

**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:	OSV-0005383
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Marie Matthews
Support inspector(s):	Thelma O'Neill
Type of inspection	Announced
Number of residents on the date of inspection:	35
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 inform a registration decision. This monitoring inspection was announced and took place over 5 day(s).

The inspection took place over the following dates and times

From:	To:
10 November 2015 09:00	10 November 2015 19:00
11 November 2015 09:00	11 November 2015 20:30
12 November 2015 06:30	12 November 2015 19:00
25 November 2015 08:30	25 November 2015 19:00
26 November 2015 09:00	26 November 2015 21:30

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 inspection was the eighth inspection of this residential service carried out by the Health Information and Quality Authority (HIQA). Details of previous reports can be viewed at www.hiqa.ie. The service was originally established in 1955 and was taken over by the Health Service Executive (HSE) in 2013. It is located approximately 5 km outside the town of Sligo.

The provider has recently reconfigured the management structure and organised the service into three designated centres each with their own management structure. During the inspection the provider advised of her intention to further reconfigure the 12 houses inspected into two distinctive centres with a manager or person in charge of each. This centre report provides residential accommodation and day services to 29 female residents with mild to severe intellectual disability, in five separate houses that are part of a larger congregated setting.

The purpose of the inspection was to inform a registration decision and to follow-up on actions from the last inspection carried out by HIQA in July 2015. As part of the inspection, the inspectors met with residents, staff members, the person in charge and the director of services, the provider nominee, and clinical nurse managers. Inspectors observed care practices and reviewed documentation such as personal plans, risk management documentation, complaints records, staff records, medical records, as well as policies and procedures and found the provider had responded to actions from previous inspections and made changes which brought about improvement in the quality of the service provided to residents. The inspector reviewed questionnaires returned by residents and their families which were generally positive and expressed satisfaction about the services and care provided. Some families felt that more staff were needed to care for residents and one family had concerns for a resident's care and felt their complaint to the provider was not management adequately.

Overall inspectors identified improvements across a number of outcomes including governance, staff deployment, risk management and social care provision. However, further sustained improvements are required in order to ensure that the service is safe, appropriate to residents' needs and is consistently monitored. The provider nominee has informed HIQA of a plan to move residents from this congregated setting to the community within a two year period in line with national policy.

The houses accommodating residents were originally designed for children and no longer met the needs of the residents accommodated. Lack of both communal and private space was impacting on residents' rights and dignity and there was an urgent need to find suitable alternative accommodation for these residents in the community. The inspector found that residents were well cared for and that their healthcare needs were generally being met. They had good access to general practitioners (GP) and support services. A clinical nurse manager level 2 (CNM2) managed the centre day-to-day. Inspectors were advised that the provider was advertising for an additional clinical nurse manager level 3 (CNM3) to take on the role of person in charge. The manager of day services was fulfilling this position at the time of inspection.

The inspectors met with both the provider nominee and the person in charge on several previous inspections. They demonstrated knowledge of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and were aware of their responsibilities. The inspectors found that staffing levels had been reviewed and additional resource hours had been allocated to residents to ensure their social needs were met which resulted in better outcomes for residents. However, staff deployment still required

review to ensure consistent, familiar staff supervised residents at all times. Staff had not completed all mandatory training as required by the Regulations. Improvements were also identified in the overall approach and management of behaviour that challenges and the majority of the staff required training in the management to help them to meet the needs of the residents in their care.

The inspectors found other areas that required attention and these are described under the relevant outcomes and identified for attention in the action plan at the end of this report. These include the need for better management of complaints received, appropriate resource planning for vehicles to transport residents to day services, management systems that encourage residents to take financial responsibility for their money, better use of assistive technology and improved risk management arrangements.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found that residents' privacy and dignity was respected by staff, but overcrowding and a poor layout of the residential accommodation impacted on some residents' rights and dignity. One house had seven occupants and two residents shared a bedroom which impacted on their privacy as there were no screening provided between beds. In addition; the space between beds restricted access.

Some residents' bedrooms were decorated to their individualised tastes and preferences however, some had limited storage space available in their bedrooms to store additional personal belongings. Not all residents had the opportunity to meet visitors in private, however, as there was no separate room available apart from the sitting room for residents to meet family and friends in private. The layout of the houses is discussed further under outcome 6.

The staff interviewed had a good knowledge of residents' personal preferences for meals, preferred activities and clothing. Residents were asked and consulted with regarding their daily routines and preferences. The manner in which residents were addressed by staff and in which their needs were discussed was observed by inspectors to be courteous and respectful. There was a chapel on the grounds of the centre and residents were supported to go to mass if they so wished.

