

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Centre A1
Centre ID:	OSV-0005386
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Suzanne Corcoran
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Announced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
25 July 2016 10:00	25 July 2016 19:50
26 July 2016 08:15	26 July 2016 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection.

This was the second inspection of this designated centre. At the last inspection the centre had been part of a larger centre however, due to a reconfiguration of the larger centre the provider had submitted an application to register this as a standalone centre. The purpose of this inspection was to follow up on actions from the inspection carried out in the larger centre in June 2014 and to inform a registration decision.

Description of the Service

This centre is operated by Peamount Healthcare and is situated on a campus based setting in County Dublin. It comprises of five units and provides care to male residents with intellectual disabilities who require additional supports in areas such as: mobility, behaviours that challenge, dementia care and medical needs. Nursing supports are available on a twenty four hour basis.

How we gathered evidence.

Over the course of this inspection, inspectors met all of the residents living in the centre with the exception of two residents. One of these residents was at home on holidays and the other resident was out when inspectors visited the unit on two occasions. Two residents asked to meet with the inspectors and a number of other residents met informally with inspectors. Some of the residents were unable to express their views on the quality of services in the centre but inspectors observed mealtimes, reviewed personal plans and observed interactions between staff and residents. The person in charge was available throughout the inspection.

In addition two staff were met and documents were reviewed including risk assessments, staff rosters and financial records. Five residents' questionnaires were completed, some of which were completed on an individual basis and some were completed collectively by the residents in particular units. Three family questionnaires were received. The findings from the questionnaires are outlined in the report.

Overall judgment of our findings.

Inspectors found that a number of the actions from the last inspection had not been implemented to a satisfactory level as highlighted in the report. Significant failings were found in 14 of the outcomes inspected against which would require significant improvements in order to meet the requirements of the regulations.

Major non compliances were found in nine of the 18 outcomes inspected against. These included Outcome 4, admissions and contracts of care, Outcome 5, social care needs, Outcome 7, health and safety and risk management, Outcome 8, safe guarding, Outcome 9, Notifications, Outcome 13, statement of purpose, Outcome 14, governance and management, Outcome 17, workforce and Outcome 18, documentation.

Inspectors found that residents' social care needs were not being met in the centre. This was impacted by inadequate staffing levels in the centre, which was also impacting on the provision of safe services for residents. The provider was contacted on the second day of the inspection around issues identified at the inspection regarding inadequate staffing levels in the centre and assurances were provided to inspectors that this issue would be addressed that day.

There were inadequate arrangements in place around risk management and fire management systems in the centre. Restrictive practices used in the centre had not been notified to HIQA and were not being reviewed in line with best practice.

The governance and management of the centre did not ensure that the services provided met the identified needs of the residents in a safe and consistent manner.

The quality and safety of care and support was not monitored on an ongoing basis by the provider and the person in charge. The person in charge was not involved in the operational management of the centre on an ongoing and consistent basis due other responsibilities in the service.

The statement of purpose did not contain the details required under the regulations, and a substantial amount of policies and procedures were either not in place or had not been reviewed. In addition the contracts of care did not clearly outline the services to be provided and the fees to be charged. Inspectors also found that the fees charged were having a negative impact on some residents in the centre.

Moderate non compliances were found in of the four of outcomes inspected against. These included Outcome 1, resident's rights, Outcome 2 communication, Outcome 12 medication management and Outcome 6 premises.

Good practice was identified in the provision of healthcare and residents' healthcare needs were appropriately met in a timely manner. Staff were also observed to treat residents with dignity and respect and were very caring in their approach.

The action plan at the end of this report addresses the improvements required.

The provider attended a meeting in HIQA's Dublin office following the inspection to discuss the findings of this inspection and provide reassurances to HIQA that the actions identified would be implemented.

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:

Overall inspectors found that the actions from the previous inspection had not been fully implemented and improvements were required in relation to resident's finances and upholding residents' rights in the centre.

Since the last inspection the provider had undertaken to review the finance policy and introduce contracts of care for all residents. Inspectors found that the residents finance policy had been reviewed and residents had a contract of care in place, however some aspects of the finance policy were in conflict to the information contained in the contracts of care. For example the policy stated that the provider would supply equipment/ aids as appropriate to care while the contract of care stated that equipment/aids were supplied under the medical card scheme.

In addition some of the information contained in the policy was not respecting residents' rights. For example it stated in the policy that requests from family members to withdraw funds from residents' monies for their own personal use should be made to the assistant director of health and social care. This was not respecting residents' rights. Inspectors acknowledge that the finance policy was being reviewed by the provider and was due to be completed by the end of August 2016.

Inspectors found that residents had their own bank account managed for them by Peamount Healthcare administration department. Staff then supported residents to access funds from this account for recreational use and this money was managed at unit level by staff. However, residents' finances in two of the units were stored in another

unit.

Samples of residents' financial records were viewed and inspectors found that a new recording system had recently been implemented at unit level. However, improvements were required in this area as it was not clear what the transactions were for and the management of receipts was disorganised and therefore records were not clear.

Residents were consulted about how the centre was run. For example monthly meetings were held. A review of the minutes of these meetings found that a range of topics were discussed including: weekly menus, furniture purchased for the centre, complaints and residents rights.

There was a complaints policy in place that was in an accessible format for residents. Inspectors viewed the complaints register for the centre and found that there was one open complaint on file since April 2015. There were no records available to indicate whether this had been followed up with the complainant and the issue had not been followed up in a timely manner.

Some residents stated in the residents questionnaires and one resident spoken with stated that did that they did not like some of the food provided in the centre, in particular the options available for suppers. Family members stated in their questionnaires and residents spoken with stated that they would make a complaint to staff if they had any issues. One family member stated in the questionnaire that they would like to see improvements in day activities for their family members, the quality of clothing provided and improved access to some allied health professionals.

