Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002469
Centre county:	Westmeath
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Joseph Ruane
Lead inspector:	Raymond Lynch
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

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

The inspection took place over the following dates and times

From:	To:
26 January 2016 10:00	26 January 2016 16:00

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 unannounced inspection was conducted to follow up on matters arising from an inspection in August 2015. The inspection conducted in August 2015 found major non compliances across all 18 outcomes. The purpose of this inspection was to identify the progress made by the provider towards achieving compliance.

The centre comprised of one residential unit, supporting five residents, was located in the midlands and operated by the Health Service Executive (HSE). The inspection was facilitated by the person in charge of the designated centre and feedback was provided in the administration offices on conclusion of the inspection. Eight outcomes were assessed as part of this monitoring inspection.

Inspectors noted that improvements had been made since the last inspection. However, the centre continued to have significant issues with continuity of staffing and physical layout of the premises which resulted in direct negative outcomes for residents. Of the eight outcomes assessed one was found to be complaint which was healthcare needs. Moderate non compliances were found in health, safety and risk management, safeguarding, residents' rights, dignity and consultation and social care needs. Major non compliances were found in workforce, governance and management and medication management.

As identified in the previous inspection, there was a failure to provide for continuity of care, which had resulted in negative outcomes for the residents. Since that inspection the Provider Nominee contacted the Authority on 11 January 2016 to state that a process for assuming operational and governance responsibility for a number of Health Service Executive (HSE) disability centres had been completed and a contract had been awarded to a new service provider. The HSE had agreed a process with the new service provider for this transfer, which included a communication approach with service users and their families. The Provider Nominee said that while this transfer of operations was in progress, the HSE were committed to putting measures in place to ensure the safety and welfare of the residents residing in this centre.

These matters are addressed further in the report and in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
Improvements had been made with regard to the provision of meaningful activities for the residents however, the physical size of the premises continued to have a negative impact on the privacy and dignity of residents.

Since the previous inspection residents were being supported to engage in meaningful activities through day services and outreach programmes. As a result residents were now engaged in activities such as walking groups, gardening, feeding animals, arts, social outings and leisure activities such as swimming. This is discussed further under outcome 5: social care needs.

The designated centre was a bungalow consisting of four bedrooms one of which was a twin room. As identified on previous inspections the size of the premises did not promote the privacy and dignity of residents particularly with regard to the two residents sharing the twin room. Although a protocol had been put in place to try to maximise residents' rights in this regard, Inspectors were not satisfied that privacy and dignity was being adequately provided for in the current premises. The room measured 2.7 metres square in width and 4.6 metres square in length (total 12.4 metres square). Included in this space were two beds, wardrobes, bedside tables and a privacy screen. There was also inadequate storage space for residents' personal belongings. This was inadequate space to meet the needs of residents and this finding remains unchanged from previous inspections. It was noted however that residents' bedrooms were colourfully decorated and personalised.

It was also observed that there was limited space available for residents to see visitors in private. While there was an adequate sized kitchen/dining room and a separate sitting room, there wasn't any other available room where a resident could see family and or friends in private.

Residents meetings were now being held on a weekly basis. This had increased from a monthly basis since the previous inspection. Inspectors reviewed minutes of these meetings and found that issues such as activities, resident achievements, menus and upcoming events were discussed.

The procedure relating to complaints was on display in the designated centre and complaints were an issue that was also discussed at resident meetings. A complaints log was available in the centre however, it did not contain sufficient detail for inspectors to determine how complaints were handled or the eventual outcome. When additional complaint records were sought Inspectors were told that these were not held in the centre.

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:
Overall inspectors found that improvements had been made with regard to supporting meaningful community based activities for the residents. However, issues remained with regard to lack of documentation and information contained within residents person centred plans.

From a sample of files viewed inspectors observed that a meaningful activities assessment had been carried out for each resident in April 2015. The person in charge also informed inspectors that she had secured day service placements for some residents where a range of social activities and social skills training was made available

to them.

For example, in these placements residents were supported to join the local gymnasium, where they loved to swim. Another resident was supported to join an active ageing group where a range of social and skills based activities were on offer and some residents had joined a local walking group. Residents also frequented local facilities such as the hairdressers, beautician, pubs and restaurants.

One resident liked to do household tasks and the person in charge informed the inspectors that as part of their day placement, the resident was supported to undertake work experience in a local bed and breakfast one day per week, which the resident looked forward to each week.

Another resident choose not to attend a day service, even though this option had been made available. The resident in question required a lot of one to one staff time and inspectors observed that the resident also enjoyed quiet time watching television. The resident also enjoyed drives and listening to music in the car and these outings were facilitated by the staff in the centre.

