

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Hillview B
Centre ID:	OSV-0001516
Centre county:	Clare
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Peter Bradley Foundation Limited
Provider Nominee:	Donnchadh Whelan
Lead inspector:	Anne Marie Byrne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	4
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 26 April 2017 09:10 To: 26 April 2017 17:30

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

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

Summary of findings from this inspection

Background to the inspection:

The purpose of this unannounced inspection was to monitor the centre's on-going regulatory compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres' for Persons (Children and Adults with Disabilities) Regulations 2013.

How we gathered our evidence:

The inspector met with four residents, four staff members, the team leader and the person in charge during the inspection. On the day of the inspection, all residents had opportunities to speak and meet with the inspector.

The inspector reviewed practices and documentation, including residents' personal plans, incidents, policies and procedures, fire management related documents and risk assessments.

Description of the service:

This centre is managed by the Peter Bradley Foundation Ltd and comprises of a purpose built four bedded house, which is 24 hours residential neuro-rehabilitation service. This service provides care to male and female residents between 18-65 years of age, who are living with a primary diagnosis of an acquired brain injury from road

traffic accidents, falls, assaults, stroke, brain haemorrhage, viral infections or anoxia. Residents may also have cognitive, physical, sensory or behavioural difficulties.

The person in charge has the overall responsibility for the centre. She is supported in her role by the team leader and by the national services manager. The person in charge holds both an administrative and operational role within the centre. The inspector met with a three staff on the staff of the inspection, who spoke respectfully of residents and were found to be very knowledgeable of residents' care and support needs. Overall, the inspector found the centre provided a warm, pleasant and homely environment for residents.

The centre is located in a village near Ennis, Co. Clare. It is a bungalow dwelling and each resident has their own bedroom with individual or shared en-suite facilities. The house has access to a garden space to the rear of building and communal areas to include kitchen, dining and living spaces.

Overall judgment of our findings:

Although this centre provided very individualised and person-centred care to the residents, a number of improvements were required from this inspection. The inspector found that the centre had implemented all measures from their previous action plan; however, not all of these measures were found to be effective.

This inspection identified that of the eight outcomes inspected, two outcomes were found to be compliant, one outcome found to be substantially compliant and three outcomes in moderate non-compliance. Two outcomes were found to be in major non-compliance relating to Health, Safety and Risk Management and workforce.

These findings are discussed further in the report and included in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Residents were consulted with, and participated in, decisions about their care and about the running of the centre. Residents had access to advocacy services as they wished. Each resident had opportunities to choose how they wanted to spend their time. Actions required from the previous inspection were found to be satisfactorily completed. However, further improvements were required to the recording of complaints.

Residents who spoke with the inspector said that they are regularly consulted in the operations of the centre. Regular residents' meetings were held and all residents were invited to attend. Minutes of these meetings were found to be accessible to all residents in the main communal areas of the centre.

Some residents' money was maintained by the centre. Each resident had their own account log book with the date of transactions and lodgements made, the current account balance and the names of the staff members who witnessed the accounts last activity. A monthly audit of residents' account books was being conducted by the team leader to identify any non-adherences to this recording system. A spot check of residents' account balances was completed by the inspector and the team leader on the day of the inspection, and all balances checked were found to be correct.

Since the last inspection, the complaints procedure was updated to include the independent person nominated to deal with complaints in the centre. The procedure was found to be displayed in the centre and complaints forms were readily available to residents, visitors and staff. The person in charge conducted a review each month of all complaints made. Although some complaints were still being managed by the person in

charge at the time of inspection, complaints which were recorded as being completed, did not include details of the complainant's satisfaction with the outcome of the complaint. In addition, not all complaints were recorded in line with the centre's complaints policy. For instance, where staff received complaints verbally from residents, some of these were recorded within residents' daily notes. The team leader informed the inspector that plans were in progress to increase staff awareness of the appropriate recording process for all complaints received. However, this had not yet commenced at the time of this inspection.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

Overall, residents' wellbeing and welfare was maintained to a high standard. Residents had opportunities to engage in regular activities outside of the centre and were supported by staff in doing so. There were no actions required from the centre's previous inspection. However, some improvements were required to the updating of residents' progression towards achieving their personal goals.