Staff members were observed to treat residents with dignity and respect and there were some measures in place to respect resident's privacy. For example intimate care plans were in place for all residents and some residents had keys to their own bedrooms.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that residents had communication plans contained in their personal plans. However, improvements were required in the implementation of some

communication plans and residents' access to the internet in the centre.

There was a policy on communication with residents available in the centre. Inspectors viewed a sample of communication plans and found that they contained details of residents' ability to communicate, ways in which they liked to communicate and their likes and dislikes. Inspectors saw where some interventions were implemented into practice.

For example, one resident had a visual plan for an activity that they had planned on the second day of the inspection. This was very important to the resident and inspectors were able to engage with the resident using the visual plan. Another resident went through their communication plan with inspectors. This was called 'all about me' and detailed the residents' likes and dislikes, their goals for the year and people important to them in their lives.

However some plans did not contain enough detail so as to guide staff practice and enhance the communication skills already learned by residents. For example, some residents who used Lamh signs did not have the signs that they knew highlighted in their plans. In addition one plan stated that a resident was learning new Lamh signs; however, staff spoken with were not aware of this and staff had not received training/guidance in this area.

Residents had access to televisions and radio, one resident was observed reading the paper by inspectors. However, residents did not have access to the internet in the centre.

Judgment:

Non Compliant - Moderate

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that there was a visitor's policy in place in the centre and residents had regular contact with family members. However, improvements were required in resident's links with their community and the visitor's policy.

Inspectors found the visitor's policy in place required some improvements in that it did not safeguard residents in the centre. This is outlined under Outcome 8 of this report.

Residents had their own bedrooms and there was space available in the centre to meet family and friends. Residents had regular contact with family members and some resident visited family on a regular basis for holidays and weekend visits.

Family members stated that in their questionnaires that overall they were happy with the services provided, one family member commented on staff being 'excellent in the centre' and spoke about a recent birthday celebration they had attended for their family member.

Inspectors found that residents had limited access to the community and this is outlined under a number of other outcomes in this report.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that residents had a written agreement in place. However, improvements were required in the admissions policy, contracts of care and residents fees in the centre.

Residents had a written agreement in place; however, they were not all signed by the resident or a representative where appropriate. Inspectors acknowledge that there were records to show that the provider had written to family members about signing the contracts of care on behalf of residents where appropriate. In addition the agreements did not include the fees to be charged, details of additional charges and it did not fully outline the services to be provided.

Inspectors also found that the fees charged to residents were not in line with the national guidelines on charges for inpatient services which were specifically referenced in the contract of care. Inspectors found that this was having an impact on some residents in the centre.

For example inspectors viewed some residents' financial records and found that one resident had 11 euro left for personal use each week once all fees and additional fees were paid. Personal use items for this resident included social outings and clothing for

the year. This was discussed at the feedback meeting and the provider agreed to undertake a review of this.

In addition some residents' finances were being used to pay for additional staff supports from an external agency provider. Inspectors found that these fees were substantial and were informed that these staff supported residents to achieve social care activities. This service was not outlined in the contract of care or the statement of purpose for the centre.

There was no admission policy in place in the centre that included transfers, discharges and the temporary absence of residents. Inspectors were given a copy of a transition policy that had been formulated to guide the transition of residents to a more independent setting in the community. However, it did not include the transition of residents between campus based centres.

Judgment:

Non Compliant - Major

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 all of the actions from the last inspection had been implemented. However, one still required improvement and significant improvements were needed to ensure that residents social care needs were being met.

Since the last inspection the provider had undertaken to ensure that assessments of need were inclusive of all residents needs. From the sample viewed by inspectors this had been implemented. A further requirement from the last inspection was that a more robust system to review personal plans needed to be implemented. Inspectors found that this had not been implemented to a satisfactory level.

While residents now had an annual review completed that included members of the

multi disciplinary team, inspectors looked at one annual review and found that this review was not meaningful. For example there were pre set items on the agenda. One item listed included 'living environment', there was no discussion recorded around this. In addition at the opening meeting inspectors were informed that family members did not attend annual reviews for residents and it was not clear from the meetings if residents were involved in the process.

One family member stated in their questionnaire that they were not aware that their family member had a personal plan in place.

Some residents attended a day service and others chose not to, inspectors acknowledged that this was some resident's choice however; there were limited activities available to these residents during the day. For example inspectors observed staff engaged in household duties for most of the time inspectors were in one unit even though three residents were present with no activities scheduled for the day. One resident spoken with stated that there was nothing to do during the day.

Goals had been developed for some residents that were meaningful. For example some residents had goals set for the year that included going on a holiday and attending a concert. However, some goals were not meaningful in that one resident's goal was to go for a walk and inspectors found that this was part of their daily routine anyway.

In addition some goals outlined for residents were not implemented. For example on assessment stated that a resident liked to attend Mass every Saturday; however, on review of records for the last two months, the resident had only attended once. Another resident's personal plan stated that they liked to go out for coffee and to the cinema. Inspectors found from a review of six months activity records for this resident, that they had been to the cinema once and apart from visits home had left the complex 9 times in a six month period. In addition financial records for two residents over a two month period showed that these residents had not spent any money on recreational activities in a two month period with the exception of a takeaway.

One resident had skills teaching programme in place and this was done in pictorial format however, there was no records to show that this was implemented with the resident and there was no review in place to assess the effectiveness of the skills teaching programme for the resident.

Judgment:

Non Compliant - Major

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:

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that the design and layout of the centre was suitable for its stated purpose and to meet the current needs of the residents living there. However, improvements were required in the general maintenance and upkeep of the centre.

The design and layout of the centre was not reflected in the statement of purpose for the centre. The provider subsequently submitted revised plans prior to the report being completed.

