Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003371
Centre county:	Meath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Dervila Eyres
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
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 2 day(s).

The inspection took place over the following dates and times

From:	To:
07 July 2015 11:30	07 July 2015 16:30
30 October 2015 12:30	30 October 2015 17:00

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

Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of this designated centre by the Authority. The provider was issued with a warning letter following the first day of inspection on the 08 July 2015. This warning letter required immediate action by the provider to address the following areas of risk to residents and major non-compliances with the legislation:
1. Protection: Residents assessed as being at risk of abuse were not adequately safeguarded as lead staff were not informed of the safeguarding measures in place.
2. Risk Management: Fire safety arrangements were not adequate for residents as a resident smoked in the living room in the centre.
3. Workforce: Staffing numbers and skill mix did not ensure a consistent and knowledgeable workforce were available to meet the needs of residents.
4. Governance and Management: Management systems in place did not ensure the service provided was safe, appropriate, consistent and effectively monitored.

The provider responded on the 09 and 10 July 2015 with a number of actions to be implemented to address these findings. The inspector reviewed implementation of the actions stated on the second day of this inspection and found that outcomes for residents in terms of safety and quality of life were improved. Risk management procedures require further improvement to ensure all hazards are risk assessed with adequate controls stated and implemented. Fire safety procedures were satisfactory with the exception of fire safety training for two staff required and a fire extinguisher

was not dated as serviced.

Residents generally had satisfactory access to allied health professionals, GPs and medical specialist services. While there was no evidence of residents having negative nutritional outcomes, a large number of staff in the centre had not received training in nutrition and food hygiene. Residents who experienced behaviours that challenged had their needs assessed and were supported with positive behavioural support plans.

All staff had not completed training in fire evacuation, management of challenging behaviour, nutrition and food hygiene as part of mandatory training and a continuous professional development programme. Formal performance management of the person in charge and staff or competency assessment had not been commenced in the centre to date.

While management systems in place in the designated centre required significant development to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

All staff-resident interactions on the days of inspection were respectful and supportive throughout the two days of inspection.

Non-compliances were identified with twelve regulations on this inspection in the seven outcomes assessed, nine of which are the responsibility of the provider and three are the responsibility of the person in charge.
The action plan at the end of this report identifies the required actions the provider/person in charge is required to take to ensure the designated centre is in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 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, 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 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

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The designated centre is a dormer style bungalow, located on the outer perimeter of the town of Navan. The inspector found that the design and layout of residents' bedrooms met their needs. Each resident was accommodated in a single bedroom with en-suite facilities. The house has a large communal shower/toilet. Assistive equipment including grab rails in toilets/showers where appropriate and handrails along the length of the corridor were fitted.

Residents' bedrooms were person centred and residents told the inspectors they had control over the décor in them. The inspectors observed that bedrooms were personalised by residents to reflect their personality and interests. There was evidence of significant delay in addressing areas requiring repair or replacement following escalation by the person in charge. For example, a flue was not fitted to the central heating boiler located along the back wall of the premises adjacent to one resident's bedroom window on the ground floor and directly under another resident's bedroom window on the first floor. While both bedroom windows were closed during the inspection, the inspector observed that the exhaust fumes circulated in the air outside these windows. The person in charge advised the inspector that he had requisitioned installation of a flue some time previously which had to date not been provided to date. The provider advised that the distance of the flue outlet from residents' windows was deemed to meet Health and Safety requirements by a fire officer. However, circulating fumes from the flue outlet were observed to circulate around residents' windows and therefore the flue outlet required redirection. A ramp with handrails provided access for residents from the centre to the back of the centre and an enclosed secure garden area. Seating was provided in the garden for residents' comfort.

A shed located at the back of the centre was designated as a smoking area for use by one elderly resident. While heating and lighting was available in this facility, this retired

resident has diagnosed health problems and is exposed to any inclement weather conditions while accessing this area. This requires review to ensure this resident's needs and wishes are met.