On inspecting a sample of daily reports, inspectors found evidence that a range of social and skilled based activities were on offer and availed of by the residents. However, information and documentation on the above improvements had not been documented or included in residents' personal plans. Person centred plans remained basic and in part not completed or reviewed.

For example, one plan detailed some goals that a resident wanted to achieve in 2015, such as a hotel break and trip to the city. There was no evidence available to ascertain if these goals had been reviewed or achieved. It was also noted that sections of some person centred plans were not completed and contained no information. This issue was also identified in the last inspection.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
While there were policies and procedures in place to manage and mitigate risk, inspectors found that some of the control measures were not being implemented adequately to ensure the safety of both residents and staff at all times.

There were policies and procedures in place regarding health and safety and risk management. There was also a risk register in place as were there systems for identifying, assessing and reviewing risk throughout the centre. Individual risk was being identified, the impact of such risk and ways in which to mitigate it. For example, one resident had a risk of choking. The resident was seen by a speech and language therapist and the way in which to mitigate the risk was to provide the resident with a specialised diet and close supervision at meal times. Inspectors observed this in practice on the day of inspection.

Individual risk assessment and control measures were also in place for the management of challenging behaviour. However, while issues with risk were clearly identified with regard to challenging behaviour and self injurious behaviour, some of the mitigating factors to reduce the risk was not being implemented. For example, it was documented in some risk assessments that continuity of staff was a factor in managing and mitigating risk associated with challenging behaviour. Continuity of staff was not maintained.

A serious incident occurred in the centre which required the intervention of the police and support from staff working in a different part of the service. The incident lasted for an hour, where two staff members and two residents were locked into the sitting room because another resident was presenting with threatening and aggressive behaviour. The risk assessment for the resident in question identified that continuity of staff was a factor in the management of their behaviour. On the morning of this incident there were 4 staff on duty however, three of those staff were agency staff and not regular workers in the centre. Issues with regard to continuity of care were also discussed in detail under Outcome 17: Workforce.

While the centre maintained records of accidents and incidents occurring in the centre, the official documentation regarding this particular incident was not made available to inspectors. The person in charge informed the inspectors that this documentation was under review in head office. Because of this inspectors were not able to identify what, if any learning took place from this incident or if it had been adequately investigated. However, the person in charge informed inspectors that the resident in question had an appointment made with the psychiatrist, scheduled for the last week in January 2016.

Inspectors reviewed the fire register and found that the fire alarm and emergency lighting had received maintenance checks at quarterly intervals with records maintained of such checks. However a record of the most recent maintenance check for the centre's fire extinguishers was not available in the centre. This was brought to the attention of the person in charge on the day of inspection.

The fire register also contained records of fire drills which were being done on a monthly basis while residents' personal evacuation plans had been updated in September 2015 following one of these drills.

A sign in sheet for fire safety training was also in the fire register which indicated that all permanent staff had undergone fire safety training. Staff members spoken with were familiar with what to in the event of an evacuation being necessary. The fire procedures were on display in the centre and fire exits were unobstructed. These exits now had thumb locks in place as opposed to being key operated. This was an issue which had been highlighted in previous inspections and had now been addressed.

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:
While it was observed that improvements had been made with regard to promoting safety and welfare in the centre, there were still issues with regard to the management of challenging behaviour which was impacting negatively on the residents.

There was a policy in place which provided guidance to staff for the prevention, detection and response to any issues relating to abuse. On speaking with staff inspectors were satisfied they were competent in verbalising what constitutes abuse and how they would manage any suspicion and or allegation of same. They were also able to identify the designated person for reporting actual or suspected incidents of abuse to.

However, inspectors were not satisfied that all mandatory training was completed by all staff members, including safeguarding of vulnerable adults, as the training records maintained in the centre were not made available to inspectors on the day of inspection.

Where required each resident had a positive behavioural support plan in place. Plans were updated and reviewed regularly and from a sample viewed they had been updated in July 2015 and again in January 2016. They were also informative on how to support a resident who may present with challenging behaviour. For example, the antecedents of the behaviour were assessed and from that a proactive and reactive strategy was

implemented. The centre was supported by a behavioural support consultant who reviewed and updated plans on a regular basis.

The centre promoted a restraint free environment and the only restriction documented was the use of a PRN "as required" medication which had just been recently prescribed. This was for a resident who had been presenting with significant challenging behaviour. There were protocols in use for the administration of the PRN and this was written up in the resident's care plan. The resident was also due for a review with the psychiatrist in January 2016.