The centre was divided into five units. Three of the units accommodated five residents, one unit accommodated six and the other unit was a self contained apartment for one resident. All residents had their own bedrooms that were personalised and there was adequate storage for residents' belongings. Two residents requested that inspectors did not enter their bedroom and their wishes were respected.

A bedroom in one of the units was small, although it had sufficient storage facilities there was not enough room for the bedside locker beside the bed. However, inspectors spoke to this resident and they stated that they were happy with their room and liked living in the unit.

There was a kitchen in each unit equipped with cooking facilities, where small meals could be prepared as the main meals were delivered to each unit from a larger kitchen on the complex.

There were adequate shower and toilet facilities in the centres. One unit in the centre was having renovation works to one toilet and a shower room on the day of the inspection. However, some of the shower areas in the centre were used to store mobility aids as there were no alternative storage areas.

Residents' clothes were laundered in an external laundry. Some of the units had washing machines that residents could use to launder their clothes if they wished. However, one resident told inspectors that the washing machine in the unit they lived in had been broken for the last month and had only been fixed. Staff also confirmed this.

Residents had access to some assistive devices including handrails and walk in shower facilities in some areas. In addition inspectors were informed at the feedback meeting that the provider was intending to have reconfiguration work completed in the centre to make the units more wheelchair accessible. The provider intended to meet the Board of Management in order to secure funding for this. No residents were currently affected by this as there were no wheelchair users however, the provider was responding to the age demographic in the centre.

The units were for the most part clean; however, considerable maintenance work was

required in the units with regard to paintwork, floor coverings and general upkeep of the centre. The provider was aware of these issues and stated that this work was on hold as there was major renovation works planned for the units.

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:

Overall inspectors found that some of the actions from the previous inspection had not been fully implemented and significant improvements were required to ensure that the health and safety of residents was protected in the centre.

As part of the action plan from the last inspection the provider had undertaken to ensure that all staff received training on risk assessments and attended additional fire training on the use of fire extinguishers. Inspectors found that staff had not completed risk assessment training and seven staff had not completed the additional fire safety training.

In addition the provider had undertaken to ensure to develop fire evacuation plans and that a fire consultant report would be completed. While a fire report had been completed for the campus and a fire evacuation plan was now in place inspectors were not assured that effective fire management systems were in place.

Failings identified included:

- there were no fire doors in the centre in order to contain fire, specifically around the kitchen area
- the recommendations from fire drills were not implemented. For example the fire drill records stated that fire drills should be increased for residents who may not respond to fire drills however, only one fire drill was taking place in the centre every year
- there were no measures in place around how residents who were left unsupervised in units should be evacuated from the unit in an emergency
- there was no evidence that fire drills had been completed at night time
- emergency exits in three areas of the centre did not open properly and were therefore not accessible to residents with mobility aids. This was rectified by the provider on the first day of the inspection
- some residents did not have appropriate measures in place to alert them in the event

of a fire. For example residents who had hearing impairments
- information contained in personal emergency evacuation plans was not consistent. For example one section stated that verbal prompts were needed while the next section stated that a wheelchair was required.

Suitable fire equipment was provided in the centre. The maintenance records for the equipment were stored in the maintenance department. Inspectors found on viewing these that they had been serviced appropriately.

There was an up to date risk management policy in place. This had been an action from the last inspection. A health and safety statement for the service was also available that outlined risks associated with the service. However, while there was a risk register maintained in the centre, it only included a record of risks associated with incidents that had already occurred in the centre and did not include all other risks. For example manual handling, lone workers and slips trips and falls were not included on the risk register.

In addition there were no risk assessments in place for residents who remained unsupervised in the centre. For example one residents plan stated that close supervision of staff was required in terms of one assessed need however, this resident remained in the unit unsupervised for periods of time and this had not been risk assessed.

Inspectors reviewed a sample of incidents in the centre over the last six months and found that some incident report forms had a review page attached that included recommendations or additional control measures that were required. This review was completed by the behaviour specialist or the health and safety officer. However, inspectors found that control measures recommended were not consistently recorded in the relevant records.

For example one review stated that a behaviour support plan should be reviewed to include recommendations and that the risk register should be updated to include additional control measures. Inspectors found no records to confirm this and on speaking with staff the control measure in place was not consistent with what the recommendations stated. In addition incident report forms were not maintained in the centre and there was no evidence that trends were identified specific to this centre in order to inform learning and guide future practice.

Residents had smoking risk assessments where required that were appropriate to the residents needs. This had been an action from the last inspection.

There was an infection control policy in place and staff had received training in hand washing techniques. Training was also provided around infection control however, not all staff had completed this.

Judgment:
Non Compliant - Major

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:

Overall inspectors found that the action from the last inspection had not been fully implemented and significant improvements were required in restrictive practices in the centre and some behaviour support plans. One action from the last inspection did not apply to this centre as this related to safeguarding one resident.

Since the last inspection the provider had undertaken to ensure that restrictive practices were applied in line with best practice. Inspectors found that while there was a restrictive practice policy in place, there were a number of restrictive practices used in the centre that had not been notified to HIQA and were not being reviewed in line with best practice. These practices included one unit's front door was locked for periods of time, door alarms were in place for some residents, bed alarms were in place for one resident, the kitchen door in one area of the centre was locked after a certain time in the evening, wardrobe doors were locked in one area and restrictive holds were recorded as an intervention on one residents plan.

Inspectors saw records of where one restrictive practice was been recorded in one of the units, however the records stated that one of the reasons for using this restrictive practice was when staffing levels were reduced in the centre. In addition there was no effective review of restrictive practices.

For example, inspectors became aware through reading a behaviour support plan that a number of restrictive practices were in place for one resident. Inspectors were informed by staff that this was reviewed at multidisciplinary meetings. A copy of the last minutes viewed by inspectors found that the records listed the restrictive practice, but the outcome stated 'on-going'. The details of any discussions around a review of these practices were not recorded and there was no record of any review of alternatives being tried.

