

**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 I.W.A. Ltd
Centre ID:	OSV-0001998
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	I.W.A. Ltd
Provider Nominee:	Michael Doyle
Lead inspector:	Mary Moore
Support inspector(s):	Margaret O'Regan
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	4

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:
10 December 2015 15:30	10 December 2015 20:30
11 December 2015 09:30	11 December 2015 19:00

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

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

Summary of findings from this inspection

This inspection was the second inspection of the centre by the Authority, the inspection was unannounced and was undertaken to follow-up on the serious failings identified at the time of the last inspection of the 25th and 26th August 2015. Given those serious and concerning findings the provider was issued with three immediate action plans, a meeting was held with the provider on the 4 November 2015 and there was a process of ongoing communication with the provider to both monitor and ascertain the progress made on the implementation of the required actions.

These current inspection findings confirmed that the provider had largely taken the action outlined by it in the provider's response to the action plan. A new and enhanced governance structure was put in place; a senior service manager had been seconded to the service and was supported on a daily basis by the providers Quality and Standards Development Officer, a lead personal assistant was also in post and a second had been recruited.

The provider confirmed its decision to cease operating the designated centre so as to relocate residents into independent but supported living as per their wishes. This decision had been communicated to residents, staff and families and transition plans for the residents were in process.

All residents again spoke voluntarily with the inspectors and inspectors again found residents to be open, insightful, and reasonable and balanced when providing feedback on their life in the centre. Residents acknowledged the change and improvement in the centre further to the previous inspection findings, residents confirmed that there had been no negative consequences for them by virtue of having made their fears and concerns known. Residents said that they liked and trusted the new management team but also clearly articulated some lingering poor practice on behalf of some staff and their anxiety that things would revert and deteriorate if the acting person in charge left.

There were obstacles and challenges to the providers change management process and these are discussed in the body of the report. Inspectors however were satisfied that the provider was aware of these and that they were being managed.

Inspectors reviewed eight outcomes and while full compliance may not have been evidenced there was evidence that the provider had and was taking action to achieve compliance and improve the quality and safety of the services and supports provided to residents.

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):

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

Findings:

Inspectors reviewed three of the four actions that had emanated from the last inspection.

The residents told the inspectors that they trusted the acting person in charge, they equated change and improvement with his presence but articulated a certain anxiety that the quality of care and supports provided to them would again deteriorate if he left. Residents said that they felt comfortable raising any concerns or complaints with the acting person in charge and there was evidence that they did, both in the complaints records and the records of residents meetings. There was no evidence that any resident had suffered adverse consequences by virtue of having raised any concerns or complaints.

There was evidence that complaints made by residents to inspectors at the time of the last inspection and repeated to the provider had been substantially addressed by the provider and the acting person in charge with positive outcomes for residents particularly in relation to the level of choice and control that they had in their daily routine. Residents confirmed that they enjoyed flexibility in relation to their meals; there was still some ambiguity in relation to the extent that residents controlled when they wished to have a shower; while there was improvement one resident said that ongoing difficulties were encountered with some staff.

Residents confirmed that they had access to meals, drinks and snacks as they were required. Residents confirmed that they were facilitated to be independent at mealtimes

or could request staff assistance if necessary; this concurred with the articulated preferences of residents as recorded by the acting person in charge.

It was clear from discussions with residents that some existing staff, the acting person in charge and other staff seconded on site by the provider were kind and respectful in their interactions with residents. However, it was also clear from these discussions with residents that residents experienced ongoing concerns and disquiet in relation to some staff. Residents said that some staff continued to talk about personal and family matters in the presence of other residents. Residents stated that some staff came to work in "bad form"; others were described as "sensitive" with residents afraid of saying the "wrong thing". One resident stated that they felt the need to "apologise" so as to placate staff though she could not identify to inspectors what it was exactly that she was apologising for.

The person in charge had commenced a process of consultation with residents on an individual and collective basis; residents confirmed this and records were maintained. These records were consistent with much of the feedback received by inspectors from residents.

Inspectors again found residents to be insightful, consistent and balanced in their accounts; change and improvement were acknowledged as were the staff that were kind and respectful; some staff were identified by residents as staff they would like to continue working with when they moved to independent living.

