**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

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|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0002471 |
| **Centre county:** | Westmeath |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Joseph Ruane |
| **Lead inspector:** | Catherine Rose Connolly Gargan |
| **Support inspector(s):** | Brid McGoldrick; |
| **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 inform a registration decision. 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: |
|---|---|
| 21 September 2015 09:30 | 21 September 2015 16:30 |

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 10. General Welfare and Development |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

**Summary of findings from this inspection**

Inspectors undertook ten inspections in eight centres operated by the Health Service Executive (HSE) through St Peter's Services in Westmeath in 2015, four of which were announced and six unannounced.

These inspections found evidence of poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued immediate actions and warning letters. Regulatory and escalation meetings were also held with the provider and members of senior management of the Health Service Executive.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to refuse the registration of one of the centres was issued. Following on from this, the provider informed the Chief Inspector of their intention to cease the operation of four houses within the region. The purpose of this was to consolidate the staffing levels in the remaining twelve houses.

HIQA has been informed by the provider that the process for assuming operational and governance responsibility is now complete and the contract has been awarded to another service provider.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection was the third inspection of the centre and was completed to assess progress with action plans identifying non-compliances with the regulations following the designated centre's registration inspection in May 2015.

Findings of major non-compliance with the regulations examined during previous inspections of the centre in November 2014 and May 2015 resulted in the Initiation of Regulatory Enforcement Proceedings by the Authority including the issuing of an immediate action plan to the provider nominee in relation to inadequate staffing at night. The provider responded by increasing core staffing at night to two care staff.

Overall the findings of this follow-up inspection demonstrated that the actions implemented by the provider had resulted in improvements in some areas but the response taken to address other findings of significant non-compliances from the last inspection in May 2015 did not sufficiently ensure that the services provided for residents were safe and effective.

While inspectors found staff on duty to be caring towards residents, the findings of this inspection, demonstrated significant evidence of a failure to recognise the rights of residents to have opportunity to develop and have the necessary supports to maximize their personal development and quality of life. Provision of suitable supports such as day service provision requires immediate action.

Management systems in place in the designated centre did not provide sufficient assurances that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. Due to the failure to provide a stable workforce, effective arrangements were not in place for adequate staff support, development and performance management as required by regulation 23(3)(a). These matters are described in outcome 17 and evidenced throughout the report.

Non-compliance was identified with thirty seven regulations on this inspection, twenty nine of which are the responsibility of the provider and eight are the responsibility of the person in charge.

Moderate non - compliance with the regulations was identified in 8 Outcomes and major non-compliance was identified in 5 Outcomes including Outcome 6: Safe and Suitable Premises, Outcome 8: Safeguarding and Safety, Outcome 14: Governance and Management, Outcome 16: Use of Resources and Outcome 17: Workforce.

Substantial compliance requiring minor improvement was found in Outcomes 2: Communication, 3: Family and Personal Relationships, 4: Admissions and Contract for the Provision of Services and 13: Statement of Purpose.

The findings evidencing actual and potential negative outcomes for residents in terms of their safety; care and quality of life are described in the inspection findings throughout this report.

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

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Inspectors' findings provided evidence that residents' rights and dignity needs were not being adequately met on this inspection. There was evidence on the last inspection that the centre was not always operated in a way that respected the needs of the residents in terms of gender and staffing arrangements. Inspectors were told by the person in charge that staffing arrangements ensured appropriate staffing was rostered at all times. A review of the duty roster by inspectors from 28 June to 19 September 2015 confirmed this to be correct with one exception. This finding is also discussed further in outcome 17.

There was evidence that a designated advocate was available for residents. The advocate had visited some residents in the centre and supported a resident with completing a hospital appointment. A further visit by the advocate took place in the week prior to this inspection in respect of another resident. Referrals were sent requesting input by this service for the other residents in the centre to assist them with making meaningful decisions to bring about changes to aspects of the service that negatively impacted on their quality of life. For example, choice of residency in the designated centre and choice of shared or single bedroom accommodation.

Inspectors confirmed that procedures had been put in place to ensure nominated family members were informed about resident incidents or accidents and that they were included in case conference meetings since the last inspection.

Inspectors found that procedures were improved to ensure resident's personal possessions were safeguarded.

As found on the two previous inspections of the centre, there were opportunities for residents to go for walks, go out for meals and go shopping with staff support. However, inspectors saw that three of the five residents were not afforded choice to avail of formalised activities for their personal development and lifelong learning needs. Inspectors reviewed a sample of weekly activity timetables for residents and whilst acknowledgement is made that improvements had been made for some residents since the last inspection in May 2015, the choice for three residents in particular was still limited and did not always reflect their individual interests or capabilities. Access to activities outside the centre by individual residents was generally limited to group activities that could be accessed by all three residents as some were dependant on wheelchairs for mobilisation. This arrangement did not optimise individual choice, interest or capability and did not ensure meaningful individual opportunities for personal development. This finding is discussed further in outcomes 10.

The designated centre has four bedrooms and is the home of five residents. As found on the last inspection in May 2015, the size and layout of a twin bedroom negatively impacted on the privacy and dignity needs of the two residents residing there. Privacy screening provided was observed by inspectors to be ineffective in meeting the privacy needs of either resident. The outcome of this finding for residents residing in the twin room was that they did not have adequate personal space or privacy in their bedrooms to meet their needs. There was an absence of evidence to support that this shared arrangement reflected these residents' wishes.