There was a policy in place on safeguarding vulnerable adults in the centre. Staff spoken with were aware of the procedures to follow if an allegation of abuse was witnessed by them or reported to them. Residents spoken with said that they felt safe in the centre and would talk to staff if they did not feel safe. However six staff had not completed

safeguarding training.

In addition inspectors were not satisfied that one practice in the centre was safeguarding some residents. This related to the visitors policy on the front door of each unit which stated that visitors should ring the door bell and wait for a response, if there was no response they should enter the unit and look for a staff. However inspectors found that residents were sometimes left in the units unsupervised for periods of time and that visitors entering the unit could compromise residents' rights and safety on the unit.

There was a behaviour support policy in place; however, this was out of date. A number of staff had not completed training in this area. Inspectors found from a review of some behaviour support plans that some did not guide practice. For example one behaviour support plan stated that a staff should respond to a behaviour using a physical restraint, however staff informed inspectors that this was no longer used.

In addition the information contained in the behaviour support plans around the use of medications as part of a therapeutic response was not in line with the details contained in the medication protocol. For example one plan stated that if a resident was verbally abusive staff should consider administering medications as a therapeutic response, however the medication protocol did not state this. In another plan viewed there was no guidance on an intervention in place around behaviours for one resident. This was discussed at the feedback meeting.

Intimate care plans were in place that outlined whether a resident needed support in a certain area; however it did not detail how that support should be delivered.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that a copy of incidents that occurred in the centre were available to inspectors however, inspectors found from viewing records that a number of restrictive practices used in the centre were not being recorded as a restrictive practice and had not been notified to HIQA.

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):

No actions were required from the previous inspection.

Findings:

Overall inspectors found that residents had some opportunities for new experiences in the centre and there was evidence that some residents were involved in training however.

There was no policy on access to education, training and development in the centre.

Inspectors found that some residents were involved in day services where some training needs were provided. For example one resident spoke to inspectors about learning to use the computer and to play a musical instrument. Another resident had a job on the campus and another resident spoke to inspectors about woodwork classes that they attended in day services. Inspectors saw where one resident was learning some activities of daily living skills.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Overall inspectors found that residents' healthcare needs were being met and that the

actions from the last inspection did not relate to this designated centre.

Inspectors viewed a sample of personal plans and found that residents had health actions plan in place for their assessed health care needs. Staff spoken to about some of these action plans were knowledgeable about implementing them in to practice. The health action plans had been reviewed by nursing staff in the centre.

Residents had access to allied health professionals where appropriate and a GP attended the centre three times a week.

Meals were prepared and delivered to the units at meal times from a large kitchen on the campus, with the exception of breakfast which was prepared in the units. Cooked breakfasts were prepared by staff on the units on Saturday mornings and snacks were available on the unit for residents. Inspectors observed one meal being served for residents and found that residents were provided with two options for this meal and found that the food being served looked appetizing.

Guidelines were in place around the nutritional needs of residents and staff spoken to were knowledgeable about these.

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:

Overall inspectors found that one action had been implemented from the last inspection. However, the other actions had not been implemented in the centre to a satisfactory level.

Since the last inspection the provider had undertaken to review the medication policy and to ensure that non nursing staff received training in the administration of medication. The policy on medication management in the centre, that was made available to inspectors, related to another service area under Peamount. In addition only two non nursing staff had completed training in medication management; therefore the action regarding training had not been fully implemented.

The provider had also previously undertaken to ensure that all medications that required crushing were clearly written on prescription sheets and that the indications for use would be written for all as required (PRN) medications. Inspectors found that only one of these actions had been implemented as not all PRN medication had the indications for use outlined on the prescription sheet.

Inspectors observed practices in one unit and found that for the most part appropriate medication management systems were in place in relation to the administration and storage of medication. For example medications that required refrigeration were appropriately stored in the centre and there was a system in place for the disposal of unused or discontinued medication.

However, inspectors viewed a sample of prescription sheets and found some discrepancies noted in the sample viewed. This included:

- One resident who was prescribed a medication that had been due for review in 1 month had not been reviewed in the specified time frame
- One PRN medication prescribed did not have a clear dosage prescribed and staff spoken to were unclear about how much medication they would administer

Medications were supplied to the centre by a community pharmacy and could also be accessed through Peamount services own pharmacy.

There were no residents self medicating in the centre.

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):

No actions were required from the previous inspection.

Findings:

Overall inspectors found that there was a Statement of Purpose available in the centre; however, it did not include all of the details required under the regulations. The following areas need to be addressed.

- The specific care needs that the designated centre is intending to meet was not upholding residents rights to privacy as the care needs stated may identify specific

residents.

- The facilities provided in order to meet those needs required more detail
- The services which are to be provided in order to meet those needs required more detail
- The admission criteria for the centre was not included
- The gender age range and number of residents for whom it is intended that the accommodation should be provided was not clearly outlined.
- A description of the rooms in the designated centre including the room sizes and specific function was incorrect
- The arrangements for residents to attend religious services of their choice was not detailed as it only included one religious faith.
- The whole time equivalents employed in the centre were not correct.
- The arrangements in place for reviewing personal plans was not found in practice.
- Details of any specific therapeutics techniques used in the centre and the arrangements made for their supervision was not included
- The arrangements in place to deal with residents social activities in the centre only detailed activities from the day services.
- The arrangements for residents to access education, training and employment was not detailed enough.
- The fire precautions in place were not evidenced in practice. For example it stated that routine fire drills are carried out. Fire drills were only completed once a year in the centre.
- The complaints procedure did not outline how complaints were dealt with. For example it stated that the complaints officer only dealt with serious complaints that were highlighted from satisfaction surveys.