The inspectors met with the Head of Finances who outlined the arrangements for managing residents' finances. Residents did not have individual bank, post office or credit union accounts set up. The residents' disability allowances were paid directly into a collective bank account managed by the HSE. The cost of the service which included

residential fees, medical expenses, nursing care meals and support services was deducted from the allowance, For example, if a resident went home at weekends, the fee was reduced proportionately. The accounts were reconciled so that that any refundable allowances were refunded. Clear transparent accounts were maintained. The balance of the money was available to the resident. An up-to-date ledger was maintained electronically for each resident and regular checks were completed. The inspectors observed practice in relation to residents accessing their finances. Arrangements were in place for residents to withdraw money twice a week on designated days. The procedure for doing this involved a clinical nurse manager signing a requisition form which was then brought to the finance department for payment. Staff informed the inspectors that money could be accessed outside of these times if required by the resident; however' the management systems did not encourage residents to take financial responsibility for their money. Inspectors were told that a financial audit was completed yearly by an independent financial auditor. Inspectors reviewed storage facilities in individual houses for small sums of money kept by residents. The balances of a small sample were checked and found to be correct. Receipts were maintained for all purchases and all transactions were signed for by a staff member. A financial consent form was found on each resident's file.

A complaints policy was available which clearly outlined in detail the steps to be taken when conducting a complaints investigation. Complaints were recorded on a log which was available in each house. The complaints procedure was displayed in each house in a user-friendly, accessible form with a picture of the complaints officer. Inspectors reviewed a sample of recorded complaints. Inspectors saw that in general complaints were promptly investigated; however, some complainants were recorded where the complainant had not been advised of the outcome of their complaint in a timely manner and where the details of the appeals process in place were not included in correspondence from the service. There was evidence of weekly residents' meetings and residents were consulted about how the centre is planned and run. Residents had access to advocacy services and information about their rights. Inspectors viewed evidence of this and how advocates were involved in supporting residents to achieve their rights in the centre.

There was evidence that a number of restrictive practices had been reviewed and subsequently reduced. A small number still in place included locked doors and locked kitchen cupboards. There was evidence that other less restrictive options had been considered before instigating these restrictions and the restrictions were included on the centres.

Judgment:

Non Compliant - Moderate

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

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

No actions were required from the previous inspection.

Findings:

There was a communication policy available and there are systems in place to meet the diverse needs of all residents. Residents were supported to communicate and systems were in place that ensured their individual needs were met.

Residents that required specific communication supports had an individualised communication profile in their personal plan. Some residents were supported through the use of pictures to tell them what activities were planned for the day. Other residents used communication books which were used between the resident's residential and day service. These communication books were in picture format and helped the resident to understand their planned day.

Some policies were in an 'easy read' format for residents and were made available in the centre, for example; the safeguarding and safety policy and the complaints policy. Pictures were used to direct residents to specific areas such as the kitchens, dining rooms and sitting rooms. In some units, there were signs to identify and locate toilet and bathing facilities. In most units residents had access to televisions and stereos in their bedrooms and also in communal areas.

Communication passports were available for each resident in the event of a resident being admitted to hospital. This summarised any special communication and medical needs. Personal plans had some pictures to aid communication. Although residents had been appropriately reviewed by a speech and language therapist, there was no evidence that they were facilitated to access assistive technology aids to promote their full capabilities.

Judgment:

Substantially Compliant

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

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

No actions were required from the previous inspection.

Findings:

There was evidence that residents living in the centre were supported to maintain links and to have positive relationships with their families and friends. A lot of the residents had lived in the centre since childhood. Some residents went home regularly for a night or a weekend; others for Christmas or festive occasions throughout the year. Some residents had limited contact with their family. Staff told the inspectors, that families and residents attended personal plan meetings and reviews and there was documented evidence of their attendance and involvement recorded in residents' visiting records. A visitor book was maintained in each house and there was a policy and procedures to support this practice as required in Schedule 5 of the Regulations.

Staff told inspectors residents were participating in their local community significantly more since they received a bank procurement card which allowed them to purchase food and personal items in local shops and residents were interacting with the local community through shopping for these items. Residents were also attending more social events in the community, since additional staff had been deployed and some transport issues addressed. Residents were developing their shopping skills with staff support as part of transitioning to the community. Some residents told inspectors they enjoy accessing the community facilities.

Judgment:

Compliant

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

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

No actions were required from the previous inspection.

Findings:

There were policies and procedures in place for the admission, transfer, discharges and temporary absence of residents. All residents and or their families had recently been sent a contract of care outlining the terms and conditions of their residential placement, however not all contracts had been returned at the time of the inspection.

Inspectors reviewed a sample of the contracts which set out the services to be provided and the fees payable were included in the contract. However, details of any additional charges were not always included. Furthermore, inspectors saw that a blanket fee was charged to each resident which covered 24 hour nursing care irrespective of whether they required any nursing care. One resident's family had made a complaint about this issue which was not adequately yet resolved. Inspectors were told that this is a national HSE policy. The person in charge was asked to provide confirmation of this in the response to the action plan which accompanies this report.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The inspectors met with the majority of residents in each house and reviewed a selection of their personal plans. Files contained information that outlined their health, intimate and personal care needs. Risk assessments were completed to inform care planning and interventions were in place in relation to identified needs. These included behavioural support plans and protocols to deal with medical issues such as epilepsy and diabetes.

