

**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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0001439
Centre county:	Dublin 20
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Mary Reynolds
Lead inspector:	Deirdre Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From: 13 January 2015 10:00 To: 13 January 2015 21:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first monitoring inspection of this designated centre for adults with an intellectual disability by the Health Information and Quality Authority (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 the parent organisation the Daughters of Charity Support Services Limited. The inspector met the nominated person on behalf of the provider at this inspection along with the centre manager and the person in charge. The inspector also met with residents and staff members.

Ms. Mary Reynolds is the services manager and the person nominated on behalf of the provider (the provider). During discussions, the management team demonstrated a commitment to providing a quality service with clear reporting systems in place.

The designated centre consists of three houses and is part of a larger campus based residential facility. It is in close proximity to the local community and the city centre.

Overall, the inspector found that residents received a good quality of service in the centre. The centre can accommodate up to eighteen residents, and all of the

residents were met during the inspection. The centre had a good atmosphere and the residents appeared comfortable in their home. The staff were familiar with the residents' needs and were observed to speak to them in a respectful and dignified manner. Staff supported residents in making decisions and choices about their lives. There were systems in place to ensure residents were safe from harm or abuse.

However, areas of non compliance over the eight outcomes were also identified. These related to outcomes on social care needs and risk management. In addition improvements were identified in relation to aspects of safeguarding and safety, and an aspect of health-care. Improvements were also required in relation to the outcome on workforce.

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, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: 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

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

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

Findings:

The inspector reviewed one component of this outcome in relation to residents' personal possessions.

There was a policy in place to provide guidance on the care of residents' property and finances. The provider and person in charge had also put systems in place to safeguard the finances of residents. However, the arrangements in place to support residents to have their own bank account required improvement. For example, the majority of residents did not have their a bank account in their own name, and residents monies such as pensions or disability allowance were paid directly into a centralised bank account of belonging to the organisation. The inspector was informed this matter would be prioritised for review in 2015.

The staff in the centre showed the inspector how some residents were using the balance of their pension or disability allowance each week. The inspector reviewed a number of these and noted transactions were being signed by two staff members with receipts kept for each transaction.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

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

Findings:

The inspector found each resident's wellbeing was maintained by a good standard of care and support. However, improvements were required in the assessment process and development of personal plans for each resident. In addition, improvements were required in the documentation of care plans.

There was evidence that residents' welfare and wellbeing was maintained by a good standard of care and support, and by staff who were familiar with their health care needs. The residents had a moderate to severe intellectual disability which required staff support and assistance. However, personal plans were mainly clinical in nature and lacked a comprehensive assessment of residents' social and emotional care needs. For example, there was limited evidence of residents' social goals, aspirations and wishes being considered. While work was underway to address this matter, only one resident's personal plan was completed. This was read by the inspector. The plan captured the residents wishes and aspirations in a meaningful way that impacted positively on their life. It was in an accessible format with photos and pictorial images. This matter was discussed with the provider and person in charge who assured the inspector the matter was a priority and would be fully addressed in 2015.

The inspector reviewed a sample of residents' medical plans in place. There was evidence of regular assessment using evidence based tools. However, the completion care plans required improvement. For example, care plans were not developed for all residents needs such as dementia and epilepsy. Also, some care plans did not fully guide practice or updated following a change in need.

There was evidence that the residents and their representatives had a personal input and were involved in the assessment process. Records read confirmed families were invited to and involved in multi-disciplinary team meetings held on an annual basis.

The inspector found suitable provision of social activation for residents that were reflective of residents' assessed needs. During the day most of the residents attend a day service on the grounds of the centre. At this inspection, staff were seen to interact

closely with the residents, and were facilitate activities during the inspection. Activities included walks, games, books, baking, beauty regimes, hand and foot massage. In addition, outings took place from the centre, such as trips to the hairdresser, the city centre, coffee shops, theatre. In addition, some residents were facilitated and supported to go on holidays.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

The inspector found measures in place to ensure the health and safety of residents, staff and visitors to the designated centre was promoted and protected. However, improvements were identified in relation to risk management.

There were improvements required in the identification and assessment of risk in the centre. The inspector reviewed the risk management policy. However, it did not fully meet the requirements of the Regulations. For example, it did not clearly outline the controls in place to manage specified risks such as self harm, abuse, aggression and accidental injury. Furthermore, it was not fully implemented in practice in relation to the risk assessment of potential hazards. For example, apart from clinical risk assessments on a number of residents files, there was no evidence if risks in the centre had been assessed and measures were in place to control them.