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

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found effective management systems were not in place so as to ensure that the quality of care was monitored on an on going basis in the centre in

order to provide a safe quality service for residents. Significant failings were identified at this inspection in relation to residents social care needs not being met, ineffective risk management and fire safety systems in place, staffing arrangements in the centre and ineffective safeguarding measures in place around the use of restrictive practices in the centre.

Inspectors met with the person in charge and found that they were suitably qualified, had considerable experience of working in the service and had a good knowledge of the residents' needs in the centre. However, inspectors found that the person in charge was not engaged in the governance and management of the centre on a regular and consistent basis due to other responsibilities assigned to them in the organisation.

The person in charge had overall responsibility for the provision of services for the campus and another community service provided by Peamount on a daily basis. In addition they were also the person in charge for another designated centre attached to this service. While the person in charge was supported in their role by a clinical nurse manager in the designated centre, inspectors found that neither of them had any protected time so as to ensure effective governance of the centre.

There was a defined management reporting structure in place. The person in charge reported to a director of services who in turn reported to the provider nominee. The person in charge met with the director of services, however this meeting took place to discuss all of the other centres in Peamount and there was no formal structure in place to discuss this specific centre.

A copy of one unannounced quality and safety review carried out in May 2016 was made available to inspectors. The review contained some recommendations; however, it was unclear what the recommendations were based on as the document did not detail the findings from the review.

An annual review of the quality and safety of care had not been completed not been completed in accordance with the requirements of the regulations.

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):

This was the centre's first inspection by the Authority.

Findings:

Inspectors were satisfied that the person in charge had not been absent from the designated centre for more than 28 days. There were satisfactory arrangements in place to cover any absences of the person in charge and the provider was aware of the requirements to notify HIQA in the event of the person in charge being absent.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

No actions were required from the previous inspection.

Findings:

Overall inspectors found that there was an appropriate skill mix in the centre to meet residents' needs.

Inspectors found that staff resources had recently been reviewed by the provider and in response, staffing levels had been increased in one area of the centre in order to meet residents assessed needs.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

implemented.

Findings:

Overall inspectors found that the one of the actions from the previous inspection had not been implemented and that significant improvements were required in relation to staffing levels provided in the centre, personnel files and staff training.

Since the last inspection the provider had undertaken to ensure adequate supervision of agency and permanent staff in the centre. Inspectors found that while there was still a considerable amount of agency staff employed in the centre. The provider was currently in the process of recruiting a relief panel for the centre in order to address this. In addition the provider had introduced an induction process for agency staff, that was completed when they commenced a shift in order to familiarise themselves with the centre.

Staff supervision had commenced in the centre for permanent staff. To date three staff had this completed and records viewed showed that actions were identified and followed up.

The provider had also undertaken to ensure that there was an adequate number of staff in place to ensure that all residents' needs were met. As already outlined in this report inspectors found that residents social care needs were not being met in the centre in some cases.

The provider had recently increased staffing levels at night in one unit of the centre. This was in response to a number of risks identified to them around some residents who were not supervised in the centre at night. However, inspectors found that there were times during the day and night where some residents in the centre were still left unsupervised. During these times a staff from an adjoining unit would go in at intervals to supervise residents.

Inspectors were not satisfied that appropriate measures had been put in place to ensure residents were safe in the centre during these times. For example one resident had a falls alarm in place, the control measures outlined, that staff should attend to the resident when the alarm sounds however, this was not possible if staff were supervising other areas of the centre.

In response to this inspectors spoke to the provider over the phone on the second day of the inspection to highlight their concerns and the provider assured inspectors, that additional staffing would be employed at night time and during the day until risks were assessed and appropriate control measures were in place to ensure residents were safe in the centre.

There was a planned and actual roster maintained in the centre.

Only some staff had completed mandatory training and some staff had not received specific training in order to meet residents assessed needs. For example only a number of staff had received training in the management of diabetes and dementia and staff had not received training on stoma care.

Inspectors found that there was a policy on the recruitment, selection and vetting of staff however, this was out of date. A sample of staff files were viewed by inspectors and some of them did not include all the details as set out in the regulations. Some files only contained one reference, there was no garda vetting on file for one staff and a record of the current registration status of nursing staff was not contained in files.

Staff meetings were being held once a week in the centre however his practice had only recently commenced and only one representative from each area attended these. Inspectors viewed the minutes from the last two meetings held and found that there was no action plans developed from them.

Inspectors were informed that there were no volunteers employed in the centre.

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):

No actions were required from the previous inspection.

Findings:

Overall inspectors found that a number of the policies required by Schedule 5 of the regulations were not maintained in the centre and some of the information set out in Schedule 4 of the regulations was not stored in the centre.

Inspectors viewed the policies and procedures as per schedule 5 of the regulations and found that:

- The safeguarding policy was out of date
- The medication policy relevant to the designated centre was not available
- The recruitment and selection policy was out of date.
- There was no policy on access to education training and development for residents.
- The policy on the provision of information for residents was not dated.
- The policy on behaviours that challenge was out of date.

- The policy on the creation of access to, retention of, maintenance of and destruction of records was incomplete as it did not include creation and access to records in the policy.

In addition inspectors found that some records as required under Schedule 4 of the regulations were not maintained in the centre. These included:

- Complaints register.
- A copy of Incident report forms.
- A record of when a resident was discharged, transferred, or was not in residing in the centre.

There was a resident's guide and a directory of residents available to inspectors. An insurance certificate for the designated centre was given to inspectors on the first day of the 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:

Anna Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Peamount Healthcare
Centre ID:	OSV-0005386
Date of Inspection:	25 and 26 July 2016
Date of response:	18 November 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:

Information contained in the finance policy was not respecting residents' rights.