Significant improvements were observed by inspectors in the assessment of residents' personal and social care needs since the initial inspections of the service. Each resident had a health and social care assessment completed and personal goals were identified. Many of the goals had been achieved and inspectors saw that goals included weekend breaks, day trips and concerts. A copy of the personal plan was available in a pictorial format to aid the residents' ability to access the information. Some goals were observed to be overly simplistic and lacked insight into the residents' preferences or aspirations. Residents attended a variety of full-time or part-time day services. Some residents chose not to attend and had an individualised service supported by staff. Use of accessible taxis to transport residents to attend social events outside of the campus had improved since

the last inspection. In discussions with staff and through observations during the inspection the availability of appropriate accessible transport was still impacting on the social activities residents could attend. This is discussed further under Outcome 16.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The suitability of the accommodation was not reviewed on the previous inspection. The provider had completed some work outside the houses to make them accessible. Some houses had been provided with new furniture. However, residents were living in small overcrowded chalets, the layout of which were inadequate and did not meet the individual or collective needs of the residents. Inspectors were advised that the six houses were originally designed to accommodate children and were not intended for adults. As discussed in outcome 1, one house accommodated seven residents and two of these residents shared a bedroom. There were no screens provided between beds to ensure privacy. In addition; the space between beds was limited making access restrictive. Most residents had personalised their bedrooms and new beds and wardrobes had been provided in some bedrooms. There were suitable kitchen appliances provided and kitchen units in each house. There were adequate furnishings, fixtures and fittings and the centre was clean and suitably decorated.

Corridors were narrow and residents were restricted in their movements due to the poor design of the building. Appropriate accessible shower facilities were not available in each house. Communal rooms were comfortable and some were tastefully decorated while others lacked character and decoration. Comfortable furniture and fittings were provided, however there was no separate room available for residents to meet their families in private or to spend time on their own. Storage facilities were inadequate and mops and cleaning equipment were left outside the front door of each house.

Records were available to indicate that equipment in the centre had been serviced as required. A central laundry service was available to residents, and some houses had a washing machine and or dryer available for residents to use.

Judgment:

Non Compliant - Major

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors observed that the overall management of risk had improved, however some areas of improvement were still required. Accidents and incident were appropriately recorded and reviewed by a risk review group which consisted of managers and multidisciplinary team members who continued to meet weekly to review accidents and incidents in the centre. Inspectors observed that the response to an incident of choking was appropriate and preventative action including review by a Speech and Language Therapist and increased supervision had been put in place. However, risk management arrangements did not always identify or manage all risks which presented as required in regulation 26. For example, inspectors identified issues where residents were not compatible and where episodes of aggression were regularly observed by staff and recorded in the incident log but this had not resulted in controls being introduced to reduce the impact on other residents. In addition, during the inspection, one nurse left four residents unsupervised while she administered medication to a resident in another house.

Inspectors also identified that where some risks were identified; the controls recorded in the 'learning from' section of the risk assessment were all of a similar nature and did not always lead to effective actions being identified to prevent a recurrence of the incident. An individual risk register was available for the centre which was a live document and contained risks identified in each unit. Staff and managers were clearer on the procedure and there was more consistent risk rating evident. Staff had received training in risk management and it was clear that they were more confident in completing risk assessments and managing and preventing risks/incidents in the centre.

There were precautions in place against the risk of fire however some areas of improvement were identified by inspectors. Staff demonstrated knowledge of what to do in the event of a fire and suitable fire equipment was available. Inspectors saw that fire safety equipment was serviced on an annual basis. A means of escape was available via the front and back doors of each house and these were all observed to be unobstructed. Fire alarms were not fitted in every house and doors linking the kitchens were not fitted with self closing devices.

A personal emergency evacuation plan (PEEP) was documented in each resident's personal plan which described the assistance the resident would require in the event of an emergency evacuation. A summary of this was also kept near the entrance in each house. A procedure for the safe evacuation of residents in the event of fire was also displayed. Evidence of monthly fire drills completed in each house was reviewed by the inspectors which included both day and night time evacuations. The time taken to evacuate all residents was recorded in the centres fire register. The local fire officer had completed a familiarisation visit of the centre in July.

Eighty three percent of staff had completed fire safety training. Inspectors saw that a training schedule was in place to ensure the remaining 17 % who had not yet completed the training were trained. An action has been included in the action plan that accompanies this report. Mobility assessments had been completed for those residents at risk of falling, however over 30% of staff were overdue training in manual handling. An emergency management policy with procedures was in place to direct staff in such an event as power outages, flooding and gas leaks. Details of local hotels where residents could be evacuated in an emergency were included in the plan.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors followed up on the actions taken in response to the last inspection which related to restrictive practices, inadequate management of behaviours that challenge, failure to protect residents from assault by other residents and inadequate training of staff on safeguarding. Three actions were complete, two were partially complete. The action related to the management of behaviours that challenge and protecting residents from episodes of aggression and assault was inadequately addressed, but action taken by the provider during the inspection addressed this.

The person in charge confirmed that there were no current allegations of abuse reported to management and no on-going Trust in Care investigations. All staff had completed training in protection and safeguarding of residents and an ongoing training schedule was in place. The centre's policy on safeguarding and protection had been reviewed and staff members interviewed were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse.

Staff identified the Area Manager as the new acting designated person to whom they would report a concern. A picture of the designated person was displayed in each house. The centre's protection policy included a form for referring any suspicious of abuse to the designated person. In discussion with residents who spoke with the inspectors they said they felt safe and inspectors observed staff and found they were patient and respectful towards residents.