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:
A risk register was in place which was reviewed on a weekly basis by the person in charge. While controls were listed to mitigate level of some risks assessed as having a high likelihood of occurring, these controls did not adequately address risks in the centre. A number of the risks identified required the intervention of maintenance services for mitigation. While there was evidence that some areas of maintenance was completed, there was evidence of delay in completing repairs and replacements as required.
Unidentified risks in the centre as observed by the inspector included
- part of the corridor in the centre was ramped, however a non-slip mat was in place on the ramp incline and handrails were fitted on both sides.
- cars accessing the back of the centre around a blind corner of the premises to designated car parking

Each resident had documented risk assessments with controls clearly stated. The level of risk was assessed and review dates were included.
On the 07 July 2015, the inspector found that the arrangements in place for residents who smoked posed a significant risk of a fire in the centre. A resident was observed smoking in the living/kitchen area of the centre. An ashtray was placed on the seating surface of the settee and ash was observed to be spilled onto the settee surface. Other residents and staff were in the area and the air in the room was contaminated with smoke. The inspector observed that a smoking risk assessment had been completed for this resident and controls referenced that this resident would engage in smoking in a designated shed located at the back of the centre which was not happening on a consistent basis.

In July the inspector viewed the designated smoking shed and found that the area contained seating and ashtrays. While a fire extinguisher was available, a smoking apron was not in place. The shed had means of heating and had adequate lighting and

ventilation. A ramp to the door aided accessibility, this shed was located a distance from the designated centre premises.
In October the risk had been addressed. The inspector confirmed that one resident who smoked used the designated smoking shed at all times and no residents engaged in smoking inside the designated centre premises. Residents who smoked were supervised during this activity. A safety apron was available in the designated smoking area. While a fire extinguisher was available, it was not dated or included on the service list of fire equipment for the centre.

On 07 July 2015, the inspector also found that all staff had not had fire safety training or participated in an evacuation fire drill. A fire drill had not been completed to ensure all residents could be safely evacuated at night by the two staff on duty. The evacuation procedure advised evacuation of all persons to an area of safety outside the centre. The inspector observed that fire exit doors were locked with a key. While a key was available in a break-glass box adjacent to the fire exit doors, it was covered by a curtain inside the front door of the centre.
On the 30th October 2015, the inspector found that day and night-time fire drill had been completed which identified residents who required additional support to ensure they evacuated the centre. There was evidence that the assistance of the psychologist was employed to work with staff to develop support plans for residents who were experiencing difficulties with evacuating the centre during fire drills. A curtain fitted inside the front door which was a designated fire exit was removed. While, fire exits continued to be locked with keys, all keys were visible in break-glass units by each fire exit. The person in charge advised the inspector that thumb-turn locks were in the process of being fitted on fire exit doors. From review of the staff training records two staff had not participated in a fire evacuation drill. One new staff member was scheduled to attend fire safety training on 07 November 2015.

The centre was visibly clean and hand hygiene dispensers were available. Staff were observed to complete hand hygiene procedures as appropriate.

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:
On the 07 July 2015, the inspector found that residents were not adequately safeguarded against the risk of abuse. A staff member spoken with was not aware of the safeguarding arrangements in place for a resident assessed as being at risk of abuse following investigation of an alleged incident notified to the Authority. Adequate procedures were not in place to ensure that safeguarding plans in place for residents who were the subject of alleged incidents of abuse were implemented in day service placements. All staff working in the centre had not completed training in protection of vulnerable adults.
The provider responded on the 08 July 2015 by increasing staffing levels from 08:00hrs to 20:00hrs to one staff nurse and three care staff. Procedures were put in place to ensure safeguarding plans accompanied residents to day service placements. Residents' safeguarding plans formed part of the handover from one staff team in the centre to the next and handover to the day service staff team. All staff in the centre would be facilitated to attend training on protection of vulnerable adults.