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:
Of a sample of health care issues reviewed, inspectors found that residents were supported to achieve and enjoy the best possible health. Health care plans were found to be updated annually or as required.

Health care needs were met in line with care plans and through timely access to appropriate health care services and treatments with allied health care professionals. Records showed that routine visits were organised as and when required to the General Practitioner (GP), dentist and chiropodist. Specific issues were also comprehensively provided for. For example, one resident who was prone to skin infections had very clear guidelines written up in their care plan to manage this. The resident's skin was monitored daily for any signs or symptoms of infection or redness and the resident had regular checkups with their GP.

Issues were identified in the last inspection with regard to staff training in the management of epilepsy and seizures in the centre. Not all staff were trained to administer rescue medication at that time. The person in charge informed the inspectors that all staff now had that training and from speaking with staff it was evident that they would know how to support a resident if they had a seizure. However, on the day of inspection some staff files could not be located to verify training. Issues with regard to staff training are further discussed and actioned under Outcome 17: Workforce.

Inspectors also noted that residents' weights were now being monitored monthly, however one resident's file did not demonstrate that this was taking place. The centre continued to monitor food intake for the residents and from a sample of files viewed, they were also monitoring fluid intake. This was an issue identified in the last inspection. However, records were not up to date and there were gaps in the documentation. This was further discussed and actioned under Outcome 17: Workforce

Judgment:
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 remained concerned regarding how learning was being applied from medication errors, while improvement was also required to ensure that standard operating procedures were being followed.

The centre had a medication policy in place which provided clear guidance to staff on the storage, administration and disposal of all medications in the centre.

However, previous inspections of this centre had identified shortcomings in the response to medication errors. On reviewing the medication administration records inspectors noted two medication errors. When querying the presence of incident reports for these two errors, as required by the provider's own policy, the person in charge informed inspectors that no such reports had been completed. Consequently it was not possible to establish what learning had occurred as a result of these errors while the absence of such incident reports meant that these medication errors could not be analysed in order to identify trends.

The person in charge informed Inspectors that medication audits had been conducted by the supplying pharmacy however records of these were not present in the centre on the day of inspection. During feedback the Regional Director of Nursing informed Inspectors that it was intended that an external nurse would audit the centre's medication practices in the future.

Prescription and administration records were reviewed and found to be eligible and containing most of the necessary information. However on one resident's prescription sheet the space to highlight any known allergies was left blank. Some discrepancies were also noted with regard to PRN (as required) medication. For one resident it was noted that the maximum dose to be administered in a 24 hour period was not stated on the prescription sheet.

Inspectors were also concerned regarding the documentation for one resident who was prescribed buccal midazolam for epilepsy. When the resident's prescription sheet and PRN protocol for this medication were compared it was noted that there were different maximum doses for a 24 hour period stated on each of the two documents. This was brought to the attention of the person in charge who was unsure as to what the correct dose was. Inspectors informed the person in charge that this situation would need to be rectified and documentation updated.

Suitable storage facilities were in place for the storage of medication including a separate locked refrigerator which was being used to store medication on the day of inspection. When inspectors reviewed the records of temperature checks for this fridge it was observed that checks were not being carried out daily in line with best practice. In the month of January up until the date of inspection the temperature had been checked on only six occasions.

Judgment:
Non Compliant - Major

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

Findings:
There was a clearly defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service. However, the systems in place did not ensure that the service being delivered was at all times safe or effectively monitored.

The centre was managed by a suitably qualified, skilled and experienced person in charge. From speaking with the person in charge it was evident that she had an in-depth knowledge of each resident's support needs. She was also aware of her statutory obligations and responsibilities with regard to the management of the centre.

The person in charge had also implemented some new initiatives in the centre that had directly impacted positively on the quality of life and quality of care for each resident. For example, she had secured new day service options which supported residents to participate in a range of meaningful community based activities.

However, no unannounced visits or review of the safety and quality of the service were undertaken by the nominee provider, which in turn meant the service was not adequately being monitored.

The person in charge also informed inspectors that due to the lack of nursing staff available in the centre, she was covering additional nursing hours required to address the gaps in care being provided. On viewing a sample of rosters, inspectors observed that the person in charge would often work additional hours to provide cover on the floor. This in turn impacted on her capacity to carry out the role of person in charge effectively. For example, review and updating of personal plans and updating of documentation was not adequate in meeting the requirements of regulation. Therefore the person in charge was not in the role in a full time capacity as required by the Regulations.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Inspectors found that the staff on duty in the centre on the day of inspection had the skills and knowledge necessary to meet the needs of the residents, however it was found that the level of core staff available was not sufficient to ensure adequate continuity of care.