Inspectors found evidence of poor management of residents who had behaviours that challenged associated with their disability and an attitude of complacency among staff in some areas. In two houses inspected, there were repeated incidents where residents were abusive or hit other residents. In the incident forms reviewed by inspectors for the previous six months, the response recorded by the manager was not adequate or person-centred and did not suggest alternative approaches which should be taken to safeguard residents. There was poor evidence that the compatibility of the residents had been considered or that any consideration had been given to separating some residents who were not compatible.

Inspectors found that most staff had not completed training in the management of behaviour that challenges. Behavioural support plans reviewed were inconsistent and did not address all of the residents' behaviours of concern or provide preventative, proactive or reactive strategies to minimise the risks to residents, their peers or staff members. The environment was also contributing to the behaviours as some residents shared bedrooms and there was also no choice of communal space or quiet area available for residents who required a quiet, low stimulus environment.

Although behavioural support plans were reviewed by a multidisciplinary team, there was poor evidence of any review of the effectiveness of the support strategies suggested. The behaviour support team included a behavioural psychologist, two clinical nurse specialists and two psychology interns. The person in charge told the inspectors that the psychologist had increased his hours to three days a week, due to the significant number of residents displaying behaviours that challenge. However, in discussion with the psychologist he advised that he had resigned from his post and planned to leave in the New Year. He was also of the opinion that overcrowding and incompatibility of residents were triggers for the incidents of aggression and self harm.

Previously, inspectors had found there were restrictive practices in operation in this centre, in particular on some internal and external doors. Most of these restrictions had been removed and restrictions that remained were risk assessed and restrictive logs were maintained to monitor all restrictions.

Judgment:

Non Compliant - Major

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

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

No actions were required from the previous inspection.

Findings:

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents, within three working days. A record of all incidents occurring in the centre was maintained using a computerised system and where necessary notified to the Chief Inspector.

The inspectors reviewed incidents and accidents and found that incidents requiring notification had been submitted to HIQA as per the Regulations. The person in charge demonstrated knowledge of their regulatory responsibility in regard to notifiable events.

Judgment:

Compliant

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that social participation, education and training had improved since previous inspections. Additional support staff had been allocated to support residents to attend social activities and there was evidence that residents were assisted to engage in social activities outside of the centre. For example, some residents attended activities such as horse riding and engaged in hobbies such as, baking and cookery.

Most residents attended a daily activities programme on the campus. Activities included arts and crafts and desktop activities. One day service was not resourced so residential staff accompanied residents to their day service.

Each resident's personal goals were recorded in their "listen to me document". Personal goals were reviewed regularly. There were on-going review meetings and residents were consulted during this process to ensure they were receiving the support they needed to achieve their identified goals.

Overall, the number of residents receiving a day service Monday to Friday had increased since the last inspection. A number of residents that previously only had a part-time service were now attending a full-time day service and other residents that had no service previously were attending one part-time. Inspectors were told that some residents went to day service in an activity room in the main campus which was not staffed. Inspectors also found that day social activities were short and restricted by residents having to return to their chalets at meal times. Residents were supported by their residential staff. Activities described for some residents required development to ensure they suited the interests and capabilities of the residents and aided their personal development; for example, classes in community integration in preparation for transitioning to community services.

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were two actions relating to the last inspection that were not fully addressed. These related to an institutional approach to the meal time experience and restrictive opening hours of the canteen. Although some staff had started preparing evening meals in the residents' homes, inspectors found that the central kitchen/canteen continued to provide most meals to residents which were delivered in insulated boxes. Residents were offered a choice of two main meals at dinner time. Each house had cooking facilities available; however, most residents were not supported to cook a meal to improve their independence in preparation for transitioning to the community. Staff on duty said they would prepare an alternative choice of meal if residents did not like the

choice available. A banking procurement card had also been provided to most houses to enable residents, supported by staff, to purchase groceries and personal items from the local shop. Some residents said they liked to eat their dinner in the canteen with their peers as part of their normal daily routine and inspectors saw that this was facilitated. Despite the fact that residents were in receipt of 24 hour care, the canteen continued to operate from 9 am to 5pm and closed at 3 pm at weekends. This was an action from the last inspection that was not addressed. The provider said that this was due to objections by trade unions representing staff.

A new general practitioner (GP) was in post and he attended the centre twice a week to attend to residents' medical needs. Residents had received an annual medical review and their healthcare needs were generally well met. Each resident was comprehensively assessed and there was evidence that they were regularly reviewed by the GP. There was good evidence that residents were referred to and reviewed by specialists where appropriate. Progress notes were completed for each resident which reported on the care provided. Care plans were reviewed and in general they were detailed and provided very clear guidance to staff on how to make residents comfortable. In some instances, a care plan had not been developed to guide staff regarding a resident's nutritional need even though the advice of a dietician had been obtained. For example, one resident was gaining weight. She had been referred to a dietician who had recommended a weight loss plan. However, a care plan was not in place incorporating this advice to guide staff as to how the resident was to be assisted with weight loss and there were no records of the resident's daily dietary intake available. Furthermore, as most meals were prepared in a central kitchen the calorific value was not available to staff caring for residents.

