option available for residents on modified diets and staff usually decided the option for other residents based on their knowledge of the residents. While this may have been appropriate for some of the residents there was no system for facilitating residents who may wish to have an alternative option. Pictorial menus were not available to support residents with communication difficulties.

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:

This was the centre's first inspection by the Authority.

Findings:

There were two medication management policies in the centre and also a new draft medication management policy that had not yet been approved for implementation. The provider and person in charge were requested to have one comprehensive policy to guide medication management practice in the centre.

Medication administration practices were not uniform throughout the centre. For example, in one part of the centre medications were delivered in a unit dose dispensing system where all medications due at one time were pre-packaged. In the other part of the centre medications were delivered in their original containers. Prescription sheets and medication administration records contained all the appropriate identifying information. There were no drugs requiring special control measures in the centre.

Improvements were required in relation to medication management practices. For example, inspectors found:

- medications stored inappropriately in a basket in one of the kitchenettes
- the fridge thermometer was not functioning in one of the medication fridges and fridge temperatures were not always recorded daily
- some medications in a stock cupboard were out-of-date
- there was no system for returning unused or out-of-date medications to the pharmacy
- there was no evidence of ongoing medication management training by all nursing staff
- there was an inadequate system for reviewing medication management practices as none of the above non-compliances were captured in a recent medication management audit

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was a written statement of purpose, however, it did not contain all the items listed in Schedule 1 of the Regulations. For example, it did not outline:

- the organisational structure of the centre
- the arrangements for residents to access education, training and employment
- the arrangements made to attend religious services.

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:

This was the centre's first inspection by the Authority.

Findings:

The centre is operated by the HSE and there was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. The centre is in the process of transitioning from mental health services to disability services and a new governance structure was developed to oversee the transition. A review of the service provided in the centre had been commissioned by the HSE in advance of the commencement of regulatory activity by the Authority. The resulting report was comprehensive and included a range of recommendations in order to comply with recognised best practice for adults with intellectual disabilities. On the days of the inspection there was evidence that the recommendations were being actively addressed even though it was still at an early stage in the process.

Overall responsibility for the service is assigned to the HSE Area Manager. Reporting to the area manager is a disability manager who is also a member of the management governance group with membership comprising various health and social care professionals and representatives from other disability services. Day to day management of the centre is the responsibility of a multi-disciplinary management team comprising a consultant psychiatrist, assistant director of nursing, disability manager, area administrator, psychologist, clinical nurse managers, housekeeping supervisor and quality manager. All nursing staff are from Kerry Mental Health Services.

The person in charge is an assistant director of nursing, works full time and had assumed the role of person in charge on the week of the inspection.

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There have been no periods when the person in charge was absent for 28 days or more. In the absence of the person in charge another assistant director of nursing assumes responsibility for management decisions and there are also clinical nurse managers to oversee the day to day management of the centre.

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

The inspector found that sufficient resources were provided to meet the needs of residents, however, as discussed in Outcome 6, the centre was in need of redecorating due to chipped paint and damaged woodwork. A small bus was provided to support residents in relation to travel and access to the community.

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 - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

All of the residents in the centre have an intellectual disability. On the days of the inspection there were eight nurses on duty during the day, including a "special" (nurse assigned to provide one-to-one care for a resident) and five nurses at night, including a "special". All of the nursing staff were registered psychiatric nurses and none of the nursing staff had a qualification in intellectual disability nursing. There were no social care workers. There were four housekeeping staff with responsibility for cleaning and kitchen duties. As part of the transition process to a social care model and in preparation for transitioning residents to a community setting, a psychologist, a community living facilitator and an intellectual disability nurse were present in the centre for various periods of time each week developing person-centred plans and facilitating training for residents.

Training records viewed by inspectors indicated that training was facilitated for staff on issues such as moving and handling, prevention and management of violence, cardiopulmonary resuscitation, person-centred approach, behaviour support, risk management and excellence in mental health care. Due to the nature of the training matrix, which also included training records for staff from other areas of Kerry mental health services, it was difficult to isolate what training had been completed by staff from the centre. However, not all staff in the centre had attended training on the prevention and detection of abuse, manual handling, fire safety training or behaviour support. While staff members were equipped to provide psychiatric and other nursing care to residents, there was minimal evidence of attendance by staff at training to support them develop the skills required to support residents with an intellectual disability.