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,

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

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:

1. The revised policy on the Management of Service users Monies is being amended to uphold the individual's rights and to clearly guide and improve practice.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

Theme: Individualised Supports and Care

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

Residents financial records maintained on the units required more detail around the recording of expenditures and the management of receipts.

2. Action Required:

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

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

1. A new system will be put in place to aid clearer transparency between individual resident's ledger submissions/transactions and their receipting records.
2. All transaction and correlating receipts will be numbered as per ledger recording and stored in a separate monthly envelope.
3. Regular auditing of the records will take place by the Person in Charge and Finance Department to ensure that recording of expenditure and receipts are in line with the policy.

Proposed Timescale: 1. 12 September 2016
2. 12 September, 2016
3. Ongoing

Proposed Timescale: 12/09/2016

Theme: Individualised Supports and Care

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

There were no records to show whether one complaint had been followed up with the complainant.

The complaint had not been addressed in a timely manner.

3. Action Required:

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

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

1. All complaints will be logged and actioned by the Person in Charge/Clinical Nurse Manager 1 in a timely manner. These will be forwarded on to the Complaints Officer as per Complaints Policy.
2. Complaint logged, relating to refurbishment being addressed.

Proposed Timescale: 1. Ongoing
2. 31 December, 2016

Proposed Timescale: 31/12/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Residents did not have access to the internet in the centre.

4. Action Required:

Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

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

1. A request has been forwarded to the IT Dept. to install internet access.

Proposed Timescale: 19/09/2016

Theme: Individualised Supports and Care

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

Some residents' communication interventions were not implemented into practice.

5. 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:

1. A Review of the Individual's Communication Passport as mentioned in report, has taken place and the missing flashcards have been inserted in his communication Passport.
2. Speech and Language Therapy Department have provided training to the Staff supporting this resident in use of these flashcards.

Proposed Timescale: 1. Complete
2. Complete

Proposed Timescale: 18/11/2016

Theme: Individualised Supports and Care

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

Staff were not aware of a residents plan to learn Lamh signs.

Staff had not received training in the use of Lamh signs.

6. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

1. A review has taken place of the Communication Passport by the Speech and Language Therapist in order to guide Staff practice, September 2016.
2. The new Communication Passport identifies two key words commands, using visual cues, such as real objects, pictures or gestures to aid comprehension for the resident.
3. As a result of this review there is no staff training requirement in the use of LAMH.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The contracts of care did not clearly set out the services provided, the fees to be charged and any additional fees.

The fees charged to residents were not as stated in the contract of care

The fees charged and additional fees were having a significant financial impact on some residents in the centre.

Some residents in the centre were being charged significant amounts for external agency staff employed in the centre. This was not detailed in their contract of care.

7. Action Required:

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

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

1. The Contract of Care will be amended to include the support, care and welfare of the resident, and will detail the services being provided and the fees to be charged.
2. This revised contract will be discussed with each individual resident and/or their representative and signed with their agreement.
3. There has been a review of the significant impact on one resident, and this has been addressed. The Organisation now pay for his transport costs.
4. Peamount Healthcare is meeting the assessed social care needs of the identified residents within its existing resources.
5. Peamount Healthcare has commissioned an external body to carry out a workforce analysis to determine staffing levels required to meet all assessed needs.
6. Where personal assistants are contracted in by a residents this is done with the consent of the resident and their families. It is discussed and decided on through the MDT process under the heading of Meaningful Activities and Community Participation.
7. The cost of contracting personal assistants is identified on each individual Contract of Care.
8. A Policy and procedure on the use of Personal Assistants and the process on sourcing and review of same will be devised.

Proposed Timescale: 1. 30 September 2016

2. 30 November 2016

3. Complete

4. Complete and ongoing

5. 30 November, 2016

6. & 7. Complete

8. 31 December, 2016

Proposed Timescale: 01/12/2016

Theme: Effective Services

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

There was no admission policy in place in the centre.

8. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

1. An Admissions Policy will be developed, outlining the admission criteria, the discharge from one designated centre and admission to another designated in accordance with the Statement of Purpose.
2. Transition plans will be developed for each resident transferring from one designated centre to another to include their wishes, needs and the safety to other residents in the centre.

Proposed Timescale: 1. 30 September 2016
2. Ongoing

Proposed Timescale: 30/09/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

Some residents social care needs were not being met in the centre.

9. Action Required:

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

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

A wider range of suitable arrangements will be put in place following:

1. Assessment of resident's social care needs and the development of plans to meet these needs
2. Following the commissioning and completion of a third party independent review of staffing structures, levels and skill mix of the Centre.

Proposed Timescale: 31/01/2017

Theme: Effective Services

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

Residents' annual reviews did not include family members.

It was not clear from the records if residents had participated in the review.

10. 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. The Annual Review preparation and arrangement of meetings is centred around the resident and their involvement in same, through the use of their 'Personal and Social Care Needs Assessment' and action plan completion.
2. When the resident's Annual Review meeting is due to take place, an invitation letter on behalf of the resident will be forwarded to their family with their consent. The purpose of this invitation is to encourage active participation by both the resident and their family in planning for the goals, achievements, wishes for the resident for the year ahead.
3. The first Annual Review meeting for the Centre is scheduled for this week and the remaining residents to have their meeting prior to the end of the year.
4. If the key worker has not received a response on whether the family is attending or not, the Person in Charge/Clinical Nurse Manager 1 will follow up with a phone call.
5. All Annual Review meetings will encompass attendance of the resident, their family, key worker and Named Nurse and /or PIC.

Proposed Timescale: 1. Complete . 2. Complete & Ongoing 3. Ongoing
4. Ongoing 5. Ongoing

Proposed Timescale: 18/11/2016

Theme: Effective Services

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

The minutes from the annual review did not detail any discussion around items discussed or whether recommendations/ changes were required.