Inspectors saw that personal and intimate care plans were available for residents. Inspectors found there was appropriate input from the multidisciplinary teams which included the GP, tissue viability nurse specialists, dieticians, and physiotherapists.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

On previous inspections inspectors observed that nurses were also administering medications to residents in other units, as well as their own, up to four times a day. This

practice had not been addressed and inspectors identified risks associated with this practice continued. During the inspection, one nurse left four residents unsupervised while she administered medication to a resident in another house. Although staff and management were aware of these risks, no alternative arrangements were made to prevent such an incident. This is actioned under Outcome 7.

A sample of prescription/administration charts was reviewed. The procedures for handling of medication were observed to be in accordance with current guidelines and legislation. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Inspectors observed that all medications were individually prescribed and were regularly reviewed by the GP. All medication in stock was monitored on a monthly basis to ensure there were no discrepancies in residents' medication. All medication that was out-of-date was appropriately managed in line with organisational policy and procedures. A pharmacist visited the units monthly to review medication stocks and discuss medication issues with the nurses. In addition, medication audits were conducted in some areas by the clinical nurse managers (CNM).

Controlled medication was kept in a secure locked press and the controlled medication register was maintained as per An Bord Altranais guidelines. Medications were securely stored in a locked cabinet in each house. Staff had received training in the administration of medication used for treating seizures and a protocol was in place regarding the procedure to follow in the event of an epileptic seizure for each individual resident that was signed by the GP. As previously discussed, training in the safe administration of medication had not yet been rolled out to all care staff to allow them to administer medication to residents in their care. An action to address this has been included under Outcome 17.

Judgment:

Substantially Compliant

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

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

No actions were required from the previous inspection.

Findings:

On the first day of inspection, there was a written Statement of Purpose that described 12 chalets in this designated centre; however, during the inspection, the provider stated her intention to further reconfigure the centre into two separate centres. A revised

Statement of Purpose has been submitted to HIQA which sets out the services and facilities provided in this centre. The Statement of Purpose met all the matters as set out in Schedule 1 of the Regulations.

Judgment:
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):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

On previous inspections, HIQA identified significant deficiencies with the governance in place in this centre. On this inspection, inspectors found governance arrangements had improved. However, further work was required to ensure that a clearly defined management structure with identified lines of authority and accountability was in place.

The service was previously defined as one large designated centre but has been reconfigured to form three distinctive centres, each with their own manager or person in charge. The director of services is identified as the person in charge on the centre's Statement of Purpose. The provider told inspectors that a new person in charge post had been approved and the person appointed will report to the director of services. A Clinical Nurse Manager 2 currently oversees the day-to-day management of the centre. The person in charge told inspectors that she hoped restructuring the management roles would ensure better day-to-day management of the centre.

There were weekly management meetings and inspectors saw that these reported on progress towards compliance with non-compliances identified by HIQA in previous inspections. Improvements were noted in areas including; annual medical reviews and social assessments, quality and safety protection issues, a reduction of accidents /incidents in each unit, accurately completed individual risk assessments, the management of complaints and critical staffing issues.

There was evidence that the provider and person in charge completed unannounced inspections of the centre to assure themselves of residents' safety and to address any ongoing issues. Findings were reported back to the weekly risk review meetings as part

of the new process of managing risks. Completed forms were available.

Judgment:

Non Compliant - Moderate

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

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

No actions were required from the previous inspection.

Findings:

A clinical nurse manager grade 2 (CNM2) was responsible for the day-to-day management of the centre and reported to the person in charge and provided cover in her absence. The person in charge had not been absent from the centre for any period in excess of 28 days which is the notification period. There were no persons participating in the management of the centre identified on the centre's application to register. As previously discussed, a new person in charge post had recently been approved and the post and expressions of interest were being sought.

Judgment:

Compliant

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

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

A significant amount of resources had been put into this centre since previous inspections. This was evident in the increased allocation of staffing in the centre, the provision for staff training, the introduction of procurement cards for resident's

individualised purchases, maintenance works and transport provision. There was evidence that resources were being deployed according to the assessed needs of residents although further improvement was still required.

The provider advised inspectors that funding had been approved to purchase/rent accommodation for residents to allow them to transition from the centre into the community. However, significant difficulties had been encountered in finding appropriate accommodation which was delaying this process. The current arrangements to rent property through housing associations rather than directly was further delaying the process. This needs to be expedited if all residents are to be relocated within the suggested timeframe. As discussed under Outcome 6, the accommodation provided was not meeting the needs of residents and overcrowding was negatively impacting on residents.

The limited availability of appropriate accessible vehicles was also impacting negatively on residents as there were insufficient vehicles to transport residents to and from their day services and on social outings.

Judgment:

Non Compliant - Moderate

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):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

On previous inspections, HIQA had issued immediate action notices requiring the provider to address concerns regarding the level and deployment of staff and the reliance on agency staff who were not familiar with residents needs. The provider had responded by recruiting additional care staff and inspectors saw that they were deployed to support residents attend social activities, particularly in the evening. This was confirmed by the staff rota. Staff told inspectors that this had made a significant difference to residents' lives.