There were some systems in place to discuss and monitor risk. The inspector was informed a health and safety committee was in place, and a new health and safety officer had recently been appointed. The person in charge said a new health and safety check was planned to take place. However, there were no records seen by the inspector to confirm this.

There were systems in place to manage adverse events. An accident record book was read by the inspector, in which a range of incidents were recorded. The person in charge informed inspectors that she would review all incidents. A copy was also forwarded to the service manager and to the relevant stakeholders for review. There was a system in place to review all incidents. The centre manager explained that a three monthly meeting would take place review all incidents on a three monthly basis and to decide on any relevant action to be taken. The last meeting took place in October 2014 and the next was due to take the day after the inspection.

A health and safety statement was seen by the inspector. There was an emergency plan

in place. However, it did not include the alternative accommodation options and transport arrangements in the event of an evacuation. Personal evacuation procedures were in place for each resident and reviewed regularly.

A policy on the prevention and control of infection was read by the inspector. There were hand gels present throughout all units in the centre and hand-washing guidelines were displayed for staff.

There was a policy on the management and prevention of fire. The fire exits were unobstructed and daily records read confirmed these were checked by staff. There were regular staff fire drills which residents took part in, and records were maintained for drills. All staff spoken with were familiar with the procedures to follow if the fire alarm went off.

The inspector saw documented evidence that fire equipment was serviced regularly such as fire extinguishers, fire alarms and emergency lighting. Fire evacuation procedures were displayed in each of the units. Records reviewed confirmed all staff had participated in fire training in the last year.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The inspector found systems were in place to ensure residents were safeguarded from abuse, and to provide positive behaviour support to residents. However, improvements were required in the provision of training in the prevention of abuse, and the management of restrictive practices.

The inspector reviewed training records which were submitted to the Authority by the person in charge following the inspection. However, records showed gaps in the provision of appropriate staff training. For example, five staff had not completed training. In addition, some staff had not completed refresher training in over three years. Records showed one staff had not completed training since 2003. This was brought to the attention of the person in charge who was required to take appropriate

action. Staff spoken to during the inspection were familiar with the types and indicators of abuse, and the reporting arrangements in place.

There was a policy on the prevention and the detection of abuse which provided sufficient guidance. There was evidence it was reflected in practice. Prior to the inspection an allegation of abuse had been notified to the Chief Inspector. The inspector discussed the incident and the screening process with the provider and person in charge. Both were aware of their statutory obligations to investigate allegations or suspicions of abuse. The person in charge described the procedure followed and the safe guarding measures that had been put in place. The provider and centre manager completed a screening process whereby a decision would be made to escalate to an investigation if an abusive event had occurred. The inspector reviewed the documentation and reports of the screening process, and there was evidence of a meaningful and structured process in which appropriate action had been taken to safeguard the resident.

There were a small number of residents with a restrictive practice in place. There was a policy on the use of restrictive practices. However, improvements were required in order to meet the requirements of the Regulations and the national policy "Towards A Restraint Free Environment". For example, where bed rails and lap belts were used, there was no risk assessment carried out, to include the alternatives considered. In addition, care plans were not developed and there was no evidence of regular review when restraint was in use. This was discussed with the person in charge, who informed the inspector a new assessment tool was being developed by the centre manager and an occupational therapist.

There were good practices in the management of behaviours that challenge. A policy was in place that provided guidance. A small number of residents with behaviours that challenged required additional support interventions. The staff were familiar with residents' needs and clearly described their behaviours, triggers and the de-escalation techniques. There was evidence of referral and review by psychology services. A positive behaviour support plan was developed, along with an accessible version for residents where required. The person in charge and a health care assistant had completed training in the assessment of positive support plans.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

The inspector 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, improvements were identified in relation to the supervision of residents at mealtimes and aspects of health care management.

There were improvements required to ensure residents were provided with appropriate support at mealtimes. The inspector observed lunchtime in one unit. All six residents were present and required a level of assistance. There was sufficient staff rostered during the day in the unit. However, at this meal the second staff member had gone on their break resulting in one staff and a housekeeping staff providing assistance. There were three residents on a modified texture diet who required supervision. Another resident who was not eating also required assistance which resulted in the staff unable to fully assist residents requiring support. The inspector noted the housekeeping staff were not rostered to work two days of the week, therefore the number of staff at lunchtime could potentially reduce to one on some days. This matter was discussed with the provider and person in charge, who explained they were aware of the matter and would review staff breaks.