Based on the profile of staff in the centre, it was unclear why staff of only one discipline were engaged in the care of residents with complex needs ranging across a range of disciplines. The evidence available to inspectors from written records, discussion with staff and observation of residents, suggested that it was not possible to optimise the potential of residents without a more enhanced skill mix.

Inspectors reviewed a sample of personnel records. Many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

- up-to-date photographic identification
- vetting disclosure
- two written references including a reference from a person's most recent employer (if any).

There were no volunteers in the centre, however, a number of residents had personal assistants from external organisations that visited the residents for a number of hours each week and records indicated that they were appropriately recruited and vetted.

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

All of the policies and procedures listed in Schedule 5 of the regulations were in draft format and not yet approved for implementation.

There was a sheet of paper in each building with the names and relevant details of each resident in that building, however, it was a loose sheet of paper and was not an adequate format for a Directory of Residents.

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:

John Greaney
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 Health Service Executive
Centre ID:	ORG-0011256
Date of Inspection:	18 June 2014
Date of response:	28 July 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: DCAD10 Individualised Supports and Care

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

There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre, such as through residents meetings or resident/relative surveys.

Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

1. A resident's forum to be established. Monthly meetings to be held. Meetings will be facilitated by a nominated CMN2 and a member of the transition team. The National Advocacy service will support the establishing of this forum.

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

2. A family forum will be set up. 2 monthly meetings or more frequently if families request same will be held. This forum will be facilitated by a member of the Management Governance Group.

3. Through the PCP process, residents with their families will be met individually where future services and supports will be planned in partnership with all the stakeholders.

Proposed Timescale: 31/10/2014

Theme: DCAD10 Individualised Supports and Care

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

Some bedrooms were locked during the day to prevent damage to their property by other residents.

Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

1. Positive Behaviour Support Plans will be drawn up and implemented in order to address behaviours where residents enter the bedrooms of other residents or interfere with others' property without permission.
2. Residents will be consulted to establish if they wish to have their bedroom locked during the daytime.
3. Those who choose to have their bedrooms locked will be assessed to determine their capacity to use a coded keypad on their door and thus provided with support as appropriate.
4. For those who choose to have their bedrooms locked and are assessed as not having capacity to use a coded keypad can choose to allow the staff to lock their door for them on request.
5. These choices will be recorded in the individual's file.

Proposed Timescale: 21/11/2014

Theme: DCAD10 Individualised Supports and Care

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

Inspectors were informed that mass was available for residents off-site, but based on discussions with staff, residents were not routinely consulted regarding whether or not they would like to attend.

Action Required:

Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

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

1. As part of each individual's Person Centred Plan, religious preferences will be ascertained and plans will be put in place to support each person to exercise their rights. This will include supporting people to attend religious services as appropriate.

Proposed Timescale: 30/09/2014

Theme: DCAD10 Individualised Supports and Care

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

Based on the degree of disability of the residents in the centre, inspectors were not satisfied that the advocacy service was sufficiently proactive in supporting residents make a complaint.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

1. As PCP plans are rolled out and key workers begin working with individuals to implement their personal plans, it is expected that the Key Workers will be advocates for the person they are supporting.
2. In the interim, the Senior Psychologist assigned to the centre will take on the role of Advocacy Officer for the residents of the centre. She will be on site one day every week. Notices will be prominently displayed with this information and residents will be informed through the resident's forum.
3. The National Advocacy Officer for Kerry will commence regular visits to the centre to start building up relationships with the residents in the centre. The Mental Health Advocacy Service and the National Advocacy Service will remain available as independent advocates for the residents.

Proposed Timescale: 15/08/2014

Theme: DCAD10 Individualised Supports and Care

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

There was inadequate evidence that all residents sharing rooms were happy to do so particularly in light of the challenging behaviour of one resident.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

1. Through the development of PCP's, individuals will be supported to express their needs, opinions and future goals with their support team. This process will be conducted in a way that allows people to participate in a meaningful way through using all available tools to maximise their understanding and communication. Every effort will be made to ensure that expressed needs and wishes of the individual are fully respected. Support plans will be developed for each resident which documents how the person wishes to be supported in all areas of their lives.
2. Appropriate PPPG's will be developed and implemented to ensure best practice in ensuring people's rights and dignity is respected. These PPPG's will include but not limited to: Intimate care policy and a communication policy.
3. In relation to the resident referred to in this report: this situation has been reassessed which resulted in a change of rooms for the resident in question.