The inspector found on 30 October 2015, that these actions were implemented with the exception of completion of refresher training for two newly employed staff as confirmed by staff training records. These staff members were scheduled to attend this training on 15 November 2015. A visitor's book was in operation to record all visitors to the centre. Access to the centre is by electric gates controlled by staff in the centre. Residents were appropriately supervised and staff spoken with were knowledgeable with regard to residents in the centre.

A regional safeguarding team supported residents' protection needs with safeguarding plan development and review as appropriate.. The safeguarding officer held review meetings to ensure residents' safeguarding plans met their needs.

The inspector also observed that thumb-turn locks were recently fitted to residents' bedroom doors to facilitate them to lock their bedroom doors for their privacy if they wished. Staff could disengage these locks if necessary in an emergency.

On the 07 July 2015, the inspector observed that a number of residents exhibited episodes of behaviours that challenge. Many of these episodes required de-escalation by administration of prescribed PRN (as required) medication. While psychological support was in place for residents, review by a psychiatric specialist since the first day of this inspection resulted in improved outcomes in terms of their quality of life for some residents. Each resident presenting with periods of challenging behaviour had a positive behavioural support plan in place. Residents spoken with by the inspector said they liked living in the centre, felt safe and that their needs were met. The inspector observed staff-resident interactions on the days of this inspection and found that staff were respectful, kind and supportive to residents at all times. Eleven out of the fourteen staff working in the centre had not completed training in management of challenging behaviour as required by the regulations.

Judgment:

Non Compliant - Moderate

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

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Residents' opportunities for new experiences, social participation, training and employment were generally supported. Goals were developed in accordance with each resident's preferences and to maximise his/her independence.

One resident was retired in the centre and attended a day centre one day per week where they mixed with other older people attending from the local community. All other residents had access to a day service programme outside the centre to pursue their personal and occupational development. While three residents chose to avail of this service on a five day week basis, two other residents preferred to remain at home during the day in the designated centre. The inspector observed that with the support of the multidisciplinary team, these two residents were being encouraged and supported to engage in activities to enhance their confidence and personal development. A schedule of activities was in place for these residents and individual daily activity records in place evidenced their participation. The inspector observed one resident choosing to watch a television programme, another engaged in art work and another resident engaged in a walking exercise supported by a staff member around the centre perimeter.

The inspector observed that residents were not regularly supported to attend social events in the evening time and outings to events generally took place during the day. This requires review to ensure residents including those who attend day services are supported to enjoy leisure activities in the evenings and at weekends. For example, one resident enjoyed going to the pub but could only engage in this when on leave with family members.

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 reviewed a sample of residents' personal plans over the two days of inspection and found that residents' needs were reviewed on an annual basis. Health care needs were identified in this annual assessment.

The inspector found on this inspection that care plans were in place to reference residents' individual healthcare needs with interventions prescribed to inform practice. However, There was evidence that healthcare referrals for assessment by allied health professionals were satisfactory with the exception of an referral for review by speech and language therapy services for a resident who experienced a choking incident while eating fruit. Residents experiencing mental health symptoms had been reviewed by a psychiatrist now available in the service in the period between the first and second days of this inspection with one resident's mental health needs reviewed o as an emergency on the 10 July 2015. The person in charge told the inspector that all residents have been reviewed which has resulted in improved quality of life outcomes for them. One resident was receiving care as an in-patient in the local hospital on the second day of inspection. The Inspector observed from review of residents' documentation that they had access to a general practitioner of their choice, including an out of hour's service. Records of referrals, clinical interventions and treatments were maintained in each resident's documentation.