As a result of non-compliance with the regulations found on the last inspection, inspectors reviewed the procedure for complaints in the centre. There were no areas of dissatisfaction recorded. However, inspectors found that dissatisfaction about aspects of the service which were expressed to service providers by a resident and families of residents on the last inspection in May 2015 were not recorded. This finding is addressed in outcome 18. While the person in charge showed inspectors two compliment cards regarding an event held in the centre and told inspectors that complainants were satisfied with the outcome of their complaints, this could not be confirmed by inspectors on this inspection. The person with responsibility for complaints and to whom residents should express any areas of dissatisfaction was displayed in accessible format which included their photograph. Blank complaint templates were available on the hall table in the centre and the procedure for making complaints by residents and others was readily available in folders.

While, a copy of the complaints procedure in accessible format was available in a folder, there was an absence of adequate evidence to confirm residents were supported to become familiar with the content of the complaint procedure folder.

**Judgment:**
Non Compliant - Moderate

**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
There were organisational polices in place regarding residents' communication. The communication policy was dated for review in November 2015; this policy was reviewed by inspectors and found to not inform the needs of some residents in the centre. This finding is discussed in outcome 18. Four of the five residents in the centre had identified needs regarding their verbalisation ability. Residents were assessed by allied health professionals for suitable assistive communication technology to support their communication needs.

The person in charge told inspectors that some staff had received training on the Lamh language system. However, this was not recorded in the staff training records. This finding was clarified following the inspection with confirmation that 11 members of staff attended training in Communication and Lamh training.

There was reference documentation available to inform interpretation of residents' individual sounds and gestures used to communicate needs. Inspectors observed that all staff were able to effectively interpret residents' various sounds and gestures on the day of inspection.

An accredited sensory based communication programme was introduced to the residents by the speech and language therapist prior to the inspection of the centre in May 2015 however as on the last inspection, inspectors observed that there was an absence of assessment documentation to determine if residents experienced positive outcomes from participation in it. On the last inspection, inspectors were told by staff that further implementation of the programme would be carried out by the speech and language therapist. However, the intensive access required to effectively implement this programme including staff training was limited due to commitments by the speech and language therapist to other parts of the service.

While there were some documents available in accessible format, there was limited evidence of their familiarisation with residents. Pictures of menus and staff were in use to inform residents. One resident had recently obtained an iPad and the person in charge told inspectors funding was being sourced to purchase similar devices for other residents. The inspectors were told that four residents had personal iPads.

**Judgment:**
Substantially Compliant

**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

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

**Findings:**
There was evidence of consultation with residents' families regarding significant events in the residents' lives such as transitioning to new accommodation within the service and health related events. There were two sitting areas in addition to the kitchen for residents to meet their visitors in private outside their bedrooms.

While inspectors found that there was improvement for some residents, most residents did not have meaningful involvement in the local community outside of their usual routine activities.

A recent party was hosted by the centre on the occasion of a house blessing, which neighbours and residents' families attended.

One resident assisted staff with grocery shopping in the local supermarket and others went to the post office. One resident expressed a wish to go to Bingo and staff advised they were assisting the resident to achieve this.

**Judgment:**
Substantially Compliant

**Outcome 04: Admissions and Contract for the Provision of Services**
*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

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

**Findings:**
Since the last inspection in May 2015, residents were provided with contracts as required by the legislation. An accessible format document was available to inform residents about the terms and conditions of their residency, was signed, dated and detailed fees to be charged for accommodation or additional services.

The policy in place for the Admission and Discharge of residents was reviewed in June 2015. This policy outlined the procedure for admission and discharge from and to external providers; however, the guidance including the practical supports required for residents transitioning between designated centres which were operated by the same provider lacked adequate detail to inform the transition process. The admission policy document did not advise on procedures and practices to protect residents from abuse by their peers. In addition, a page was missing from this document for reference by staff in the centre. This finding is also addressed in outcome 18.

**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 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:**
Each resident has an Individual Personal Plan which referenced assessments of their individual needs including risk assessments, interventions and treatment plans to address those needs. On this inspection, inspectors observed increased involvement by residents or efforts made to involve them in the review process. Involvement by residents' families was also improved and demonstrated.

Goals developed for residents were observed to be more resident focused and promoted improved opportunities for skill building and lifelong learning for some residents. For example, one resident went on a hotel break, had opportunity for occupational experiences and had started using an iPad. However, this was not the finding for all

residents. Findings demonstrated that goals developed for some residents were short term and did not promote meaningful skill building and lifelong learning for three residents in particular. Considering the age range of these residents, this finding did not promote a culture of support and expectation in terms of developing their abilities and strengths.

Not all residents were satisfied with living in this centre. Inspectors were told by the person in charge that there was currently no suitable alternative accommodation in the service and the housing waiting list was being used as a way of identifying possible alternatives. However, there was an absence of evidence that housing needs were adequately assessed to inform definitive accommodation requirements and support resource needs.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Services

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

**Findings:**
Aspects of the design and layout of the centre were not suitable for its stated purpose and did not meet some residents' needs.

Findings from the inspection in May 2015 identified an absence of adequate storage for residents' assistive equipment in the centre. The provider stated in the action plan response that storage for residents' equipment and supplies was located in a facility to the back of the centre following the last inspection of the centre. However, inspectors found on this follow-up inspection that this facility was not adequate. The person in charge advised inspectors that the facility was not suitable for storage of the hoist equipment. Inspectors observed that an assistive wheelchair and walking frame were placed in the corridor, a wheelchair was in one of the sitting rooms and a hoist was stored in the twin bedroom. The outcome for residents was compromised access along the corridor, their communal space in the sitting room and space available to two residents in the twin bedroom.