Both the provider nominee and the person in charge told inspectors that they were fully aware of the lingering difficulties and challenges in the service but were confident that this was and would be managed by their presence on site, the system of supervision introduced since the last inspection and the fact that residents believed they were listened to.

Improvement had taken place; residents confirmed this. However, in summary there was evidence that some staff were not engaged in this process as evidenced by the feedback received from residents, staff non-attendance at training, non-attendance at staff meetings and the non-completion of daily support records. It was difficult to see how, in this context residents would in the long-term be supported to fully maximise their autonomy and independence.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
As committed to in the response to the action plan the provider had commenced a process of reviewing in consultation with and with the full participation of each resident, their individual support requirements. Support plans based on this process were in draft format at the time of inspection and there was evidence that plans were not for implementation until fully agreed with each resident. The support plan addressed seven domains including healthcare, daily supports, personal goals and social supports. The assessment process was comprehensive and the plans seen were person centred in their approach and in the language used. Actions/needs were identified but action plans, responsible persons and timeframes were not yet complete.

Residents had key-workers but this was not functioning optimally at the time of inspection. On a daily basis staff were provided with a record of each resident's required supports and staff were required to complete a daily record of the supports provided. This record included a narrative/qualitative section for staff to complete but inspectors noted that these were largely blank. Inspectors were informed that this was dependent on individual staff. Where supplementary information was provided by staff it was not clear how or by whom this information was followed up on.

In relation to the planned relocation of residents to independent but supported living arrangements each resident had an explicit transition plan. Some residents had since the last inspection experienced with the support of the provider, more independent living arrangements to assist them in their decision making. One transition plan was at an advanced stage but the others were not as alternative accommodation that was agreeable to the resident and suited to their needs had not yet been identified.

Workshops had been provided to staff on the completion of documentation.

Judgment:
Substantially Compliant

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 reviewed seven of the eight actions that emanated from the last inspection. Two actions were reissued in relation to fire safety.

Since the last inspection reassurances had been sought from the provider in relation to fire safety matters in the centre given the deficits identified by a fire safety audit completed in December 2014 and seen by inspectors. While difficulties were encountered by the provider who was not the legal tenant, the requested information was supplied.

Following the inspection of August 2015 and the reassurances sought by the Authority a further fire safety review of the premises was undertaken in October 2015 which again identified a broad range of potential deficits and the "critical importance" of "fire safety management" in the building.

Inspectors saw that upgrading works to the emergency lighting including its extension to areas previously not serviced, had been completed and a commissioning certificate was in place to this effect. The inspectors saw that residents had been removed from the second floor and were now accommodated on the ground and first floors only, as requested by the fire authority. Each resident had a personal emergency evacuation plan and these had been updated to reflect the resident's relocation; the required evacuation assistive devices were seen to be in place. Fire fighting equipment was prominently located and was marked as inspected in November 2015. Certificates were in place confirming the inspection and testing of the fire detection system in June and October 2015. Records indicated that staff completed weekly and monthly inspections of fire safety measures. Training records indicated and staff spoken with said that specific and practical training had been provided for staff on 11 November 2015 on the centre specific evacuation procedures. Records indicated that approximately fifteen simulated evacuation exercises had been undertaken since the last inspection; the acting person in charge confirmed this.

However, given the critical importance of fire safety management, deficits were identified in fire safety measures, for example the records of the completed fire drills were difficult to interpret; one seen indicated that it had been possible for three staff to evacuate three dependent residents in two minutes. However, staff spoken with confirmed that no simulated evacuation of a dependent person was undertaken during this particular drill. Staff spoken with also said that a full evacuation of the building was now required in the event of fire rather than staying in a protective compartment within the building as outlined in the evacuation plan; the person in charge and the provider nominee said that this information was incorrect. A cross reference between the current staff rota and staff training records indicated that three staff on night duty at intervals had not attended the fire evacuation training on the 11 November. The provider nominee and the person in charge committed to address this latter failing with immediate effect and stated that only staff who attended training would work at night time.

The inspector saw and the nominated provider confirmed that the required programme of fire safety upgrading works had not commenced. The inspectors requested an update on these works and reassurance as to the extent and duration of compartments provided in the building in the event of fire. Reassurance was provided post inspection from the nominated provider who clarified that the evacuation procedure had been clarified and consolidated; staff without the required training would not work at night-time until training had been completed and further fire evacuation drills based on the revised evacuation procedure were planned.