11. 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. The Minutes from Residents' annual reviews will detail discussions held and whether recommendations / changes are required with regard to each aspect of the review.

Proposed Timescale: 30 September 2016 and ongoing

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

One skills teaching programme for a resident did not have a review system in place in order to assess the effectiveness of the programme.

12. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

1. A review with Resident and Key worker will take place on this programme and its current effectiveness
2. Implementation of any changes required as per advice of Occupational Therapist and other relevant training staff.

Proposed Timescale: 19/09/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Parts of the units in the centre were poorly maintained and required updating, for example, with regard to paintwork.

13. 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 full refurbishment of the Centre, addressing all safety features shortfall and maintenance issues, is planned in the short term.

Proposed Timescale: 30/11/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk register did not include all risks in the centre.

Incidents were not effectively reviewed and the recommendations from reviews were not implemented consistently.

There were no risk assessments in place around residents who remained unsupervised in the centre.

Staff had not received training in risk assessments.

There was no review of incidents in the centre; that identified trends in order to inform learning and future practice.

14. 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 risk register for the Centre has been updated.
2. New risk assessments are currently being developed and old risk assessments reviewed and changed as necessary or in accordance of the Risk Management Plan.
3. A number of Staff have availed of the Risk Assessment Training held over the past two weeks and the remainder will be scheduled to attend over the next few weeks.
4. Weekly reviews as part of the weekly Staff meeting to inform learning for the Staff.
5. A system for Responding to Emergencies will be developed in conjunction with the Person in Charge, Risk Manager and Fire Officer.

Proposed Timescale: 1. Complete

2. Ongoing

3. 30 September, 2016

4. Ongoing

5. 30 September, 2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

- There were no fire doors in the centre in order to contain fire, specifically around the kitchen area

- The recommendations from fire drills were not implemented.

- There were no measures in place around how residents who were left unsupervised in units should be evacuated from the unit in an emergency
- There was no evidence that fire drills had been completed at night time
- Some residents did not have appropriate measures in place to alert them in the event of a fire. For example residents who had a hearing impairment
- Information contained in personal emergency evacuation plans was not consistent.

15. Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

1. Fire Doors will be provided in all bungalows of the Centre.
2. Individual Fire Evacuation Plans have been reviewed and adjusted. No unsupervised areas in the centre, all areas have 24 hours staffing.
3. A night time fire Drill has taken place and the learning outcomes from this passed on to both residents and Staff.
4. Resident with a hearing impairment evacuated in a timely manner, a new flash card indicating fire has been sourced.
5. All fire drill information in the fire evacuation plans is now consistent.

- Proposed Timescale:
1. 30 November, 2016
 2. Complete
 3. 5 September, 2016
 4. Complete
 5. Complete

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Seven staff had not completed fire training on the use of fire extinguishers.

16. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape

routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

One Staff member left to complete fire training.

Proposed Timescale: 14/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some behaviour support plans did not guide practice.

The details of one intervention for a resident was not recorded in their personal plan.

17. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

1. All Behaviour Support plans have been reviewed and now guide practice.
2. All Staff will receive training in the Positive Management of Violence and Aggression.

Proposed Timescale: 1.Complete and ongoing
2. 30 November, 2016

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Restrictive practices were not applied in accordance with best practice in the centre.

18. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

1. All restrictive practices have been reviewed and now guide best practice.
2. All restrictive practices are reviewed by the Multi Disciplinary Team on a quarterly basis or as required.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 18/11/2016

Theme: Safe Services

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

Restrictive practices were not being recorded or reviewed in the centre.

19. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

1. All restrictive practices are now recorded on the weekly Service user Monitoring Form.
2. All restrictive practices within the Centre are reviewed by the Multi Disciplinary Team on a quarterly basis or as required and recommendations enacted.
3. All restrictive practices are identified on the HIQA Quarterly Report.

Proposed Timescale: 1. Complete and ongoing
2. Ongoing
3. Ongoing

Proposed Timescale: 18/11/2016

Theme: Safe Services

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

Some staff had not completed training on the management of behaviours that change.

20. 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:

All Staff will receive training in the Positive Management of Violence and Aggression.
Proposed Timescale: 30 November, 2016

Proposed Timescale: 30/11/2016

Theme: Safe Services

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

Not all staff had completed training in safeguarding vulnerable adults.

21. 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:

All Staff have now completed their training in Safeguarding of the Vulnerable Adult.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

Theme: Safe Services

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

Intimate care plans required more detail.

22. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

Intimate Care plans are now in place outlining in more detail best practice in the provision of intimate care for each resident.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

Theme: Safe Services

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

The visitor's policy was not safeguarding residents in the centre.

23. 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:

The Visitor's policy has been reviewed to ensure the safety of all residents.
All notices at entrance points to resident's homes to be re evaluated to endorse this.

Proposed Timescale: 1. Complete
2. Complete

Proposed Timescale: 18/11/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

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

A number of restrictive practices were being used in the centre that had not been notified to HIQA.

24. Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

These restrictive practices are now detailed on the weekly Service Users Monitoring sheet and on have been notified on the Quarterly Report.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 18/11/2016

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:

One resident who was prescribed a medication that had been due for review in 1 month had not been reviewed in the specified time frame.

- One PRN (as required) medication prescribed did not have a clear dosage prescribed and staff spoken to were unclear about how much medication they would administer.

- There were no indications for use on two PRN medications prescribed.

25. 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:

All Residents medications are reviewed six monthly or as needed.

PRN protocols now have drug use indication and dosages are clear.

Individual resident's medication review is completed.

Individual resident drug prescription discrepancy has been corrected

Proposed Timescale: 1. Complete and ongoing

2. Complete and ongoing

3. Complete and ongoing

4. Complete

Proposed Timescale: 18/11/2016

Theme: Health and Development

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

The medication policy made available to inspectors related to another service area in Peamount.