The twin bedroom measured 14.65m² and was occupied by two residents, both used assistive equipment and the room was not adequate in meeting the needs of the residents. A hoist was stored in the twin bedroom. There was inadequate space between the beds to enable these residents to undertake personal activities in private. There was inadequate space for safe manoeuvring of wheelchairs. Only one resident could comfortably view the television in the room. The room was not personalised and did not reflect or facilitate either resident's personal preferences in terms of décor or display of personal possessions. As stated in previous inspection action plans, this room continues to be in non-compliance with the requirements of Schedule 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The main corridor in the centre measured 750mms and did not have handrails fitted to meet the needs of residents. Inspectors observed residents using the walls and furniture for support with mobilising. The inspectors were advised that while a requirement for handrails was acknowledged, these could not be fitted as wheelchair access would not be possible. The inspectors also observed that wood around door-frames and skirting boards were scored by equipment passing on the corridor.
These findings did not ensure residents comfort and safe mobility needs were met and did not meet the stated purpose of the centre.

While ramps were in place accessing the centre, safe access to a garden pagoda which was used by residents with mobility difficulties was not provided. The floor of the pagoda was higher than the garden level and did not have a safe pathway fitted from the existing garden pathway. Access to the pagoda had been recommended by a behavioural specialist as part of a positive behavioural support plan.

Linen cupboards located in one of the walls of the corridor, fitted with doors that opened out into the corridor were decommissioned since the last inspection. The inspectors observed these cupboards to be empty of linen. Residents' bed linen and towels were personalised and stored in their bedrooms.

The inspectors observed large cracks in a wall on the corridor and in the wall behind a resident's bed in the twin room. A pier at the entrance to the centre was broken and at risk of falling over.

The maintenance process was poor and did not ensure repairs were assessed and prioritised as necessary. The inspectors viewed a log of telephone calls by staff in the centre reporting areas that required maintenance in the centre. However many of these remained outstanding. Staff were not aware of a schedule for these repairs and there was no process in place where these issues could be escalated.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
While there was some systems in place for the assessment, management and ongoing review of risk in the centre, findings of unidentified risks did not adequately ensure the health and safety of residents, visitors and staff was promoted and protected.

Inspectors reviewed the risk register in place on the day of inspection and found that it did not adequately identify all hazards within the designated centre with concomitant controls to mitigate risks identified. While some hazards identified on the last inspection by inspectors were addressed, other hazards were identified on this inspection. For example, access to a garden pagoda, storage of residents' personal information and documentation in an open shed exterior to the centre, a broken pier at the entrance to the site and storage of residents' assistive equipment in the communal and circulation areas. Risk mitigation controls did not ensure provision of adequate first aid equipment if required. However, all staff in the centre had attended cardiopulmonary resuscitation training as evidenced by the staff training records.

While inspectors observed that risks posed by and to individual residents was assessed with controls identified in their individual documentation, this information was not documented as active risks in the centres risk register. This practice did not ensure that all clinical and non-clinical risks present in the designated centre could be reviewed as part of the overall governance procedures by the provider to ensure requirements for mitigation were adequately resourced and managed.

The inspectors also found that while incident forms were completed by staff in the centre and forwarded to the provider, review of some incidents were not signed off by the person in charge and did not reference actions taken at centre level or by/on behalf of the provider. As a result, inspectors saw evidence where recurring incidents were not proactively and comprehensively managed by the organisation. For example, as found on the last inspection in May 2015, behavioural issues continued to present a risk when using the transport vehicle. There was an absence of evidence to support comprehensive action was taken by the organisation to mitigate risk of potential injury to other residents and/or staff. This and other findings also demonstrated an absence of learning from incidents that occurred in the centre as required by regulation 26(1)(d).

While staff told inspectors what actions they would take in the event of an emergency including a medical emergency, the documentation advising on this was inadequate. This insufficient information poses a significant risk as inspectors found that staff not directly employed by the provider were contracted to work in the centre and continuity

of core staffing levels was not consistently maintained.

There was evidence of fire drills at night and during the day including reference to residents who delayed in evacuating. Personal evacuation risk assessments detailed the arrangements in place to address this in the event of evacuation being required. The record of the staff participation in fire drills was unclear and therefore it was not possible to conclude that staffing levels were adequate to ensure residents could be safely evacuated. The training records referenced that all staff with the exception of two staff not directly employed by the provider had attended annual fire training for 2015. An email to management was viewed by inspectors scheduling training for both these staff members. The designated fire exit through the front door of the centre was observed to be partially obstructed for a short period due to placement of residents' assistive equipment.

**Judgment:**
Non Compliant - Moderate

**Outcome 08: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

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

**Findings:**
Inspectors observed staff engaging with residents and found that interactions were respectful and supportive throughout the day of this inspection.

On the last inspection in May 2015, safeguarding mechanisms had not been adequately implemented, such as comprehensive assessments and plans of care. Inspectors found that the implementation of recommendations from an investigation report requested by the Authority were in progress, however had not been completed to date. This included developing a meaningful day for residents, however inspectors found on this follow-up inspection that this was not yet been achieved for three residents.

However, on this inspection a further incident of unexplained bruising recorded in one resident’s documentation was not comprehensively investigated and followed-up by management at an organisational level as advised by the safeguarding policy in place.