There was evidence that residents with confirmed swallowing difficulties received prescribed modified consistency foods and fluids. One resident was referred for insertion of a percutaneous endoscopic gastrostomy (PEG) nutrition system due to evidence of aspiration. The person in charge together with the multidisciplinary team were preparing for the resident returning to the care of staff in the centre. The person in charge advised that all staff will receive training in this area prior to this resident's discharge and a policy document was available to inform practice. The resident's quality of life was also addressed by the multidisciplinary team and the inspector was told that a protocol was developed to ensure the most suitable PEG food administration schedule was in place. The speech and language therapist also prescribed a schedule for providing the resident with food samples to enable food tasting to continue for this resident as they enjoyed their food and the social aspects of mealtimes in the centre. Another resident was supported to enjoy a lactose free diet. However, only six of the fourteen staff working in the centre had completed training in food hygiene procedures. Three staff had completed training in nutrition. This finding requires review to ensure residents nutritional needs are met and is further discussed in outcome 17.

Residents spoken with by the inspector stated that they liked the food provided. There was evidence that residents' body weights were monitored with increased frequency for those at risk of weight loss/gain. No residents had unintentional weight loss on the days of inspection. One resident was supported to attend a slimming club and a diet plan.

Menus were in accessible format and inspectors observed that residents were provided with opportunity to have snacks and drinks throughout the day outside of their main meals.

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:
There is a clear management structure in place. The provider nominee is the general manager for the service. The provider nominee is supported by a regional director of nursing and two assistant directors of nursing. The person in charge reports to an assistant director of nursing who reports to the director of nursing. The person in charge is employed as a clinical nurse manager grade 2 (CNM2) and has responsibility for two designated centres within reasonable proximity to each other. There was evidence that the staff employed to work in the designated centre met regularly as a group with the person in charge. However, there was limited evidence that the person in charge formally met with the director of nursing as part of a performance management process or as a member of the regional nursing team. Formal performance management of staff or competency assessment had not been commenced in the centre to date.

The person in charge was available throughout the two days to facilitate the inspection. The person in charge has the necessary qualifications and experience to ensure compliance with the legislation and demonstrated adequate knowledge of the residents' needs and the operation of the designated centre. On the first day of this inspection on 07 July 2015, the inspectors found insufficient on site leadership, because the person in charge was engaged in operational duties and not available on a full time basis and this impacted on the service to residents who required high levels of support to ensure their needs were met.
The person in charge was designated with supernumerary responsibility for this designated centre on its own for a period of eight weeks following the first day of this inspection as part of the provider actions submitted to the Authority in response to the warning letter in relation to findings of risk to residents, issued by the Authority on 08

July 2015.
On the second day of this inspection, the inspector found that while the person in charge had resumed responsibility for two designated centres, this role was now on a supernumerary basis. A robust regional senior management on-call support schedule was also implemented following the first day of this inspection. The inspector observed that this was up to date and clearly displayed for reference if necessary in the centre. The persons in charge in the region also provided on-call support to specified designated centres on a rota basis. The findings also evidenced that the person in charge was satisfactorily involved in the governance, operational management and administration of the centre.

Although at an early stage, there was evidence of a system in place to monitor the quality and safety of care and quality of life of residents. The inspector reviewed a documentation audit for each resident which clearly and comprehensively identified deficits. While some actions were taken to address the deficits identified it was not clear what action was taken, when it was taken or by whom as deficits identified were not addressed with an action plan clearly identifying the actions to be taken, persons responsible and to enable tracking to satisfactory completion. A record of staff training completed to date was provided to the Authority

The audit was not the subject of an overall review to inform areas requiring further staff training. There was evidence that the provider and/or the director of nursing nominated on behalf of the provider had visited the designated centre in the previous six months. However an annual report on review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards was not available.

Judgment:
Non Compliant - Major

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:
On the first day of this inspection on 07 July 2015, the inspector found that staffing levels and skill mix in the centre did not ensure the needs of residents were met.