Some residents were assessed as requiring one-to-one staffing 24/7 and this had also been resourced. However, inspectors found that some aspects of staff deployment still required review to ensure consistent, familiar staff supervised residents at all times. For example, inspectors were told that where residents had to attend a medical appointment the normal practice was for a nurse from another house to accompany them to the appointment rather than the care staff who normally worked with the resident. Similarly inspectors found that some care staff had still not been provided with training in medication administration and could not administer medication to residents in their care. As previously discussed, this was resulting in nurses, who were less familiar with residents, having to come to the house to administer medication.

The provider stated that difficulties were still being encountered in recruiting staff and there continued to be a reliance on agency staff. Improved arrangements had been put in place to help ensure agency staff were fully aware of the residents' care needs before working residents. An induction folder had been developed for each house which identified key clinical risks such as epilepsy, a risk of choking or behaviours that challenge and the emergency evacuation plans for each resident. A copy was available in each house.

On previous inspections, inspectors also identified that staff did not have up-to-date training in fire safety, protection of vulnerable adults, managing behaviours that challenge and in manual handling. A training programme was ongoing. Inspectors found that while some improvements had occurred, some staff had still not completed all the mandatory training identified in the regulations. For example, 97% of staff had completed training in adult protection, 83% of staff had completed fire training. However, only 35% of staff had completed training in manual handling and only 22% of staff had completed training in the management of behaviours that challenge. Inspectors were told that the remaining staff members who had not completed training were being prioritised and dates were confirmed for this training.

The six houses inspected were managed by a clinical nurse manager level 2 (CNM2) who worked with a team of nurses, care staff and a multi disciplinary team made up of Speech and Language Therapist, Clinical Nurse Specialist (CNS) in behaviour, a CNS in mobility, a CNS in dementia, and a CNS for older person's services. Two clinical nurse managers level 3 (CNM3) provided nursing cover at night for all units on the campus.

Inspectors observed good staff interaction with residents and those staff members interviewed had a good knowledge of residents' needs. Residents appeared comfortable in the company of staff.

Inspectors reviewed a sample of three staff files and most documents outlined in Schedule 2 of the Regulations were available in each of the files. One staff file did not have references from the staff member's previous employer. There was evidence that arrangements had been put in place since previous inspections to ensure staff supervision. The inspectors also reviewed minutes of staff meetings which took place weekly.

Judgment:

Non Compliant - Moderate

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

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

No actions were required from the previous inspection.

Findings:

Inspectors found that information relating to residents and staff members was securely maintained and easily retrievable. Personal plans for residents were up-to-date and gave a good reflection of the care practices and interventions that were in action for each resident at the time of inspection. The centre had all of the written operational policies required by Schedule 5 of the Regulations and records required were maintained to ensure completeness, accuracy and ease of retrieval. A Statement of Purpose and resident's guide were available in the centre and had been recently revised.

Judgment:

Compliant

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:

Marie Matthews
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:	OSV-0005383
Date of Inspection:	10 November 2015
Date of response:	12 February 2016

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

Some residents shared a bedroom which impacted on their privacy.

Residents did not have opportunities to meet visitors in private as there was no separate visitors room available separate from the sitting room for residents to meet family and friends.

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

1. 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:

Privacy curtains have been installed in the shared bedrooms to ensure more privacy for residents.

A decongregation plan is being developed. Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus will be afforded more room to facilitate accommodating visitors in a communal area.

In the interim on Saturdays and Sundays and evenings during the week visitors will be accommodated in day services which are in a convenient location to the Service

Sheds are being provided for equipment that can be stored outside. Vacuum bags will be provided for residents to store clothing in, spring cleaning and rotation of winter/summer clothing will be undertaken to ensure maximum space for residents is available.

A day service in close proximity to this service is available for residents use in the evening and at weekends if they so wish as additional communal space. A decongregation plan will be submitted to the Authority by March 31st 2016. Following the initial transition of 1 house to the community a review will take place within the service to address the overcrowding and lack of space through a reassessment of the service.

Proposed Timescale: 11/04/2016

Theme: Individualised Supports and Care

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

Residents did not have individual bank/post office or credit union accounts set up.

2. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

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

Financial competency assessments have been sourced and will be undertaken for each resident to access supports required. Opening of Post Office accounts will commence following this process.

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

Some complaints were not resolved in timely manner and details of the appeals process were not relayed in correspondence from the service.

3. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

Complaint/appeal procedure has been sent to all families/NOK.

Complaints and appeal process in easy read format is displayed in prominent area in all houses.

As per the complaints procedure all complainants will be contacted by letter and informed of the status of their complaint within 5 days.

Details of the appeals process are included in correspondence from the service. A complaint log with a monthly summary sheet is in place in all houses.

Complaints are reviewed as part of the Quality and Safety Workarounds.

Complaints are formally reviewed and submitted to the HSE complaints officer on a monthly basis.

Proposed Timescale: 15/02/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

There was limited evidence of assistive technology aids to promote residents full capabilities.

4. Action Required:

Under Regulation 10 (3) (c) you are required to: Ensure that where required residents are supported to use assistive technology and aids and appliances.