Two staff had not attended protection of vulnerable adult training however, inspectors viewed an email evidencing that this training was scheduled for October 2015.

As stated in Outcome 1, procedures were reviewed and implemented to ensure residents finances were appropriately protected and managed.

While positive behavioural support plans were developed for residents with challenging behaviours, there was limited evidence of comprehensive review undertaken of ongoing repeated episodes of these behaviours. Two thirds of staff had attended training on management of actual or potential aggression and on behavioural support planning as evidenced by the staff training records. This finding did not provide evidence that all staff had the skills to meet residents' assessed needs. This finding is also discussed further in outcome 17.

Residents' personal information was observed to be stored in an open shed exterior to the centre.

**Judgment:**
Non Compliant - Major

**Outcome 10. General Welfare and Development**
*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

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

**Findings:**
The assessment and provision of day services to meet the activation/developmental and lifelong learning needs of three residents in the centre had not been substantially progressed since the first inspection of the centre in November 2014.

The opportunities for residents to part-take in activities were limited.

Two of the five residents living in the centre were facilitated to attend a structured day service five days per week. One of the two residents attended a formal day programme and had work experience increased from one to three days each week since the last inspection. As stated in Outcome 1, inspectors observed that the opportunities for residents to part-take in activities outside the centre were limited and were generally facilitated as a group. Art therapy and reflexology was provided once each week in the centre on a 1:1 basis. Inspectors found that this aspect of care required improvement to

ensure the activation needs of three residents in particular were met and their right to develop their strengths and individual abilities was ensured.

**Judgment:**
Non Compliant - Moderate

**Outcome 11. Healthcare Needs**
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

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

**Findings:**
There was evidence to support residents healthcare needs were identified with treatment plans to address these needs.

Inspectors reviewed a sample of residents' care plan documentation and found that healthcare needs of residents identified as requiring improvement on the last inspection in May 2015 had been progressed. A resident who did not have timely investigations completed in relation to a healthcare issue on the last inspection in May 2015 was found on this inspection to have had investigations completed with a treatment plan in place. An accredited pain management assessment tool was made available but was not being used, as advised in the provider response to this action following the last inspection.

There had been improvements in the management of epilepsy but the interventions were not sufficient and further improvements were required.

The daily meal menu was displayed in written and pictorial format. The food provided for the evening meal as observed by inspectors was nutritious. Food and fluid consistency was modified for two residents with swallowing deficits as recommended by the speech and language therapist. Three residents went out to a local hotel for their lunchtime meal on the day of inspection.

Residents requiring assistance with eating received help from staff discretely and sensitively. While a record of residents' intake was recorded, it did not contain sufficient detail. Inspectors also found that a record of the food prepared for residents' meals was not recorded to facilitate assessment. During the last inspection, the provider advised inspectors that a dietician was scheduled to advise staff on nutritional assessment using an accredited tool, menu planning and to assess the nutritional value of current menus to ensure residents were provided with a balanced diet. Residents' documentation reviewed confirmed this was completed. The staff training records confirmed that all

with the exception of two staff members had received training on use of the Malnutrition Universal Screening Tool (MUST). Approximately 50% of staff had completed food hygiene training and 25% had completed dysphagia (difficulty with swallowing) training. The policy informing management of residents' nutritional needs did not reflect all areas of practice. This finding is discussed in outcome 18.

Residents' weights were recorded monthly and there were no residents with documented evidence of unintentional weight loss. A resident who used a treadmill to support them with exercising in their previous placement accessed this equipment in day services as the designated centre did not have suitable space for same.

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
As found on the last inspection in May 2015 and repeated on this inspection, the medication management policy was dated 2010 and required review. The person in charge told inspectors that the policy was undergoing review at regional level and would be implemented when circulated. The person in charge advised inspectors that care staff had completed training on medication administration and had not commenced administering medications to date.

The inspector viewed a medication audit completed by the pharmacist and arrangements were in place for the pharmacist to visit residents. Some medications had been changed to liquid preparations for two residents with assessed swallowing deficits.

However, the inspectors found that the medication crushing unit was soiled and contained medication residue from previous tablet crushing undertaken. This posed a risk to residents in relation to medication dosage or inadvertent administration of residue from another resident's prescription.

A registered nurse was intermittently rostered on duty at night in the centre as referenced by the duty rota. The centre had a policy in place where medication was administered by a registered nurse only. As there was two care staff rostered on duty each night as a core staffing level, there was an arrangement where a nurse with a support role administered medication to residents in the centre and a centre next door.

While there was no further evidence of delayed medication administration incidents, this arrangement did not ensure adequate medication administration procedures and depended on registered nurse availability. .

**Judgment:**
Non Compliant - Moderate

**Outcome 13: Statement of Purpose**
*There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The registered provider submitted an updated Statement of Purpose to the Chief Inspector as part of the application to register the designated centre under the Health Act 2007 on 22 September 2015. Inspectors reviewed the document and found whilst it contained the items as stipulated by Schedule 1 of the regulations, the information contained was not accurate or reflective of practice. For example, the objective of the organisation as to nourish education, empowerment, and 'recreational and educational supports are provided through staff within the home and day service'. The findings of this inspection did not adequately evidence that this occurred in practice for some residents.

The person in charge input was not on a full-time basis and required review.