Each residents' health, personal and social care needs were fully assessed before admission and, a re-assessment of these needs was carried out on an annual basis. Residents had personal plans in place which detailed their individual needs and guided staff on how to support and care for residents each day. Residents were encouraged by staff to participate in the local community as much as possible. Some residents told the inspector that they hold part-time employment and are part of a local music group. Other residents told the inspector of how they are supported each week to go to the post office and to day-care services. The centre had access to a full-time vehicle which was used to bring residents on social outings, and residents were also supported to access local transport services to go to the nearest town. Some residents were assessed as requiring one-to-one staff support to engage in social activities, and the inspector found that adequate staffing levels were in place to support this.

Residents had personal goals in place and these were developed and reviewed with residents on an annual basis. Action plans were developed following these reviews, detailing the goal the residents' wished to achieve, the objectives of the goal and the timeframe in which progress towards the achievement of these goals was to be reviewed. A progress report was also developed by the centre to demonstrate the various objectives completed by residents for each of their identified goals. However, the inspector found some gaps in providing up-to-date information on the progress made by residents to achieve their personal goals. Furthermore, in some personal goal action plans, it was unclear who were the named persons responsible for supporting residents to achieve their goals.

There were no residents for transition to or from the centre at the time of this inspection.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

Residents, staff and visitors health and safety was promoted and protected within the centre. The centre had put measures in place to address the actions from the previous inspection; however, the inspector found these measures did not adequately address the action required. Further improvements were also required to fire safety, infection control and risk management practices.

The centre had risk management systems in place to manage both residents' specific risks and organisational risk. Residents had risk assessments in place and these were found to be reviewed on a three monthly basis. A risk register was also in place and this was regularly overseen by the team leader and the health and safety representative; however, the register did not always include when risks were last reviewed or next due for review. Risks were found to have severity ratings in place; however, it was unclear what control measures were in place to mitigate some risks identified. There was a risk management policy in place to support the risk management practices within the centre; however, the policy did not adequately guide on the measures and actions in place to control the risks identified.

The inspector observed that the use of door clasps was in place in the centre to manage the risk of residents' falls. The person in charge and the team leader informed the inspector that these were in place to support residents who were identified at high risk of falls, to safely mobilise around the centre. However, there were no arrangements in place to demonstrate the provider was adequately managing the risk these door clasps posed to the containment of fire. For example, fire drill records and fire procedures did not guide on the manual closing of these doors in the event of a fire.

The centre had fire precautions in place against the risk of fire in the centre. Fire fighting equipment and fire detection systems were regularly maintained, and zones were identified on the fire panel to guide on the location of fire. Emergency lighting was available internally and externally to safely guide towards the fire assembly point located at the front of the building. The fire procedure was displayed in the main hallway and this informed staff what to do and who to contact in the event of a fire. There were a number of fire doors in the centre, with each resident having their own personal fire exit in their bedroom. However, the inspector was unable to open one of the resident's personal fire doors on the day of the inspection. The inspector brought this to the attention of the team leader on the day of inspection.

Regular fire drills were taking place, and involved all residents and staff members. Residents told the inspector that they were involved in these drills and of their evacuation performance to date. However, the inspector found fire drills did not include all possible scenarios such as the evacuation of residents where minimum staffing levels were in place. Each resident had a personal emergency evacuation plan (PEEP) in place which informed on the level of support each resident would require in the event of an evacuation. Although PEEPs were reviewed on an annual basis, the inspector found they did not include information on the behavioural support or falls risk measures required by some residents in the event of an evacuation. Furthermore, not all staff had received up-to-date training in fire safety at the time of the inspection.

There were cleaning schedules in place for the centre which outlined the cleaning tasks to be completed by nominated staff members each day. However, these schedules did not guide staff on the cleaning arrangements for all bedrooms, with the inspector observing some surfaces in residents' bedrooms to be unclean. The team leader informed the inspector that the deep cleaning of residents' bedrooms currently occurred in an unstructured manner, but that plans were in place to introduce new cleaning procedures for the centre.