Inspectors saw that staff were now utilising the providers agreed reporting template for recording and reporting accidents and incidents. There was documentary evidence that staff took action as necessary including contacting the person in charge and seeking medical advice and or care.

The risk register had been updated to include the risks as specified in Regulation 26 (1) (c).

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:

At the time of the last inspection information was available to the Authority and inspectors alleging abusive staff behaviours that compromised residents' privacy, dignity and rights. The provider was instructed to implement the provider's policy and procedure in relation to managing allegations of abuse including implementing with immediate effect a suitable safeguarding plan for residents. This was done; the provider had also largely implemented the actions identified by them as necessary to safeguard residents from harm and abuse. A senior service manager had been appointed to oversee the service (the acting person in charge); lead personal assistants were in post and/or had been recruited. An external consultant had been commissioned to conduct a comprehensive review of the service; this process had commenced. A process of individual and collective engagement with residents was in place and inspectors based

on the feedback from residents were satisfied that this was a meaningful process.

As part of the process of reviewing resident's support plans, the plan now included plans for the delivery of personal and intimate care to residents.

Education and training for staff in responding and managing behaviours that challenged was planned for January 2016.

There was evidence that residents spoke openly with the acting person in charge in relation to their ongoing fears and anxieties and that they received the required support and reassurance. Residents also articulated these residual fears and anxieties in their conversations with inspectors.

No new information was available to inspectors; the acting person in charge said that since his arrival in the centre he had no knowledge of any alleged, suspected or reported abuse.

Residents spoken with in general articulated enhanced confidence in the governance structures and said that they were slowly regaining their confidence. Residents did convey some lingering anxiety but confirmed that they trusted the acting person in charge and while it was not perfect in the centre they were "ok".

However, it was of concern to inspectors that all staff had not fully engaged with the provider in the process of enhancing measures to protect and safeguard residents and indeed staff themselves. The majority but not all staff had attended the provider's centre-specific safeguarding briefing delivered on the 15 October and the customer care briefing on the 16 September; however only approximately 50% of staff had attended the session on work practices and development (incorporating dignity, respect, the code of conduct and the use of language in delivering supports).

Further reassurance was received post inspection from the provider confirming its commitment to robustly investigate any further information that may be brought to its attention and to safeguard residents from all forms of harm and abuse.

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:

Staff confirmed that residents accessed their General Practitioner (GP) of choice. There was narrative evidence that staff sought medical review and treatment for residents if required for example following a fall.

At the time of the last inspection inspectors had identified that there was a lack of evidence to support an evidence base and a comprehensive approach to the management of residents' health related supports. It was also difficult for inspectors to be definitive that the review of each resident's support plan was multidisciplinary as required by Regulation 5 (6) (a).

Since that inspection the providers own review of each resident's needs had identified that there were significant gaps in the information available on each resident particularly in relation to access to other healthcare professionals such as physiotherapy, occupational therapy, dietetics, speech and language therapy and counselling. There was some evidence that there may have been too great an expectation that residents would and could autonomously manage their own health. Staff spoken with repeatedly referred to "the resident's choice" while it was clear from speaking with residents that residents were unlikely to approach some staff for support and guidance.

The nominated provider and the acting person in charge confirmed that each resident's needs in these areas were now identified, the required referrals had been sought, some reviews had been completed but some residents were still awaiting the required appointments; there was also documentary evidence in this regard. This was of some concern to inspectors given the plan to transition residents to independent but supported alternative living arrangements within a defined timeframe. Based on risk assessments seen it was also of concern in the context of the prevention and management of falls as the risk assessment had identified the requirement for an occupational therapy review.

A further area identified as requiring attention and input for some residents was dental review and care. While there was no evidence that residents had refused or were reluctant to access dental care, based on records seen there was some evidence that perhaps residents required enhanced staff support and guidance in this area.

Judgment:

Substantially Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

implemented.

Findings:

Inspectors reviewed the two actions that emanated from the last inspection.

Staff were still supporting residents in all aspects of their medication management. The provider confirmed and inspectors saw that a draft policy on residents' self-administration of medication was in place as was a proposal for a staff training programme on assessing and supporting residents who wished to self-administer or become more involved in the management of their medication.