Proposed Timescale: 30/11/2014

Theme: DCAD10 Individualised Supports and Care

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

Based on the degree of disability of the residents in the centre, inspectors were not satisfied that the advocacy service was sufficiently proactive in supporting residents make a complaint.

Action Required:

Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

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

1. For residents wishing to make a complaint, they will be offered and encouraged to avail of an advocate. The following options will be available to the person:
 - Their Key Worker,
 - The Senior Psychologist in the centre
 - An independent Advocate through the National Advocacy Service or the Mental Health Advocate Service.
2. This will be documented in the Complaints Policy and displayed on notices.

Proposed Timescale: 31/10/2014

Theme: DCAD10 Individualised Supports and Care

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

The complaints notice was on display in the visitors room in one of the units, however, it was not on prominent display throughout the centre and was not in an accessible format.

Action Required:

Under Regulation 34 (1) (d) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

1. The complaints notice will be put into an accessible format, laminated and will be on display throughout the centre on all the main access corridors.

Proposed Timescale: 30/09/2014

Theme: DCAD10 Individualised Supports and Care

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

There were two complaints processes in operation in the centre.

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

1. Complete and sign off draft Complaint procedure
2. Translate into an accessible and age appropriate format for the residents.

Proposed Timescale: 30/09/2014

Theme: DCAD10 Individualised Supports and Care

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

There was no person nominated to oversee the complaints procedure.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

1. The Person in Charge will be the nominated person under regulation 34 (3)
2. Complete as part of complaint procedure and sign off

Proposed Timescale: 30/09/2014

Outcome 02: Communication

Theme: DCAD10 Individualised Supports and Care

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

There was no evidence of the use of assistive technology to support residents with communication difficulties to communicate.

Action Required:

Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

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

1. This will be an ongoing part of the PCP process. The needs will be identified and options/referrals will be placed accordingly.

Proposed Timescale: 31/12/2014

Theme: DCAD10 Individualised Supports and Care

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

Information was not routinely provided in a format accessible by residents based on their communication requirements.

Action Required:

Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

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

1. Resident's communication styles and preferences will be identified through individual Support Plans. This will provide guidance for staff regarding how best to communicate with each individual
2. Accessible information will be made available to residents in verbal, easy read, sign and visual forms, in response to individual communication needs.
3. Accessible information will be provided in relation to resident's rights, their contract of care, person-centred plans, choices regarding menus, services and activities available to them, and other issues as appropriate.
4. The Communication PPPG will be reviewed and modified to take account of this action.

Proposed Timescale: 31/12/2014

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Based on a sample of records viewed, and this was confirmed by the provider, residents do not have a contract of care.

Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

1. There will be no admissions into the centre.
2. A contract of care has been developed. Individual meetings will be held with families and residents to outline this contract. In line with HSE National Consent Policy, unless the person is assessed to have capacity to understand the nature of the contract, it is not expected that the Contract of Care will be signed by the resident but the resident and his family will be aware of same.

Proposed Timescale: 31/10/2014

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:

On the days of inspection residents did not have a comprehensive operational personal support plan in place.

Action Required:

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

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

1. As part of the transition we are currently preparing PCPs and support plans for all residents. Some of the support plans will require extensive behavioural assessments before they are complete. We are also in the process of changing the format of the support plan to a more user friendly format.

Proposed Timescale: 30/12/2014

Theme: Effective Services

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

Improvements were required in the development of personal plans in relation to the involvement of other members of a multidisciplinary team such as speech and language therapy and occupational therapy.

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:

1. Through the Transition team, circle of support meetings are starting to commence. All appropriate professionals will be part of each individual's circle of support. Multi D input will include: Occupational therapy, Physiotherapy, Speech and Language Therapy, psychology, psychiatry, nursing, social care workers and GP's.

Proposed Timescale: 31/12/2014

Theme: Effective Services

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

Evidence-based tools for the assessment of issues such as falls risk and the risk of developing pressure sores were not used. Additionally, a small number of residents had wounds but there were no wound management care plans in place demonstrating ongoing assessment of the wound or directing the care to be provided.