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

If a resident does not have an individual communication profile a referral will be made to the Speech and Language Therapist to have their communication profile

administered.

The residents' individual communication profiles will be reviewed by their key workers: where this profile identifies a need for assistive technology to support an individuals' communication system, a referral will be made to the Speech and Language Therapist.

Access to social media through the use of assistive technology for residents can be explored via staff awareness training with the HSE Assistive Technology Department.

HSE Assistive Technology representative to meet with staff to discuss how social media can be used to improve residents' contact with their natural network and enhance their life experience.

Proposed Timescale: 30/04/2016

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:

Details of any additional charges were not always included in the contracts of care and a blanket fee was charged to each resident which covered 24 hour nursing care irrespective of whether they required any nursing care.

5. Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

Review of the agreement for the provision of services will be undertaken so that it includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged. The reviewed agreement for the provision of services will be issued to all families/NOK.

Cregg Services apply long stay charges to residents in line with the HSE 'Charges for In-Patient Services' National Guidelines. The main requirements for the charge to apply are 'inpatient services' (residential care) and nursing care. Where 24 hour nursing care is provided at the residential facility Class 1 charges apply. Where less than 24 hour nursing care is provided at the residential facility class 2 charges apply. Currently where there is no nursing care at a residential facility no charges apply. At the time of the introduction of the charges we were advised that Class 1 charges should apply to all residents on Cregg Campus as 24 hour nursing care is provided on the campus.

In calculating the applicable charge for each service user there are certain 'allowable expenses' provided for in the Guidelines. In addition for 'community type residences' the guidelines provide for 'socialisation/care plan expenses' which relate to 'additional expenses incurred as a result of greater independence and integration into the community'. We have been advised that a reasonable interpretation of this would be that socialisation allowance is granted where the personal allowance is not enough to cover the costs incurred by "greater independence and integration into the community". We are currently reviewing each service user's expenditure to determine if they are spending all of their personal allowance on an ongoing basis and therefore if a socialisation allowance is required.

Proposed Timescale: 31/03/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Some goals in residents personal plans were found not to contain detail of the residents' preferences or aspirations.

6. Action Required:

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

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

Goals in residents' personal plans will be reviewed to ensure they are person centred, SMART and that they contain details of the residents' preferences and aspirations. A responsible person will be identified to support the resident to achieve their goal; this will be time framed and following achievement of the goal it will be evaluated and a new goal will be identified. Residents' personal goals will be reviewed as part of the annual MDT review.

Proposed Timescale: 16/03/2016

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 layout and facilities provided were inadequate and did not meet the individual or collective needs of the residents.

7. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

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

New suitable accommodation is currently being sourced for residents in the service
A decongregation plan is being developed which will be based on capacity and compatibility. The decongregation Plan will be submitted to the Authority by March 31st 2016.

Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus for the interim will be afforded more personal space.

A monthly transition/decongregation meeting has commenced to ensure smooth transition of overall decongregation plan. Project Officer to be appointed by May 18th 2016 to support decongregation process.

Proposed Timescale: 18/05/2016

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:

Risk management arrangements did not ensure that all of the risks which presented were identified or managed as required.

Episodes of aggression were resulting but no action had been taken to mitigate or control the impact on other residents.

The controls recorded in the 'learning from' section of the risk assessment were generic and did not identify effective actions to prevent a recurrence of the incident.

During the inspection, one nurse left 4 residents unsupervised while she administered medication to a resident in another house

8. 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 newly aligned clinical support services, Positive Behavioural Support Services, is currently addressing the format/content of behaviour support plans to ensure a balance of proactive/reactive strategies. All support plans will be required to 1) identify function

of behaviour, 2) list proactive strategies, 3) define reactive strategies, and 4) assess impact upon other residents

Each support plan will be required to produce evidence of the effectiveness of support strategies on the defined behaviour and will be discussed in monthly meetings.

A risk workshop will be conducted to support staff in the risk management process.

Risk assessments will identify all residents' risks including incompatibility.

Management plans will be implemented to address all identified risks.

All episodes of aggression will be addressed through the incident management policy and the protection of vulnerable adults' policy 2015; this will include initial screening by the designated officer and development of a management plan to ensure safety. The designated team and social work department will be notified of all incidents of abuse, screening and resulting management plans.

All incidents will be reviewed on a regular basis to ensure a person centred effective action plan is identified to prevent recurrence of incidents.

A supervision meeting will be conducted with the staff nurse to include the safety of residents at all times.

Proposed Timescale: 29/02/2016

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:

Most staff had not completed training in the management of behaviour that is challenging.

9. 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:

A rolling schedule of mandatory training has been developed to ensure all staff are trained appropriately for their role and to ensure staff have the knowledge and skills to manage behaviours that challenge. This is a priority for the service in 2016 and will continue throughout the year in order to achieve full compliance. Staff will be prioritised in accordance with the environment they work within e.g. in areas where there is a high risk of behaviours that Challenge; staff are being trained as a priority. All staff in Oceans Crescent will have undertaken training in Behaviours that Challenge by 31st Oct

2016.