Of the staff that inspectors spoke with during the course of the inspection they were found to have a detailed knowledge of each residents needs and spoke very positively about each resident residing in the centre. However, and as highlighted throughout this report, significant issues with regard to staff retention for this designated centre

remained an area of concern for Inspectors. From a sample of rosters viewed, inspectors noted that there was a high turnover of nursing staff and a significant reliance on agency staff in managing the day to day operations of the centre.

A sample of staff files were reviewed by inspectors found that evidence of Garda vetting was in place. However it was apparent that a number of the files inspected were not complete. For example some files did not have proof of identification, such as a birth certificate, driver license or passport, full employment histories, training/qualification records or details of the work performed by some staff members.

The need for further staff training was highlighted as an area for improvement at previous inspection. From speaking to some staff members present on this inspection it was evident that further training had been provided for these staff. However, inspectors were not satisfied that all mandatory training was completed by all staff members as the training records maintained in the centre were not made available to inspectors on the day of inspection.

Judgment:
Non Compliant - Major

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:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002469
Date of Inspection:	26 January 2016
Date of response:	20 April 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' privacy and dignity was not adequately being provided for due to the physical size/layout of the premises and the size of the shared bedroom.

[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:
1. There is a plan in place for an alternative service provider to provide a service for each individual residing in the designated centre. 30th April 2016

In the interim provision will be made to install a fixed privacy screen/curtain rail in the shared bedroom to ensure that each resident's privacy and dignity is respected in relation to his or her personal and living space, intimate and personal care. 26th March 2016

2. There is a plan in place for an alternative service provider to provide a service for each individual residing in the designated centre by the 30th April 2016. A transition plan is in place. Initial meetings have taken place in relation to the transition with residents and families.

This process will involve the residents and their families, drawing up a transition plan for each individual resident to a level of service requirement that is suitable to the individual needs of each resident. 30th April 2016

3. A review of the purpose of the activity room has taken place and is now available as an additional recreational space to afford privacy to residents to meet with their family and friends. Complete 1st February 2016

Proposed Timescale: 30/04/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A complaints log was available in the centre however, it did not contain sufficient detail for inspectors to determine how complaints were handled or the eventual outcome.

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

Please state the actions you have taken or are planning to take:
1. There is an accessible document in place for the recording of concerns/complaints from individual residents. The PIC will ensure that all staff at the designated centre will use this document and ensure that follow up actions are taken as appropriate. 18 March 2016

Complaints training has since taken place on the 8th March 2016 at which two staff from the designated centre attended. Further training is scheduled to take place on Wednesday 23rd, Thursday 24th March and the 7th April 2016 at which three staff from the designated centre will attend on each day. 30th April 2016

Proposed Timescale: 30/04/2016

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:
Not all personal plans were reflective of adequate consultation with residents.

3. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
1. Consultation with residents will be clearly documented in relation to their participation, the achievement and review of their goals.

2. PCP review meetings are scheduled to take place on 14th, 21st 22nd and 23rd March 2016.

3. Letters have been circulated to family members / circle of support for involvement in the process. PIC will be present for these meetings.

Proposed Timescale: 31/03/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was an absence of adequate information to support how some personal plans would be achieved.

4. 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:
1. Each individual in the designated centre will have a full review of their person centred plan by the 30th April 2016.

2. PCP review meetings are scheduled to take place on 14th, 21st, 22nd and 23rd March 2016.

3. Letters have been circulated to family members / circle of support for involvement in the process. The PIC will be present for these meetings. 31st March 2016

4. All staff in the designated centre will receive Training in Person Centred Planning. Three staff will attend Training on 21st of March. 30th April 2016

5. The key worker will draw up an action plan in collaboration with each resident to review goals in person centred plans. The PIC will review current practice and documentation to ensure that all staff document progress for each individual's goals. 30th April 2016

6. A template is in place to record and follow up on PCP goals in SMART way to ensure that the process is evaluated by the Key Worker. 30th April 2016.

Proposed Timescale: 30/04/2016

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:
Adequate measures were not in place for the appropriate management of risk associated with incidents of challenging behaviour.

5. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
1. The serious incident is being reviewed as appropriate in line with the HSE Serious Incident Management Policy. 30th April 2016

2. Complaints and Incidents Review is a standing agenda item for the PIC Quality Assurance Group, Comprising Assistant Directors of Nursing of PICS and PPIMs with the first meeting scheduled to take place on 16th March 2016 and monthly thereafter.