Findings included;
- a staff nurse spoken to by the inspector had not worked in the centre previously and was not knowledgeable about the residents' needs regarding safeguarding plans in place to protect them from risk of abuse and/or controls in place for some residents as a result of risk assessments completed
- not all staff had completed fire safety training including evacuation. A staff nurse on duty had not completed protection of vulnerable adult training or management of challenging behaviour training.
- some staff grades of the workforce were contracted from an external provider on an as required basis to replace staff vacancies/leave without due consideration to ensuring consistency and continuity for residents
- the person in charge did not work full-time in the centre and was regularly part of the operational workforce
- staffing levels did not ensure residents could engage in recreational activities outside the centre

In response to a warning letter issued by the Authority to the provider on 08 July 2015, the provider took the following actions:
- the person in charge was assigned on a full-time basis in the centre for a period of eight weeks and thereafter on a supernumerary basis with responsibility for two designated centres
- an additional staff nurse and three care staff were assigned to work in the centre ensuring consistency and continuity for residents
- a robust regional senior on-call rota was implemented to support the person in charge and staff in the designated centre
- staff training requirements were met regarding fire safety and evacuation. However not all staff had completed training in challenging behaviour and protection of vulnerable adults.

On the second day of this inspection, the inspector confirmed that the actions taken improved outcomes and quality of life for residents. The person in charge told inspectors the staffing levels and skill mix were subject to on-going review and monitoring to ensure the needs of residents were met. There was evidence that person in charge had facilitated review of all residents' personal support plans. Auditing of the quality and safety of care and the quality of life of residents was commenced. The staffing roster confirmed that there was a staff nurse and three care staff on duty from 08:00hrs to 20:00hrs each day. Night-time fire evacuations together with completed risk assessments for some residents as required confirmed that staffing numbers were adequate to ensure residents' could be safely evacuated. However, staff training was adequately completed to ensure staff had the skills and knowledge to meet the needs of residents. As discussed in other outcomes in this report, all staff had not completed training in fire evacuation, management of challenging behaviour, nutrition and food hygiene as part of mandatory training and a continuous professional development programme. Training was scheduled for two new staff members on protection of vulnerable adults and one staff member on fire safety in November 2015.

While staff supervision arrangements on a day to day basis in the centre was satisfactory on the second day of inspection with the implementation of the actions taken by the provider, procedures were not in place in the designated centre for the

formal performance management of the person in charge and staff as discussed in outcome 14.
There were no volunteer staff working in the centre. Although in process, the documentation as required by schedule 2 of the regulations for each staff member was not fully obtained.

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:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003371
Date of Inspection:	07 July 2015
Date of response:	01 December 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 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A flue was not fitted to the central heating boiler adjacent to one resident's bedroom window on the ground floor and directly under another resident's bedroom window on the first floor.

There was evidence of significant delay in addressing areas requiring repair or

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

replacement.

1. 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:
As interim intervention we have sought review on the requirements which must be met to comply with current building regulations in relation to this matter. The boiler outlet/low level discharge should be situated externally to allow the dispersal of the products of combustion and be at least 600mm from any opening into the building which the boiler currently is.
However based on HIQA recommendations in this report the Provider Nominee has commissioned an architect and requested draft plans to relocate the boiler to a shed further back in the garden (Same completed, see draft plans attached) We plan to finalise relocation of boiler planning and execution of same.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A shed located at the back of the centre was designated as a smoking area for use by one elderly resident which requires review to ensure this resident's needs and wishes are met.

2. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
The resident is supported at all times by staff to access smoking shed whilst ensuring his safety and wellbeing. This process is documented in the residents Smoking Risk Assessment/Support Plan. The shed has been facilitated with light, heat and all comforts requested by the resident.
However based on HIQA recommendations in this report the Provider Nominee has commissioned an architect and requested draft plans to build a small conservatory with exit and ventilation attached to the residents bedroom but closed off also (Same completed, see draft plans attached) We plan to finalise plans and execute same by date below

Proposed Timescale: 30/06/2016

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:
Unidentified risks in the centre as observed by the inspector included
- part of the corridor in the centre was ramped, however a non-slip mat was in place on the ramp incline and handrails were fitted on both sides.
- cars accessing the back of the centre around a blind corner of the premises to designated car parking

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

Please state the actions you have taken or are planning to take:
We have implemented a one way system for all vehicles entering the premises to avoid any blind spots. Same documented on risk assessment with interventions in place. A one way sign has been ordered for the garden to ensure compliance. Risk assessment in place.