**Judgment:**
Substantially Compliant

**Outcome 14: Governance and Management**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The governance and management arrangements were not adequate in the designated centre. The Authority was advised that the person in charge was absent for greater than 28 days from 21 April 2015. A person in charge from another centre in the service commenced in the role of the management of the this and another designated centre two weeks previous to the registration inspection in May 2015.

While the designated centre was found to be in major non-compliance with the legislation in a number of areas as described in this report, there was evidence found reflecting some areas of improvements made since the last inspection. The improvements enhanced the quality of life of residents in this short time period with the leadership of the current person in charge overseeing the service. However, there was no confirmation that the centre would be resourced with a robust management structure going forward. The person in charge, a staff nurse and carers spoken with on the days of inspection demonstrated their commitment to meeting residents' needs and supporting the person in charge to bring the centre into compliance with the legislation.

The duty rota confirmed the person in charge attended the centre three to four days each week for varying periods of time. However due to the on-going significant non-compliance with the regulations as found on this inspection, inspectors confirmed this arrangement was not adequate to ensure the needs of residents were met and the centre was in compliance with the legislation as required.

Findings supported insufficient resourcing of the centre to ensure the effective delivery of care and support in accordance with the statement of purpose and contracts of care. An adequate system was not in place to effectively and comprehensively monitor quality and safety and quality of life of residents in the centre. Some audits were completed; however they did not positively influence improvement in some practices and procedures. Management systems in place in the centre did not support sufficient assurances that the service provided is safe, appropriate to residents' needs and consistent and effectively monitored as suitable measures had not been taken or put in place to address or control risks identified and associated with a lack of nursing staff.

The procedure for obtaining staff for the centre completed by the person in charge was via an allocations officer. Inspectors were told and confirmed by review of the staff rota since July 2015; that in some instances there was an absence of staff availability and in some instances the allocations office was unable to provide the skill mix required to meet the assessed needs of residents. In this regard the person in charge did not have the necessary authority and autonomy to manage the service and was not sufficiently resourced to ensure the effective governance, operational management and

administration of the designated centre or address deficiencies that negatively impacted on residents' general welfare and development needs and aspirations.

There was ongoing evidence of a failure to recognise the rights of some residents to have access to opportunities and supports to maximize their personal development and quality of life. Provision of suitable supports such as day care provision requires immediate action. There was evidence of inadequate systems in place to supervise and manage staff performance.

The provider had completed an investigation, external to the centre into unexplained bruising as requested by the Authority however some of the recommendations had not been implemented and therefore did not safeguard residents. The findings to support actual and potential negative outcomes for residents in terms of their safety care and quality of life is described in the inspection findings throughout this report.
The cumulative findings of this report evidenced weak governance and management arrangements.

**Judgment:**
Non Compliant - Major

**Outcome 15: Absence of the person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Leadership, Governance and Management

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

**Findings:**
As discussed in outcome 14, the person in charge was not working in a full-time role. The inspectors found that adequate deputising arrangements were not in place. Inspectors were told that the person deputising for the person in charge was a staff nurse. Two staff nurses were identified in the statement of purpose as persons deputising in the absence of the person in charge. However, a notification and associated documentation was not received by the Authority referencing this arrangement as required by regulation 23.

Inspectors were informed that the registered nurse on duty is responsible for the day to day operations in the centre however, as the staff nurse on duty was regularly not directed employed by the provider, this arrangement was not satisfactory.
Give the cumulative findings of this inspection there is a requirement for a permanent, full time person in charge to be assigned to this centre with suitable deputising arrangements for absences.

**Judgment:**
Non Compliant - Moderate

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

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

**Findings:**
Inspectors found that the designated centre was not resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

The centre did not have a full-time person in charge or adequate deputising arrangements in place.

Inspectors found that there were not adequate staffing resources to ensure the effective delivery of care and support to residents in accordance with the centre's statement of purpose. This finding compromised residents' social care and access to scheduled activities. The centres transport could only accommodate one resident in a wheelchair. Inspectors confirmed two residents used wheelchairs.

Some residents did not have access to adequate developmental/educational and lifelong learning opportunities. There was evidence that one resident moved from an unsuitable placement to a similar placement in this designated centre. The records confirmed on the inspection in May 2015 that this resident has expressed their dissatisfaction with this placement to staff and to inspectors on the days of that inspection. While there was evidence of some action taken to locate accommodation to meet this residents needs, the resource needs of this resident had not been assessed in relation to same.

The centre premises did not meet its stated purpose as discussed in outcome 6. This finding is discussed further in outcome 6 and was identified in an action plan following the last inspection of the centre in May 2015.

**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:**
As discussed in previous outcomes in this report, the findings on this inspection did not ensure that staffing levels and skill mix was appropriate to meet the needs of residents in accordance with the statement of purpose and function and regulation 15 (1).

The staffing resource for the centre depended on non-permanent staff to replace four staff positions. This did not always lead to residents receiving continuity of care and support.

A staff nurse and two care staff were rostered on duty each day and two care staff were rostered on duty each night as core staffing levels for the centre. A staff nurse was also rostered on night duty at other times but this arrangement varied from night to night and week to week. Inspectors were told that the staff nurse rostered in the designated centre or the centre next door administers night medications to residents as part of their role.

However, there were a number of instances where the core compliment of staff was not provided as per the centres statement of purpose. Inspectors found two incidents recorded on the duty rotas reviewed where a staff nurse was not working in the centre for a 24hour period. Staff were also engaging in working additional hours beyond their contracted hours on an overtime basis. There were incidents recorded where core staffing was not maintained. This finding did not ensure effective staff rostered to consistently meet the assessed needs of residents in the centre and in accordance with statement of purpose and function.