3. All risk assessments in relation to the management of risk associated with incidents of challenging behaviour will be reviewed by the PIC. 31st March 2016.

4. A review of staff at the designated centre with regard to continuity of care has taken place. Measures have been taken to address continuity of care for the individuals residing at the designated centre including assigning regular agency staff familiar to the designated centre. Four new staff have commenced as regular staff and have been assigned key-worker roles. Complete 28th February 2016

Proposed Timescale: 30/04/2016

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:
Not all staff training records were kept on file in the centre. It was not demonstrated that all staff had training in safeguarding of vulnerable adults.

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

Please state the actions you have taken or are planning to take:
1. All mandatory training records are now held at the designated centre, The PIC will ensure that all records are kept up to date and evidence of training will be available at the centre. The PIC will follow up with individual staff re adherence to statutory and mandatory training. 31st March 2016

2. All staff in the designated centre have received updated training in safeguarding vulnerable adults with the exception of one newly recruited staff member who is scheduled to attend safeguarding training on the 8th April 2016.

Proposed Timescale: 08/04/2016

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:
Refrigerator temperature checks were not being carried out a daily basis.

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:
Refrigerator temperature records are now delegated to an identified member of staff on a daily basis.

Proposed Timescale: 28/02/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication errors were not being appropriately followed up to promote learning. For some residents the maximum doses of PRN medication was either not stated or inconsistent. One resident's prescription sheet was not fully completed as it contained no information as to whether the resident had any allergies. It was also observed that the system of ordering, administrating, storing and disposal medication was not subject to adequate auditing procedures.

8. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
1. All nursing staff have completed medication management training. Complete 8th March 2016

2. All prescription sheets have been reviewed by the GP, all known allergies for each resident have been identified, the PRN sections have been reviewed and all discrepancies have been rectified, the documentation for one resident who was prescribed buccal midazolam has been rectified to coincide with the residents epilepsy protocol. Incidents reports have been completed for all errors. Complete 5th February 2016

3. A review has taken place, all medication errors are being followed up with a medication error form and incident report, and will be review on a monthly basis. Complete 29th January 2016

4. Medication audits completed by the pharmacist will be kept at the designated centre. 31st March 2016

5. A medication audit at the designated centre is scheduled to take place by an independent auditor. 8th April 2016

Proposed Timescale: 08/04/2016

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:
While the person in charge was found to be competent, she was not working in a full-time capacity in this role which impacted negatively on her carrying out the duties required of a person in charge

9. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
1. The PIC will have protected time to fulfil her role. 10th April 2016

2. The pharmacist will provide blister packs to the designated centre. 28th March 2016

3. All non-nursing staff in the designated centre will receive SAMS training. 10th April 2016

Proposed Timescale: 10/04/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No unannounced visits had been carried out in the centre and no report was available on the safety and quality of service being delivered.

10. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
The Register provider or his representative will conduct regular unannounced inspections of the centre, and a written report will be made available on the outcomes of the visit.

1. An unannounced inspection is scheduled in the designated centre for 8th April 2016, and a written report will be made available on the outcomes of the visit. 30th April 2016

2. An infection prevention and control audit has been conducted in the designated centre. A report was circulated to the PIC on the 14th March 2016

3. A risk register audit in the designated centre is scheduled for the 18th April 2016 in respect of individual residents and the environment.

4. A medication management audit in the designated centre has been scheduled for the 9th April 2016.

Proposed Timescale: 30/04/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Continuity of care and support was not adequate due to staff turnover and significant reliance on agency staff.

11. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
A review of staff at the designated centre with regard to continuity of care has taken place. Measures have been taken to address continuity of care for the individuals residing at the designated centre including assigning regular agency staff familiar to the designated centre. Four new staff have commenced as regular staff and have been assigned key-worker roles. Complete 28th February 2016

Proposed Timescale: 28/02/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files were not complete as required by Schedule 2 of the Regulations.

12. 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:
The PIC will review all staff files at the centre, all information required by Schedule 2 of the Regulation will be obtained by the PIC and will be available at the centre.

Proposed Timescale: 31/03/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
On the day of inspection gaps were identified in staff training records

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

Please state the actions you have taken or are planning to take:
1. All mandatory training records are now held at the designated centre, The PIC will ensure that all records are kept up to date and evidence of training will be available at the centre. The PIC will follow up with individual staff re adherence to statutory and mandatory training. 31st March 2016

2. All staff training needs will be assessed by the PIC. All mandatory training specific to the centre needs will be identified. The PIC will schedule staff to the necessary training. 31st March 2016

Proposed Timescale: 31/03/2016