The Clinical Nurse Specialist in behaviours has a schedule of reviews in place for residents' behaviour support plans to ensure appropriate guidance to staff members.

Proposed Timescale: 31/10/2016

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:

Some social activities provided were short sessions and restricted by having to return to their chalets for meal times.

Activities required development to ensure they suited the interests and capabilities of the residents and aided their personal development and prepared them for transitioning to community services.

10. 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:

Activities will be provided for residents in line with their personal preferences.

Opportunities will be made available so that residents can choose to eat in the restaurant if they so wish; additional snacks will be made available in the restaurant for residents.

Support hours are available to facilitate residents integrating into their community to partake in individual interests.

Procurement cards have been made available to facilitate residents shopping for groceries which they can then cook in their homes.

A referral to the Adult Referral Committee will be made for residents to access opportunities for education, training and employment where appropriate and sampling of community based activities will be undertaken where appropriate.

Proposed Timescale: 29/02/2016

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:

A care plan was not available incorporating the advice of the dietician to guide staff as to how the resident was to be assisted with weight loss.

11. Action Required:

Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

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

A review of the care plans has been completed to ensure incorporation of the advice of the dietician so as to guide staff as to how the resident is assisted with weight loss. A nutritional committee is established within the service and meets every 2-3 months with reps from each area attending.

The minutes of these meetings are circulated to all staff for their information.

All residents with weight gain or loss will be referred to the dietician for recommendations and actions which will be included in the residents' care plan to support the desired goal.

All staff will adhere to the portion control recommendations of the dietician.

Proposed Timescale: 15/02/2016

Theme: Health and Development

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

The approach to meal times continued to be institutional and residents were not supported so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

12. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

Residents are supported to exercise choice in their daily lives by being provided with opportunities to shop in their local communities through the provision of social support hours; procurement cards have also been supplied to facilitate these opportunities. Preparation of meals within residents' homes is facilitated following shopping outings. Saucepans, baking equipment, blenders, juicers and microwaves etc have been purchased to support this practice. Meals are prepared within the home with resident involvement as appropriate. Residents are enjoying the preparation and associated

smells of food preparation within their homes.

Food menus in pictorial format are provided in each house to provide opportunities for choice.

Residents enjoy ordering foods from local restaurants and takeaways and are supported to dine out and have picnics where possible.

Records are maintained of residents cooking activities.

Residents can access the restaurant while attending day services if they so wish. The restaurant will provide a larger selection of snacks for residents.

Proposed Timescale: 29/02/2016

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:

Review and action was required to ensure that a clearly defined management structure with identified lines of authority and accountability was in place.

13. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The management structure in the service has been reviewed to ensure a clearly defined management structure with identified lines of authority and accountability in place. As part of this review a number of meetings have taken place with the relevant managers outlining all staff roles, responsibilities and accountability within individual units.

A staff at CNM 3 level has been appointed from the Learning Disability team for 2-3 days a week to support the current PIC and facilitate the achievement of the national standards. HSE National Recruitment is currently undertaking a campaign to appoint a permanent PIC for this designated area. We expect this campaign to be concluded and a person to have taken up position by the 1st June 2016.

Proposed Timescale: 01/05/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

The limited availability of appropriate accessible vehicles to transport residents to and from their day services and on social outings was impacting negatively on residents.

14. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

A business case has been submitted and is currently being considered for additional buses across the learning disability service. Approval has been granted for a vehicle in another service within Cregg Services and this will facilitate other vehicles being more available for this service. It is hoped to have this vehicle obtained by April 30th 2016. Accessible taxis are also available to support residents in their transport needs.

Proposed Timescale: 30/04/2016

Theme: Use of Resources

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

The current approach to procuring alternative community based accommodation required review to expedite delivery.

15. Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

A team has been developed to expedite the delivery of alternative appropriate community based accommodation; the team includes the Estates Dept the Placement and Assessment Officer Service Manager, member of the Local Implementation decongregation group and the OT.

A monthly transition/decongregation meeting has commenced to ensure smooth transition of overall decongregation plan.

The Service Manager has been successful in gaining approval for the post of Project Officer to support decongregation process. It is expected that Project Officer will be in post by May 18th 2016. A decongregation plan will be submitted to the Authority by March 31st 2016

Proposed Timescale: 18/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The documents specified in Schedule 2 were not available on all staff files reviewed.

16. 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:

It is a priority that all staff working within our service have the appropriate documents as specified within the legislation. We are currently undertaking this on a voluntary basis as there is an ongoing national industrial relations issue that has prevented us from undertaking this on a compulsory basis.

Proposed Timescale: 30/06/2016

Theme: Responsive Workforce

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

Staff had not completed appropriate training, including refresher training, as part of a continuous professional development programme.

Training in the safe administration of medication had not yet been provided to all care staff to allow them to administer medication to residents in their care.

17. 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:

Training in the safe administration of medication to allow care assistants to administer medication to residents in their care has been provided to a number of staff and a training schedule has been developed to continue to ensure all care assistants have the prerequisite skills. However an industrial relations issue has developed in relation to the job description of care assistants not containing this role. HSE management and unions are currently engaged in negotiations to achieve a satisfactory outcome by April 30th 2016

Proposed Timescale: 30/04/2016