The medication management policy now included policy on the practice of transcribing; this was allowed in controlled circumstances by specific staff and incorporated a risk management control; verification of the transcribed prescription. However, transcribing practice was not in line with the providers own policy and regulatory body guidance.

Staff spoken with confirmed that all medication prescriptions in the centre including any changes were transcribed by a designated person. However, this was not evident from the prescription record as the signatures of the transcribing nurse and the verifying staff member were not evident. Staff confirmed that transcribing was routine and frequent rather than the exception.

The use of both generic and trade names continued.

Staff confirmed that medications no longer in use or no longer required were returned to the pharmacy but records of their return were not maintained.

Staff were reporting medication related incidents on the correct reporting template. There was documentary evidence that staff reported such incidents and took action as necessary. However, one such incident indicated a transcribing error where a medication prescribed to be administered at 20:00hrs was transcribed to be administered at 08:00hrs.

One PRN (as required) medication did not have the administration dosage stated; neither was the medication in stock should it be required by the resident.

Judgment:

Non Compliant - Moderate

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:

Based on the feedback received from residents and records reviewed by inspectors there was still some lingering evidence of poor quality care and services. However, inspectors were satisfied that the nominated provider and the acting person in charge were aware of this and had put systems in place to oversee the centre, monitor the quality and safety of the support and services provided to residents on an ongoing basis and take action as necessary; residents spoken with confirmed this. There was also some evidence that some staff had exercised their personal responsibility for raising concerns as to the quality and safety of the services delivered. Like residents, the acting person in charge told inspectors that staff also perceived that they were not listened to in the past.

The acting person in charge told inspectors that when he was not on site, another senior staff member was (the quality and assurance development officer). The acting person in charge said he remained on site until residents returned from their respective day services and had also made unannounced visits to the centre most recently on the 22 October.

The nominated provider was on site at a minimum once a week, daily contact was reported between the nominated provider and the acting person in charge and formal monthly reports were submitted by the acting person in charge to the nominated provider. These reports were made available to inspectors and reflected these inspection findings and the feedback received from residents.

Based on the previous inspection findings the provider commissioned an external review of the services provided in the centre. The stated objectives of the review were to enhance regulatory compliance, ensure a culture of quality, person centred service and supports and facilitate learning both within the centre and within the wider organisation. This review based on records provided to inspectors commenced on 24 November 2015.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

Inspectors reviewed two of the five actions that emanated from the last inspection; two were not applicable to this inspection as there were no volunteers working in the centre.

Residents spoken with and records reviewed again indicated that all staff did not have the required skills and attributes for their role in the centre.

Staff and their representatives had been informed of the provider's intention to cease operating the centre and a process of engagement had commenced with staff and their representatives to manage the consequent human resource implications of this. Inspectors were informed that the provider's implementation of the action plan to ensure that services and supports provided to residents were based on quality and person-centred, faced challenges and obstacles from some staff; this manifested in staff non-attendance at training and meetings convened by the provider. The nominated provider told inspectors that this situation was being actively managed by the human resources department and documentation to this effect was seen by inspectors.

In response to the last inspection findings the provider delivered a schedule of staff training; staff were advised that attendance at this training was mandatory. The training delivered included customer care, safeguarding, manual handling, fire evacuation procedures, work practices and development (included dignity, respect, the code of conduct and the use of language) and speech and language training. With the exception of manual handling full staff attendance was recorded for none of the training provided with the poorest recorded attendance for the work practices and development programme (approximately 50% of staff) and speech and language training on the 9th December with only one recorded staff attendance.

Records were in place for two staff meetings convened since the last inspection; a third had been planned but was cancelled due to the number of staff who indicated their non-attendance; inspectors were informed that only two staff had confirmed their intention to attend the meeting. The first meeting in October had a good and representative staff attendance; only six staff attended (again approximately 50%) the most recent meeting on 24 November 2015.

These findings were of concern to inspectors given the evidence of lingering poor practices and the concerns and anxieties articulated by residents.

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:

Mary Moore
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 I.W.A. Ltd
Centre ID:	OSV-0001998
Date of Inspection:	10 December 2015
Date of response:	26 January 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:

Residents experienced ongoing concerns and disquiet in relation to some staff.