Inspectors findings during the two previous inspections of the centre evidenced a need for additional supports and training to ensure residents' needs were appropriately met. Following the last inspection, the provider nominee committed to providing training for staff. The inspectors reviewed staff training provided and found that training was taking place but was not completed to date for all staff to ensure staff had the skills and knowledge to meet the needs of residents.

Further staff training was required to ensure the needs of residents with episodes of challenging behaviour, food hygiene and management of residents with swallowing difficulties were met.

Mandatory training requirements were not completed by all staff. Mandatory training was not completed by all staff in safe moving and handling, protection of vulnerable adults and annual fire training. The inspectors viewed emails from staff requesting to be scheduled for attendance at training in fire safety, protection of vulnerable adults and care planning.

No staff were recorded as having received training in pain management, which was required to meet the assessed needs of residents. As detailed in outcome 11 and 12.

Staff supervision and performance management arrangements were not adequate as the most senior member of staff on-duty was regularly contracted on a sesssional non-permanent basis.

Based on the deficits identified on this inspection, staff required additional support to ensure they had the skill set and competency to ensure positive outcomes for residents

**Judgment:**
Non Compliant - Major

**Outcome 18: Records and documentation**
*The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.*

**Theme:**
Use of Information

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

**Findings:**
Some policies as described throughout this report required review and updating or were not in place as required by schedule 5 of the regulations. For example the policy advising on admission, discharge, transfer and temporary absence and the medication policy required review to ensure they were up to date and informed evidence based practice.

| |
|---|
| Records were not maintained of the food provided for residents in sufficient detail to determine adequacy and special diets prepared for residents as required by schedule 4, paragraph 5. |
| **Judgment:**<br>Non Compliant - Moderate |

## Closing the Visit

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

**Acknowledgements**

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

***Report Compiled by:***

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

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**


**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0002471 |
| **Date of Inspection:** | 21 September 2015 |
| **Date of response:** | 14 October 2015 |

## Requirements

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

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

## Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre was not operated at all times in a way that respected the personal needs of one resident.

[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 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

**Please state the actions you have taken or are planning to take:**
The staff roster has been reviewed and the gender and skill mix is now appropriate to the assessed needs of all the residents.

This is monitored by the PIC and the PIIM based in the house.

**Proposed Timescale:** 23/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents were not afforded adequate freedom for choice in respect to some aspects of their daily lives.

**2. 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.

**Please state the actions you have taken or are planning to take:**
A formal day service has been accessed for three residents providing opportunities to engage in meaningful activities of their choice.

They will attend two days weekly to attend on a sessional basis.

Two residents currently have a full time placement with an outside provider.

**Proposed Timescale:** 23/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The privacy and personal space needs for residents accommodated in a twin room were not adequately met.

**3. 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:**
There is a proposal in place for one resident to transfer to another service provider at their own request. This will then ensure every resident has their own bedroom and private space. A number of options have already y been explored but have not been suitable to meet her needs to date. A number of other options continue to be explored. These options are being explored in conjunction with the resident and their family

**Proposed Timescale:** 31/12/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not consistently facilitated to participate in activities in accordance with their interests, capacities and developmental needs.

**4. Action Required:**
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

**Please state the actions you have taken or are planning to take:**
A formal day service has been arranged for three residents which will provide opportunities for them to engage in meaningful activities of their choice. They will be able to attend two days weekly on sessional basis.

Two residents have an individual day service with an outside service provider. Opportunities are created from their home each day in line with their interests, capacities and developmental needs.

There are planned activities and experiences when the residents are not attending their day service which incorporates their likes and dislikes through trying new opportunities, through this we can identify appropriate and meaningful activities.

**Proposed Timescale:** 23/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was an absence of adequate evidence to confirm residents were supported to become familiar with the content of the complaint procedure in the folder.

**5. Action Required:**
Under Regulation 34 (1) (b) you are required to: Ensure that each resident and their family are made aware of the complaints procedure as soon as is practicable after admission.

**Please state the actions you have taken or are planning to take:**
The Complaints Procedure and content has been discussed at the residents' meeting using the Accessible Format on 11th October 2015 and will continue as a regular item on the agenda at all future residents' meetings.

**Proposed Timescale:** 23/10/2015

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As found on the last inspection, inspectors observed that there was no documentation to determine if residents experienced positive outcomes from participation in an accredited sensory based communication programme or when its' implementation would be completed.

**6. Action Required:**
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

**Please state the actions you have taken or are planning to take:**
A TacPac programme has been introduced to the residents by the Speech and Language Therapist on a trial basis. This was subsequently found to be unsuitable for the residents' needs. The Speech and Language Therapist is currently trialling a new sensory aid with one resident. We will continue to identify appropriate communication systems for the residents.

**Proposed Timescale:** 30/12/2015

**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents did not have meaningful involvement in the local community outside of their usual activities.

**7. Action Required:**
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

**Please state the actions you have taken or are planning to take:**
Sample trialling of clubs is underway in the local community including library, GAA clubs, horse riding, and bingo. This should promote the identification of individual preferences of residents.

**Proposed Timescale:** 30/12/2015

**Outcome 04: Admissions and Contract for the Provision of Services**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The admission policy document did not advise on procedures and practices to protect residents from abuse by their peers.