26. 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:

The Medication Policy is currently being revised and a new policy will be implemented on the 30th September 2016.

Proposed Timescale: 30/09/2016

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:

The statement of purpose did not contain all of the details required under the regulations, the details of which are outlined in the report.

27. 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:

A full Statement of Purpose, including all elements as laid out in the HIQA Guidance Document is in place

The Statement of Purpose has been updated to include all of the details required by the Regulations.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

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:

The person in charge was not engaged in the governance and management of the centre on a regular and consistent basis due to other responsibilities in the service.

The person in charge had no protected time available, so as to ensure effective governance of the centre.

28. Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The Person in Charge is now actively involved in the governance and management of the Centre and is supported by a Clinical Nurse Manager 1 and a nursing structure. This facilitates protected time to ensure oversight of quality of care and services. The level of protected time is dictated by service need and will be kept under stringent monthly review between the Person in Charge and their Line Manager to ensure that the Person in Charge has sufficient protected time to carry out the duties of their role.

Proposed Timescale: Complete and ongoing

Proposed Timescale: 18/11/2016

Theme: Leadership, Governance and Management

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

There was no annual review completed for the centre.

29. Action Required:

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

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

An annual review of quality and safety of care will be completed.

Proposed Timescale: 30/09/2016

Theme: Leadership, Governance and Management

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

Management systems in place were not effective so as to ensure that the quality of care was monitored consistently to ensure that residents received a safe quality service in the centre.

30. 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:

1. The Person in Charge, Clinical Nurse Manager¹ and the nursing structure are in place.
2. This new staffing arrangement will ensure there is management of risk, fire safety systems, safeguarding measures are in place and ensuring the residents social care needs are met.
3. Monthly staff meetings to take place or as required, action plans to enhance the service delivery will be devised and implemented.
4. A work force analysis is to be completed by an external agency on the Centre and this will guide future Staffing levels and skills mix.

- Proposed Timescale: 1. Complete and ongoing
2. Complete and ongoing
3. Complete and ongoing
4. 31 January, 2017

Proposed Timescale: 31/01/2017

Outcome 16: Use of Resources

Theme: Use of Resources

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

Residents were paying for external staff to support them in meeting their social care needs.

Residents had limited access to transport in the centre.

31. 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:

1. A number of residents have chosen to contract in Personal Assistants on a weekly basis to facilitate additional outings, as per their choice.
2. This is identified in the individual resident's Contract of Care.
3. This has been discussed and decided on with the resident, their Next of Kin and Multi Disciplinary Team.
4. Residents have access to transport provided by the Organisation, in the absence of this, a taxi service is provided.

- Proposed Timescale: 1. Complete and ongoing
2. Ongoing
3. Complete and ongoing
4. Ongoing

Proposed Timescale: 18/11/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The number of staff needed to be reviewed in order to meet residents' assessed needs in the centre.

32. 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 full work force analysis is been undertaken in the Intellectual Disability Service by an external agency this will determine staff structures, levels, and skill mix to be commissioned.

1. Two whole time equivalent Healthcare Assistants have been added to the previous Staffing quota since August, 2016.
2. A third party (independent external) review of staffing structures, levels and skill mix will be commissioned.

Proposed Timescale: 1. Complete
2. 31 January, 2017

Proposed Timescale: 31/01/2017

Theme: Responsive Workforce

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

Personnel files did not contain all of the records required under Schedule 2 of the regulations.

33. 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:

All Human Resource personnel files have been reviewed and the relevant documents are now in place.

Proposed Timescale: Complete

Proposed Timescale: 18/11/2016

Theme: Responsive Workforce

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

Staff had not received training in order to meet the assessed needs of residents in the centre.

34. 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. A review of the assessed needs of residents to take place involving keyworkers and the MDT. Clinical Nurse Specialist in the Older Person Service and Management of Behaviours will be available also to contribute to this learning process
2. Any deficits in training to be addressed by the Person in Charge by arranging training programmes for the Staff.

Proposed Timescale: 1. 30 September, 2016

2. 30 September 2016 and ongoing

Proposed Timescale: 30/09/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

There was no policy on access to education training and development for residents.

The policy on the creation of access to, retention of, maintenance of and destruction of records was incomplete as it did not include creation and access to records in the policy.

The medication policy relevant to the designated centre was not available

35. 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:

1. Policy on Access to Education, Training and Development of Residents will be developed.
2. The Policy on the creation of Access to, Retention of, Maintenance of and Destruction of Records will be revised to ensure it will include creation and access to records.
3. The Medication Policy will be devised and will be held in the Centre.

Proposed Timescale: 1. 30 November, 2016

2. 30 November, 2016

3. 30 September, 2016

Proposed Timescale: 30/11/2016

Theme: Use of Information

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

The safeguarding policy was out of date

The recruitment and selection policy was out of date

The policy on behaviours that challenge was out of date.

The policy on the provision of information for residents had no implementation date

36. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

All policies forwarded to the Policy Development Group and relevant Depts. For updating.

1. The Safeguarding Policy will be reviewed and revised.
2. The Policy on Behaviours that Challenge will be reviewed and revised.
3. The Recruitment and Selection Policy will be reviewed and revised.
4. The Policy on the Provision of Information for Residents has been revised and an implementation date inserted in the document.

Proposed Timescale: 1. 30 November,2016
2. 30 November, 2016
3. 30 November, 2016

Proposed Timescale: 30/11/2016

Theme: Use of Information

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

Some of the records required under Schedule 4 of the regulations were not maintained in the centre. These included:

Complaints records

Incident report forms

A record of when a resident was discharged, transferred, or was not in residing in the centre.

37. 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:

All named records are now maintained in the Centre.

Proposed Timescale: Complete.

Proposed Timescale: 18/11/2016