1. Action Required:

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

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

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

- A. The Provider has reduced the staffing level by 9, this process commenced in December 2015 with the last of these staff finishing on the 18th of January 2016. Neither of the two individuals against whom allegations were made remains working in this or any other service operated by the service provider.
- B. The Provider has recruited a new Supervisor, who has experience in similar services. This individual commenced employment on the 4th of January 2016. This Supervisor will monitor and support the remaining staff while also operating hands-on in the service while the residents are at home.
- C. The Person in Charge (PIC) in conjunction with the new Supervisor will hold regular formal Staff meetings and individual supervision meetings with staff on a monthly basis. These meetings will address any concerns which the residents bring to the attention of the PIC, Supervisor or any other member of staff. Concerns residents may have will also be supported through the ongoing development of the residents individual support plans; which will be formally reviewed monthly.
- D. Residents will be supported to have the freedom to exercise choice and control in their daily lives through the continued development of their individual support plans.
- E. Staff will receive the following training to support them to ensure that residents have the freedom to exercise choice and control in their daily lives: Adult & Child Protection, Safety & Health at Work, Customer Care, Work Practices & Development and Fire Training will all be delivered before 26th February 2016

Proposed Timescale: 26/02/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Actions/needs were identified but action plans, responsible persons and timeframes were not.

The daily care record included a narrative/qualitative section for staff to complete but inspectors noted that these were largely blank. Where supplementary information was provided by staff it was not clear how or by whom this information was followed up on.

2. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

- A. The PIC with the support of the Supervisor will ensure that actions identified in the individual support plans will be followed up by an identified individual member of staff and within a specified timeframe. This practice will commence 21st of January 2016.
- B. The PIC with the support of the Supervisor will review and monitor individual support

plans and daily record-keeping to ensure that there is evidence that the stated actions identified have been delivered. This practice commenced on the 21st of January 2016.

C. A review has been carried out with regards to the daily records and a revised process is in place to improve the quality of information been recorded and to ensure that any follow-up actions required are delivered. This review and change process took place on 12th January 2016.

D. Staff have been directed in how to complete and record appropriate information. They are also being supported by the PIC, the Supervisor and other provider support staff to ensure that accurate information is being recorded and any specified actions required are delivered.

E. The individual supervision meetings will provide on-going learning and support to staff with record keeping.

Proposed Timescale: 21/01/2016

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:

The required programme of fire safety upgrading works had not commenced.

3. 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 Provider has had confirmation from the HSE (tenant of the premises) that the landlord Limerick and City County Council will not commence the programme of fire safety upgrading works until the residents have vacated the premises due to the nature of the work to be carried out. The break clause option issued by the HSE to the landlord means that we will have to vacate the building by 26th of April 2016.

Proposed Timescale: 26/04/2016

Theme: Effective Services

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

Given the critical importance of fire safety management deficits were identified in fire safety measures;

- 1.the records of the fire drills were difficult to interpret
- 2.three staff had not attended fire evacuation training
- 3.there was a lack of clarity as to the evacuation procedure for the centre in the context of identified deficits in the fabric of the building.

4. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

A. The PIC has reviewed the fire evacuation records and re-assembled them in a format which makes them easier to follow and transparent. This work was completed on the 21st of January 2016. Staff who had not received fire evacuation training at the time of the inspection have now received this training; this training was delivered on the 19th of January 2016. All staff working in the service has now received up-to-date fire evacuation training.

B. The company that carried out this training, will supervise a fire evacuation drill using two mannequins in the beds on the first floor. A representative of this company will also talk to the residents about fire evacuation process and demonstrate to them the use of evacuation matts. This fire evacuation drill under the supervision of company staff will take place before 5th February 2016.

C. The Provider and the PIC reviewed the evacuation process on the 14th of December 2015 following HIQA's last inspection. Following this review the fire evacuation process was amended to reflect that the fire evacuation process is designed to transfer all residents on the first floor from their bedrooms to the stairwell, furthest away from any fire, and then to transfer them immediately to an external fire refuge area. As part of this review an external safe refuge area was identified and has been included in the fire evacuation process.