There were central catering facilities in the centre where the majority of residents meals were prepared. Lunchtime meals were distributed to the units in the centre in hot trollies. Throughout the meal, staff interacted with the residents in a patient, calm and respectful manner. The meal looked wholesome and nutritious. There was a pictorial menu to guide residents to choose the meal they would like. A kitchenette was also provided in each unit and light meals were prepared here by staff. While residents did not prepare their own meals, some residents could purchase their own food, and it would be prepared by the staff.

The inspector reviewed records that confirmed residents had access to the services of a medical practitioner. A senior physician based in the centre visited residents regularly. There was also weekly visits to the centre from a general practitioner (G.P.) based in the locality. Primarily residents were attended to by the centres senior physician unless out-of-hours care was required in the centre. 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 in house access to occupational therapy, dietician, and physiotherapy. Additionally, there was evidence of good access to speech and language therapy, occupational therapy, ophthalmic services, dentistry and, and chiropody services. A psychiatric and psychological service for behavioral management and support for residents were available both internally and externally respectively 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.

A documented annual review of each resident health care needs was completed by the physician. Overall, care plans were developed to provide guidance to staff. However, some were not developed for all residents identified needs. For example, dementia and

epilepsy. In addition, some personal plans did not provide sufficient guidance for epilepsy and mobility issues. The action in relation to this is detailed under Outcome 5 (Social Care Needs).

Judgment:

Substantially Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Health and Development

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

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

Findings:

The inspector found there were policies and procedures in place for medication management. However, improvements were required in relation to the policy, prescribing of medication and training.

There were written operational procedures and policies on the ordering, administration and disposal of medications. However, there were no procedures to provide general guidance on the prescribing of residents' medications.

The inspector reviewed a sample of residents administration and prescription sheets which were contained in booklet format. Overall, good practices were observed with an area of improvement required. For example, crushed medications had not been individually prescribed by the General Practitioner (GP).

All staff who administered medication in the centre were nursing qualified. Staff were knowledgeable of the procedures and adhered to best practice guidelines in the administration of medications. However, no staff had completed training in the safe administration of medication. This is an action under Outcome 17 (Workforce).

There were no resident prescribed medications that required strict controls (MDAs) at the time of inspection. In addition, there were no residents self medicating at the time of the inspection. There were procedures in place for the safe storage of medications, which were kept in locked trollies in the centre.

There was regular GP reviews of the residents' medications. There was a system of monitoring and reviewing safe medication practices and records were read of weekly audits that had taken place. The inspector also read input and recommendation made by the pharmacy service which based in the service.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

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, the inspector found that governance arrangements were satisfactory, with evidence of a regular review of the safety and quality of care provided to residents of the service.

The person in charge of the designated centre was experienced, and fully participated in the inspection process. She demonstrated appropriate knowledge of the Regulations and her responsibilities therein. She held regular meetings with staff of the centre. The person in charge also attended management meetings with the centre manager and the provider. There were suitable deputising arrangements in place, with a clinical nurse manager (CNM1) and the centre manager supporting the person in charge. Prior to the inspection, a full review of persons in charge had just been completed to reflect the newly reconfigured designated centre. Staff were clear of the management structure and the reporting systems in place. The residents were familiar with the person in charge who was observed to spend time to talk and interact with them.

As reported earlier, the provider was present during this inspection. She worked full time in the organisation and was based close by in another service of the wider organisation. There was evidence of regular management meetings with the staff of the designated centre. The provider was also supported by a centre manager who oversaw the management of the service where the designated centre was located.

A number of processes were used to monitor and oversee the safety and quality of care. There was a yearly quality report completed, that looked at 18 outcomes, from safety to protection of residents. While the residents had not yet been provided with a copy of the report, this was discussed with the provider at the feedback meeting, who said systems would be put in place to ensure this would be addressed.

In addition, a quality and safety audit was carried out in each of the units of the designated centre. These audits were unannounced and took place every six months. They were completed by the centre manager on behalf of the provider. The audit

included key performance indicators such as quality, safety, medication, risk and the environment, and where actions had been identified there were systems in place to follow up and monitor them.

Audits also took place at unit level, and included, medication audits, finance audits and infection control audits. The reports of these were seen by the inspector and highlighted where improvements were required.

Judgment:

Substantially Compliant

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

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

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

Findings:

The inspector found there was an adequate number and skill mix of staff to meet the needs of the residents. However, improvements were required in relation to staff training and the system of supervision.

There was no formal system of staff supervision in place. The centre manager informed the inspector that to date supervision meetings were held with the person in charge and it was a matter of priority for the service. It was expected that the supervision of all centre staff would be carried out in 2015.