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Controls to mitigate risks identified were not adequate to address risks in the centre.

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

Please state the actions you have taken or are planning to take:
We are currently reviewing all risks in the house and management of same including measures and actions in place to reduce identified risks. The PIC is developing a numbered index to precede collation of active risks on file for ease of reference

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While a fire extinguisher was available in the designated smoking area, it was not dated or included on the service list of fire equipment for the centre.

5. Action Required:
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The PIC contacted the fire department. The fire safety service has visited the house and checked and registered the extinguisher in the smoking shed. Same dated 11/2015.

Proposed Timescale: 30/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
From review of the staff training records two staff had not participated in a fire evacuation drill. One new staff member was scheduled to attend fire safety training on 07 November 2015.

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

Please state the actions you have taken or are planning to take:
All staff now has fire training. Management have prepared a business case for training needs in 2016.

Proposed Timescale: 30/11/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not received training in managing behaviours that challenge including de-escalation and intervention techniques.

7. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

Training has been provided for all staff in management of behaviour that is challenging including de-escalation and intervention techniques.

Proposed Timescale: Completed 30th November 2015 (Training 29th &30th Nov 2015)

Proposed Timescale: 30/11/2015

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:
Residents were not regularly supported to attend social events in the evening time and outings to events generally took place during the day.

8. Action Required:
Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

Please state the actions you have taken or are planning to take:
Discussion with residents weekly regarding their preferences for social activities. Discussion with staff regarding reconfiguration of roster to include a weekly 10am to 10pm(or midnight as required) shift to support pm social activities.

Proposed Timescale: 11/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans were not readily accessible for persons unfamiliar with the centre's documentation arrangements due to presentation format.

9. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
The PIC has reviewed the structure of all files in the house. The PIC has ensured only current information and active plans/risk assessments are on file. All other information is archived. Each resident has a communication passport which is at the front of their file for ease of reference for all staff. The file index for all files is to be reviewed imminently

Proposed Timescale: 30/01/2016

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:
Management systems in place in the designated centre required significant development to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

10. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The PIC is super numery in both locations and has been supported in second location by a 1wte staff nurse post 5/7. Staff support/supervision meetings were completed for some staff at time of inspection and are ongoing again since return to work of PIC for all staff. The DON has circulated a 2016 monthly schedule of Quality and Safety CNM monthly meetings. A schedule of Q&S audits has also been prepared and a schedule commenced which will roll into 2016.

Proposed Timescale: Completion by 30th Jan 2016 and Q&S audit ongoing

Proposed Timescale: 30/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care and support in the designated centre was not available.

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

Please state the actions you have taken or are planning to take:
The DON & ADON have commenced a new annual audit following HIQA report for Quality and Safety review and same on completion will develop and 2016 action plan from same with persons responsible and timeframes

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Formal performance management of the person in charge and staff or competency assessment had not been commenced in the centre to date.

12. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Formal performance management of the person in charge and staff or competency/support/supervision meetings were completed for some staff at time of inspection and are ongoing again since return to work of PIC for all staff. Same lead to action plans with timeframes and follow up. Copies are held in staff files on site

Proposed Timescale: PIC review completed since return to work and all staff review for Completion by 30th Jan 2016

Proposed Timescale: 30/01/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Although in process, the documentation as required by schedule 2 of the regulations for each staff member was not fully obtained.

13. 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:
Staff files all underwent review and completion. Administrative support assigned to assist PIC with same.

Proposed Timescale: 01/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not completed training in fire evacuation, management of challenging behaviour, nutrition and food hygiene as part of mandatory training and a continuous professional development programme.

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

Please state the actions you have taken or are planning to take:
All staff have now completed fire training. PIC has planned a fire drill to coincide with 2 staff who have not participated in fire drill on duty.

Proposed Timescale: 21/12/2015