Action Required:

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

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

1. Evidence based tools for the assessment of risks such as trips and falls will be completed for all residents. A wound management care plan will be used for any resident who sustains a wound or injury.

Proposed Timescale: 31/10/2014

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The centre was in need of redecoration due to damaged wardrobes and chipped paintwork

Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

1. HSE Maintenance Department have been requested to view the premises and advise and cost for essential or urgent maintenance work.
2. As advised, the centre will be closing down so it is expected that only urgent and essential maintenance work will be carried out.

Proposed Timescale: 31/12/2014

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:

There was insufficient evidence of feedback to staff for the purpose of learning and prevention of recurrence.

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:

1. Include as part of the Risk management policy and procedures. Complete draft Risk Management PPPG and sign off.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

The risk management policy did not address the measures in place to mitigate against the unexplained absence of a resident.

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:

1. Include as part of the Risk management policy and procedure. Complete draft Risk Management PPPG and sign off.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

The risk management policy did not address the measures in place to mitigate against aggression and violence.

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:

1. Include with Risk Management procedures. Complete draft Risk Management PPPG and sign off.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

The risk management policy did not address the measures in place to mitigate against self-harm.

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:

1. Include with Risk Management procedures. Complete draft Risk Management PPPG and sign off.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

There was an emergency plan, however, it only addressed the evacuation of residents in the event of an emergency but did not address the safe placement of residents in the event of a prolonged evacuation or other emergencies such as loss of electricity, loss of heating, loss of water or flooding.

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:

1. Review and update draft evacuation plan to include evacuation in the event of fire, loss of electricity, loss of heating, loss of water, flooding or other emergencies.
2. Ensure staff training and awareness of same.

Proposed Timescale: 30/10/2014

Theme: Effective Services

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

Fire extinguishers were located in locked offices making them difficult to access in the event of an emergency.

Action Required:

Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

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

1. This issue has been discussed with the fire officer and it is planned that locked units for all fire extinguishers will be placed on the walls of the corridors with the exception of Unit A as due to the challenging behaviour of the residents in this unit it is not possible to have extinguishers in open areas.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

Training records indicated that not all staff members had received up-to-date training in fire safety.

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:

1. All staff to complete Fire Safety Training
2. Training on fire safety will be included with overall staff training records for the centre

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A small number of fire doors were held open with door wedges, which was not in compliance with good fire safety practices.

Action Required:

Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

1. A requisition has been sent to maintenance identifying all doors that require magnetic door holders

Proposed Timescale: 30/09/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Personal care plans did not adequately outline positive behavioural support to alleviate the underlying causes of behaviour that is challenging. For example, the report of a psychological review of one resident clearly identified interventions to alleviate challenging behaviour, however, this was not adequately addressed in the care plan and there was insufficient evidence to demonstrate that the interventions identified in the report were routinely implemented.

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:

1. Positive Behaviour Support Plans will be devised with the support of external professional services and overseen by the Senior Clinical Psychologist for the centre.
2. Existing behaviour support recommendations will be reviewed and addressed in the individual's care plan and routinely implemented, with recording of same in the resident's file.
3. Staff support and training will be provided in relation to implementing individual Positive Behaviour Support Plans.
4. Monitoring, review and amendments will be scheduled regularly to ensure maximum effectiveness of the plans.

Proposed Timescale: 13/02/2015

Theme: Safe Services

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

There was evidence that staff were facilitated with training on behavioural support planning but training records indicated poor attendance.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

1. Training for staff in relation to the implementation of Behaviour plans will be provided through applied learning as individual plans are ready for implementation. Ongoing training and support for staff on the implementation to the Behaviour Support Plans will be provided by Senior Psychologist and the Behaviour Support Specialist service.

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

Records indicated, and it was confirmed by the provider and person in charge, that staff had not received training on the prevention, detection or 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:

1. Training will be provided in this area for all staff. Training dates set for 17th + 23rd Sept 14. Further training will be planned immediately after this to ensure all staff receive the training by target date.

Proposed Timescale: 30/10/2014

Outcome 10. General Welfare and Development

Theme: Health and Development

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

There was insufficient evidence to demonstrate that residents had been facilitated with education and training to support them achieve their potential.

Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

1. Through the transition team, all residents will be provided with opportunities to explore training, education and employment opportunities

Proposed Timescale: 31/03/2014

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:

There insufficient evidence of access to other allied health/specialist services such as speech and language therapy and dietetics or of a programme of referral to dental services as part of a programme of preventive care.

Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

1. All clients requiring specialist services such as S.A.L.T will be referred as required. For residents who require special diets a referral will be sent to dietetics for a full review of their diet plan. As part of each residents physical exam a referral to dental services will be included as part of this overall assessment

Proposed Timescale: 30/11/2014

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:

Improvements were required in relation to medication management practices. For example, inspectors found:

- medications stored inappropriately in a basket in one of the kitchens
- the fridge thermometer was not functioning in one of the medication fridges and fridge temperatures were not always recorded daily
- some medications in a "stock" cupboard were out-of-date
- there was no system for returning unused or out-of-date medications to the pharmacy
- there was no evidence of ongoing medication management training by all nursing staff
- there was an inadequate system for reviewing medication management practices as none of the above non-compliances were captured in a recent medication management audit

Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

1. Immediate actions taken:

- Medications stored in the kitchen were immediately removed and staff were requested to review the policy on medication management with particular reference to the Storage of Medication.
- A new fridge has been put in place in one unit so both units are now doing daily checks on fridge temperatures which are being recorded.
- The practice of storing medications that are not in use has been dispensed with. All out of date or unused medication are being returned to the pharmacy.
- Staff have been requested to read the policy on medication and take part in HSE on line training course on medication management.
- Medication audit planned for Sept 2014

2. Community pharmacy to give presentation to staff on Thursday 31st of July with view to development of universal community based safe medication system. Both houses will be operating the same system with the PPPG amended to reflect the changes to the management of medication.

Proposed Timescale: 30/09/2014

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not contain all of the items listed in Schedule 1 of the Regulations.

Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. This will be amended to reflect the required changes.

Proposed Timescale: 31/07/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

Inspectors formed the view that, based on the profile of residents in the centre and the absence of staff with suitable training in intellectual disability, that the care of residents could be enhanced by the addition of social care staff to support nursing staff in the provision of care.

Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

1. A disability agency has been contracted and have commenced working in the centre, to support the following:
 - Development of PCP's
 - Implementation of PCP's
 - Development of Community Transitional plans
 - Provision of individualised supports to develop independent skills and community linkages.
2. This agency will use a combination of staff to deliver on the above, including social care staff. The agency will provide their staff with the relevant training for supporting the individuals that they will be working with.
3. The housekeeping staff are being offered the opportunity to train as HCA's if they wish to remain with Intellectual Disability Services as the service moves out to the

community.

Proposed Timescale: 15/07/2014

Theme: Responsive Workforce

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

Based on a review of a sample of personnel records many of the items listed in Schedule 2 of the Regulations were not in place for staff, including:

- up-to-date photographic identification
- vetting disclosure
- two written references including a reference from a person's most recent employer (if any).

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:

1. The Person in Charge is working with the staff to ensure that all the required information is obtained for inclusion in their personnel file.

Proposed Timescale: 31/08/2014

Theme: Responsive Workforce

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

While staff members were equipped to provide psychiatric and other nursing care to residents, there was minimal evidence of attendance by staff at training to support them develop the skills required to support residents with an intellectual disability. For example:

- staff had not received adequate training in communicating with residents that required support, such as using LAMH
- staff had not attended training on behavioural support
- staff had not received training on the prevention and detection of abuse

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:

1. Mandatory training courses will be reoffered to staff in learning formats that may better enhance their experience.

2. It is planned that staff will be encouraged to learn through applied learning techniques, particularly in relation to Behaviour Support Planning.
3. Training in Lamh to commence end of August

Proposed Timescale: Training programmes will be ongoing as per training plans. New training programmes will be rolling out in Sept 2014.

Proposed Timescale: 30/09/2014

Outcome 18: Records and documentation

Theme: Use of Information

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

All of the policies and procedures listed in Schedule 5 of the regulations were in draft format and not yet approved for implementation.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

1. All PPPGs currently in draft form. Review and sign off required.

Proposed Timescale: 31/12/2014

Theme: Use of Information

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

There was a sheet of paper in each building with the names and relevant details of each resident in that building, however, it was a loose sheet of paper.

Action Required:

Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

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

1. A new template for each resident will be created which will be maintained as a file on computer and also in hard copy format as an official register of all residents.

Proposed Timescale: 31/08/2014