While there was an adequate number and skill mix of staff on duty to meet the residents needs, and a planned and actual staff roster was in place that reflected the staff on duty, the inspector found there was an over reliance on agency staff. A service level agreement was in place. The centre manager explained due to a moratorium on employing staff, it resulted in a requirement to use agency staff. However, for continuity care the same staff were used as regularly as possible and rostered in to the same units in the centre as much as possible.

The inspector did not review staff documents required by the Regulations. This had been reviewed by the Authority at previous inspections of the larger organisation and found to be adequate.

Staff training records were reviewed and a range of training was provided including mandatory areas. However, training was not provided for all staff in the safeguarding of

vulnerable adults (see Outcome 8), or in medication management practices.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0001439
Date of Inspection:	13 January 2015
Date of response:	27 February 2015

Requirements

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

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The residents own monies were not paid into a financial institution account of their own name.

Action Required:

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

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

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

(a) A financial capacity assessment will be completed for each person in the designated centre

(b) Each person in the designated centre will be supported to open an individual bank account

Proposed Timescale: 31/12/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

The completion of personal plans that outlined individual needs, aspirations and choices required improvement.

Care plans did not fully guide the care in relation to some residents identified needs for example, epilepsy and dementia care.

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:

All care plans to be reviewed and updated by local team with the support of a facilitator who will work with the team to achieve this outcome. Each service user will have a Person Centred Plan which focuses on their individual wishes and desires, as identified from meeting service users and their significant other persons.

Proposed Timescale: 30/06/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The identification and assessment of risk in the centre required improvement.

Action Required:

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

centre.

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

A risk register will be developed to identify hazards and assess risks in the designated centre.

Proposed Timescale: 28/02/2015

Theme: Effective Services

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

The risk management policy did not include all the information required by Regulations.

Action Required:

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

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

The risk management policy will be reviewed to include the measures and actions required to control risks identified in relation to:

- The unexpected absence of any resident
- Accidental injury to residents, visitors, or staff
- Aggression and Violence
- Self Harm

Proposed Timescale: 30/01/2015

Theme: Effective Services

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

The emergency plan did not fully guide practice and required review.

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:

The emergency plans will be reviewed to include methods of transport to alternative accommodation.

Proposed Timescale: 28/02/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

There were improvements required in the management of restrictive practices.

Action Required:

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

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

All restrictive practices in place including use of lap straps & bed rails will be reviewed in accordance with DOCS Policy 053 Restrictive Practices by the MDT to identify the least restrictive option possible.

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:

There was no formal programme of training for staff in place for example, some staff were not trained and large gaps existed between training dates.

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:

- (a) All staff will receive appropriate training in relation to service user protection and welfare procedures
- (b) A system of providing refresher training in relation to service user protection and welfare procedures has been implemented. All staff will receive refresher training at a minimum of every 3 years

Proposed Timescale: 30/05/2015

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:

The staff levels at mealtimes where residents require assistance shall be reviewed.

Action Required:

Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

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

Staffing roster to be reviewed .

Unit 1 : In the morning, breakfast is served to each Service User at their preferred time. Revised roster to commence in March which incorporates ensuring that staff lunch breaks are shortened at this time by 30 minutes per staff member.

In the evening time staff breaks will not coincide with the Service Users` meal.

Unit 2 and Unit 3 : Staff will take their break after Service Users` breakfast.

Revised roster to commence in March which incorporates ensuring that staff lunch breaks are shortened at this time by 30 minutes per staff member.

In the evening staff breaks will not coincide with the Service Users` meal.

Proposed Timescale: 31/03/2015

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:

The practice in the prescribing of crushed medication required improvement.

There was no prescribing procedure to provide guidance to staff.

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:

(a)Any person who requires medication to be crushed will have a note documented in the special consideration section of the MPARS and signed by the prescriber.

The prescriber will also make a note in the person`s medical file.

(b)The medication management policy will be updated . Information regarding same has been inserted into the current policy.

Proposed Timescale: 28/02/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

A copy of the annual review of the safety and quality of care has not been made available to residents or their representatives.

Action Required:

Under Regulation 23 (2) (b) you are required to: Maintain a copy of the report of the unannounced visit to the designated centre and make it available on request to residents and their representatives and the chief inspector.

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

A copy of the annual review of safety and quality of care will be made available to residents or their representatives

Proposed Timescale: 30/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

There was no system of staff supervision in place.

Action Required:

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

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

A procedure will be developed to provide guidance on staff supervision

Proposed Timescale: 30/01/2015

Theme: Responsive Workforce

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

Staff had not been provided with training in medication management.

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:

- (a) All nursing staff will complete the online HSE land training in medication management
- (b) The service pharmacist will provide information sessions on medication safety issues to staff

Proposed Timescale: 30/04/2015