**8. Action Required:**
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

**Please state the actions you have taken or are planning to take:**
The Admission Policy is being reviewed with a view to including a resident compatibility and associated risks if they are identified. The next Policy Review Group Meeting will develop this policy to protect residents from peer abuse.

**Proposed Timescale:** 30/12/2015

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Goal-setting for residents who did not have access to a formal day programme did not consistently focus on developing their strengths and individual abilities.

Resources required to meet a resident's goal of moving to new accommodation were not assessed

**9. Action Required:**
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

**Please state the actions you have taken or are planning to take:**
All residents have a care plan and person-centred plan in place and they have all been reviewed with the residents and their families.

All staff are to receive Person-Centred Planning Training which includes development of individual goals and the implementation of them for the residents. Skill building is to be developed for each resident.

A resident's goal of moving to new accommodation is actively being supported.

Currently we are exploring new experiences in our local community; through this we will be able to discover each resident's preferences and likes/dislikes.

**Proposed Timescale:** 15/12/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design and layout of the centre did not meet its stated purpose in terms of:
- A twin bedroom in the centre did not adequately meet the needs of the two residents residing in it.
- There was an absence of suitable storage for residents' assistive equipment.
- The circulation areas in the centre did not meet the needs of residents.

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

**Please state the actions you have taken or are planning to take:**
One of the residents has been assessed for more suitable accommodation outside of the designated centre. This is being actively sought.

Alternative storage arrangement for residents' assistive equipment has been put in place.

**Proposed Timescale:** 29/01/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre was not in a good state of repair due to;
- large cracks in a wall on the corridor and in the wall behind a resident's bed in the

twin room
- a pier on entering the designated centre site was broken and at risk of falling over
- wood around door-frames and skirting boards were scored by equipment passing on the corridor.

The maintenance process was not adequate.

**11. Action Required:**
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

**Please state the actions you have taken or are planning to take:**
A schedule of work required has been agreed with the Maintenance Department and works will commence during November.

**Proposed Timescale:** 30/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Handrails were not fitted in circulation areas.

**12. Action Required:**
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

**Please state the actions you have taken or are planning to take:**
MDT involvement has been request to ensure that the application of hand rails will not impinge on the mobility of any wheelchair resident.

**Proposed Timescale:** 30/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents' accessibility needs were not adequately met in the following areas;
- inadequate access to a garden pagoda
- access for one resident was significantly hindered by an absence of handrails in circulation areas.

**13. Action Required:**
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required

alterations to the premises of the designated centre to ensure it is accessible to all.

**Please state the actions you have taken or are planning to take:**
A risk assessment has been carried out and control measures have been put in place.

Maintenance work has drawn up a schedule of works and this should be complete by December 2015

**Proposed Timescale:** 30/12/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all hazards within the designated centre were assessed with concomitant controls to mitigate risks identified.

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

**Please state the actions you have taken or are planning to take:**
The Risk Register was updated to include any unidentified risks in the centre.
The Risk Register will be reviewed and updated on a regular basis

**Proposed Timescale:** 23/10/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate systems were not in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**15. 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:**
A new emergency plan is now in place that outlines the measures to take in the event of an emergency.

The Risk Assessments have been reviewed and senior cover roster is available in designated centre.

**Proposed Timescale:** 23/10/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Designated fire exits were not kept clear at all times.

**16. Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
All exist are now clear and are being monitored by daily checks.

All staff have reviewed the Fire Safety Policy in relation to leaving fire exit doors clear at all times.

A ceiling hoist has been ordered for bedroom and bathroom, this will ensure extra space and prevent fire exits being blocked by mobile hoists.

**Proposed Timescale:** 30/12/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff did not have training in challenging behavioural management and positive behavioural support.

**17. Action Required:**
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

**Please state the actions you have taken or are planning to take:**
A plan has been drawn up with the behavioural support team to implement all outstanding training

**Proposed Timescale:** 31/12/2015

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Incidents of unexplained bruising had not been adequately investigated to ensure residents' safeguarding needs were adequately met.

**18. Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
A Preliminary Screening was conducted the allegation of unexplained Bruising identified at the time of inspection. The risks identified are being addressed and ongoing risk assessment is being carried out.

In future a Preliminary Screening will be conducted by into any allegation of unexplained Bruising. The outcome will be addressed immediately following this.

**Proposed Timescale:** 30/11/2015

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The assessment and provision of day services to meet the activation/developmental and lifelong learning needs of three residents in the centre had not been a progressed since the first inspection of the centre in November 2014.

The opportunities for residents to part-take in activities were limited and were generally facilitated as a group which did not ensure residents had access to activities that met their individual interests and capabilities.

**19. Action Required:**
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

**Please state the actions you have taken or are planning to take:**
A formal day service has been accessed for five residents providing opportunities to engage in meaningful activities of their choice. Two residents attend five days weekly with an outside organisation and three residents attend twice weekly on a sessional basis. We will continue to review residents' ongoing daily activity and educational requirements.

**Proposed Timescale:** 23/10/2015

## Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The need for specialist medical review was not adequately assessed for the management of epilepsy.

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

**Please state the actions you have taken or are planning to take:**
The resident in question has an appointment with the Specialist in Neurology in December 2015. His needs have being assessed and reviewed by the local GP.

**Proposed Timescale:** 30/12/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents' pain medication as prescribed was not informed by an accredited assessment and monitoring tool.

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

**Please state the actions you have taken or are planning to take:**
The Nurse Practice Development Officer is presently sourcing alternative pain assessment and monitoring tools and will work with the Centre in identifying the most appropriate tool.