Proposed Timescale: 05/02/2016

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:

All staff had not fully engaged with the provider in the process of enhancing measures to protect and safeguard residents and indeed staff themselves. The majority but not all staff had attended the provider's centre-specific safeguarding briefing delivered on the 15 October and the customer care briefing on the 16 September; however only approximately 50% of staff had attended the session on work practices and development (incorporating dignity, respect, the code of conduct and the use of language in delivering supports).

5. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

The Provider has reduced the staffing level by 9, this process commenced in December 2015 with the last of these staff finishing on the 18th of January 2016. The PIC with support from the Supervisor will ensure that the remaining staff who have not received the following training Adult & Child Protection, Safety & Health at Work, Customer Care, Work Practices & Development and Fire Training will receive this training before 26th February 2016

Proposed Timescale: 26/02/2016

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:

Some residents were still awaiting the required appointments with the multi-disciplinary team. This was of some concern to inspectors given the plan to transition residents to independent but supported alternative living arrangements within a defined timeframe.

There was some evidence that perhaps residents required enhanced staff support and guidance in accessing the required health care services including dental care.

6. Action Required:

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

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

- A. All residents has been referred to HSE Multi-Disciplinary Team 27th November 2015
- B. The HSE Disability Manager emailed Multi-Disciplinary Team to prioritise referrals for residents 03th December 2015
- C. Confirmation received that referrals to Multi-Disciplinary Team has been accepted 8th January 2016
- D. Dental Treatment referrals have been made to the HSE Dental Services as needed
- E. One resident transitioned to another service during 2016; the following actions were taken to support her move:
 - Resident supported to develop a transition plan prior to transitioning
 - Resident visited a number of GP's in the area before choosing a suitable GP
 - Through the new GP the Resident has registered with a new Chiropodist
 - The Resident attended a Physiotherapy appointment during December 2015
 - Resident is now accessing Multi-Disciplinary supports near her new residence
 - Resident has been supported to access MAABS service to support with money management
 - Resident has received supports from the Community Welfare Officer to furnish her home
 - Resident has engaged with Day Services in the area.

Proposed Timescale: 12/01/2016

Outcome 12. Medication Management

Theme: Health and Development

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

Transcribing practice was not in line with the providers own policy and regulatory body guidance.

The use of both generic and trade names continued.

Staff confirmed that medications no longer in use or no longer required were returned to the pharmacy but records of their return were not maintained.

One medication incident indicated a transcribing error.

One PRN (as required) medication did not have the administration dosage stated; neither was the medication in stock should it be required by the resident.

7. Action Required:

Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

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

A. The Provider has reduced the staffing level by 9 this commenced in December 2015 with the last of these staff finishing on the 18th of January 2016, refresher training will be provided to all remaining staff to ensure that they adhere to the providers policies with regards to all aspects of Medication Management including transcribing.

B. The Provider will develop a protocol for recording returns of medication to a pharmacy. This will be completed by the 26th February 2016.

C. The Providers Medication Manager will review the prescriptions for all the residents on the 27th February 2016 to ensure that they only contain current medications and prescribed PRN listed.

D. The management and staff working in the centre will receive ongoing support from the Providers Medication Manager, with a formal monthly review of medication practices.

E. The Provider has developed a protocol for Generic and Trademark Medication. This protocol will be brought to the providers Medication Management Committee for signoff on the 12th February 2016.

F. The Provider has engaged an external trainer to work with residents and staff to implement self-medication processes for residents, this process will be completed by 26th of February 2016.

Proposed Timescale: 26/02/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

While staff were advised that attendance at training was mandatory, not all staff had attended the required training.

8. Action Required:

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

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

A. The PIC communicated to all staff on the 24th November 2015 that failure to participate in mandatory training would result in disciplinary actions.

B. The PIC meeting with the reduced team of staff, on the 4th of January 2016, reiterated the importance of training for all staff and that it would not be acceptable by management if staff did not fully participate in any future training. It should be noted that the remaining staff in the service have demonstrated commitment and dedication to meeting the core requirements of the residents to date.

C. The Association has reduced the staffing level by 9 this commenced in December 2015 with the last of these staff finishing on the 18th of January 2016. The PIC with support from the Supervisor will ensure that the remaining staff who have not received the following training Adult & Child Protection, Safety and Health and Work, Customer Care, Work Practices & Development and Fire Training will receive this training before 26th February 2016

Proposed Timescale: 26/02/2016