**Proposed Timescale:** 30/11/2015

## Outcome 12. Medication Management

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspectors found that the medication crushing unit was soiled and contained medication residue.

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

**Please state the actions you have taken or are planning to take:**
A new medication crusher has been purchased and is in use. It has individual once only use bags that ensure safe practice with no cross contamination.

All Nurses have completed medication management training

**Proposed Timescale:** 23/10/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Arrangement in place did not ensure adequate medication administration procedures as depended on registered nurse availability.

**23. 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:**
Arrangements are in place to ensure that the medication needs of the residents are met in a timely fashion on a daily basis. Nursing resources are available to ensure compliance

**Proposed Timescale:** 23/10/2015

## Outcome 13: Statement of Purpose

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some areas of the statement of purpose required review.

**24. Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose has been reviewed and submitted to the Regulatory body.

**Proposed Timescale:** 23/10/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not a permanent, full-time person in charge in the centre.

**25. 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:**
The Deputy Person Participating in management in the designated centre has progressed through national recruitment will become a permanent staff member in November.

The staff member, Person Participating in Management is supported by a Person in Charge.

The Person in charge has been allocated Administrative time to manage the Designated Centre.

**Proposed Timescale:** 23/10/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An adequate system was not in place to effectively and comprehensively monitor quality and safety and quality of life of residents in the centre.

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

**Please state the actions you have taken or are planning to take:**
Formal staff supervision sessions have now commenced in the designated centre. Centre.

a schedule of audits has been drawn up the governance team and are due to be carried out an audit in the designated centre in November.

**Proposed Timescale:** 30/11/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Actions were not taken at an organisational level to address vacant staff posts. Effective performance management procedures were not in place for staff.

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

**Please state the actions you have taken or are planning to take:**
The Supervision policy has been finalised and formal supervision has commenced with staff.

National Recruitment has commenced filling vacant posts.

A Staff Nurse from this recruitment panel will commence duty on 2nd November in the Designated Centre.

**Proposed Timescale:** 30/11/2015

**Outcome 15: Absence of the person in charge**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspectors found that adequate deputising arrangements were not in place for the person in charge.

**28. Action Required:**
Under Regulation 33 (2) (a) you are required to: Give notice in writing to the Chief Inspector of the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.

**Please state the actions you have taken or are planning to take:**
A Deputy/Person Participating in Management has been identified for the Centre and the required documentation will be forwarded to Registration.

**Proposed Timescale:** 30/10/2015

## Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The designated centre was not adequately resourced to meet the needs of residents in accordance with the centres statement of purpose.

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

**Please state the actions you have taken or are planning to take:**
A deputy PIC has been identified.

National Recruitment have recruited a Nurse who will commence working in the Designated Centre. 2/11/2015.

Another nurse has been appointed to the another house in designated centre which will facilitate the PIC in managing two houses (24/11/2015)

**Proposed Timescale:** 30/12/2015

## Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Review of staffing arrangements is required to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**30. Action Required:**
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
A Staff training schedule has been drawn up by the Person in Charge.

This will meet the assessed needs of the residents.

The recording of the scheduled duties has identified the shift patterns of the regular staff.

The gender and skill mix is appropriate to the assessed needs of the residents.

This is monitored by the PIC and the PIIM based in the house.

**Proposed Timescale:** 23/10/2015

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were 24 hr periods where a staff nurse was not rostered on the duty rota to meet residents needs.

**31. Action Required:**
Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

**Please state the actions you have taken or are planning to take:**
A Staff Nurse will be rostered daily in the designated centre to meet the needs of the residents.

A Staff Nurse has been recruited by the National Recruitment centre and will commence working in the Designated Centre.

**Proposed Timescale:** 02/11/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff had not attended training, including refresher training, as part of their continuous professional development to meet the needs of residents.

Some staff had not fulfilled mandatory training requirements.

**32. 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:**
Two staff who had not attended Fire Training have completed this training on 14th October 2015. All staff now.All staff will receive refresher training in Safeguarding the Vulnerable Person.

**Proposed Timescale:** 14/12/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Arrangements were not consistently in place to ensure staff were appropriately supervised.

There was no arrangement in place for performance management of staff.

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

**Please state the actions you have taken or are planning to take:**
The Person Participating in Management has been recruited as a full-time member of staff. Formal staff supervision policy has been developed. Supervision has commenced in the designated centre.

**Proposed Timescale:** 30/10/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some policies as described throughout this report required review and updating or were not in place as required by schedule 5 of the regulations.

**34. Action Required:**
Under Regulation 04 (2) you are required to: Make the written policies and procedures as set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 available to staff.

**Please state the actions you have taken or are planning to take:**
The Medication Policy has been reviewed and is in draft format and is ready to sign off. The Dietician is currently working with staff developing a Nutrition Policy.

While all scheduled policies were available to all staff they are in need of review. They are currently being reviewed by the Policy group and will be re- circulated to all staff.

**Proposed Timescale:** 30/12/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records were not maintained of the food provided for residents in sufficient detail to determine adequacy and special diets prepared for residents as required by schedule 4, paragraph 5.

**35. Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

**Please state the actions you have taken or are planning to take:**
A Community Dietician has been seconded to work with and support staff in the designated centre with daily menu planning, to determine adequacy, and special diets and to develop a local policy on nutrition with the Nurse Practice Development Officer.

**Proposed Timescale:** 30/12/2015