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):

No actions were required from the previous inspection.

Findings:

Measures to protect residents being harmed or suffering abuse were in place. There was a policy on, and procedures in place for the prevention, detection and response to abuse. No actions were required from the centre's previous inspection; however, improvements were required to the appropriate assessment of restrictive practices and to up-to-date staff training in safeguarding.

There were residents who presented with behaviour that challenges residing in the centre. Staff who spoke with the inspector were knowledgeable of residents' specific behaviours and of their responsibility in supporting these residents. Staff were supported in the management of these behaviours by a psychology team who were involved in the development and review of behavioural support plans. Behaviour recording charts were maintained by staff which detailed the circumstances surrounding residents' episodes of behaviour that challenges, and these were found to further inform the review of behaviour support plans. Low impact peer-on-peer incidents which had recently occurred, were under review by the team leader at the time of the inspection, and there were planned programmes in place to support residents. The inspector found that not all staff had received training in safeguarding

There were some doors locked for shared en-suites in the centre at the time of the inspection. Staff who spoke with the inspector informed that these locked doors were in place as a control measure to mitigate a specific resident's risk. However, there was no risk assessment in place to support the rationale for this restricted access or to guide staff on the appropriate application of locked doors in the centre.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents' assessed healthcare needs were met through timely access to health care services and appropriate treatment and therapies. The inspector found that residents had access to allied health care services which reflected their varied health care needs.

Each resident was observed to have a concise record pertaining to their previous and current health care needs. Documented accounts of interactions with various allied health professionals were maintained for all residents. Residents had a choice of General Practitioner (GP). Staff spoken to were knowledgeable of each resident's specific healthcare needs and demonstrated a clear understanding of their responsibilities in supporting residents with these needs.

The inspector reviewed a sample of personal plans for residents who presented with neurological healthcare needs. These personal plans were found to contain guidance to staff how to support these residents during a seizure event. Staff spoken with demonstrated a clear understanding of residents' specific indicators which alert staff that a possible seizure event may occur. Some residents were being supported with reduced calorie diets at the time of the inspection. Staff were found to further support these residents through regular weight monitoring and social support.

Residents were facilitated to develop the menu choices with their peers each week. Staff supported residents with their cooking skills, in accordance with their rehabilitation programmes. A large dining area was available for residents to use in the centre and residents were also encouraged and supported to dine out in the local town if they wished.

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):

No actions were required from the previous inspection.

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medications to residents. No actions were required for this outcome from the centre's previous inspection. However, some improvements were required to medication administration practices.

Each resident had a medication management plan in place which outlined residents' preferred method to take their medications. No residents were self-administering their own medications at the time of the inspection; however, risk assessments were completed to assess their suitability to take responsibility for their own medications. Staff completed a check system once a month to ensure that medications received from pharmacy were dispensed in accordance with residents' prescriptions. Staff who spoke with the inspector had a clear understanding of what incidents warranted reporting as a medication error to the team leader or person in charge. No residents were prescribed controlled drugs at the time of the inspection.

Medications were found to be stored securely within a locked cabinet. Blister pack compliance aids were in place which were clearly labelled with the name and photo of medications dispensed within the pack. Prescription sheets and medication administration records were found to be neatly maintained. Prescription sheets included the resident's photograph, outlined the name and address of the resident, name and address of GP, date of birth and any allergy related information. However, medication administration records reviewed by the inspector showed gaps where medications were not signed for by the administering staff members.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistently and effectively monitored. No actions were required from the centre's previous inspection; however, improvements were required to the completion of the annual review of the quality and safety of care in the centre.

The person in charge had the overall responsibility for the centre. The organisation had made some changes to its governance structure since the last inspection and the person in charge was now supported in her role by the team leader and by the national service manager. The person in charge visited the centre a number of times each week to meet

with staff and residents. The person in charge informed the inspector that she sometimes covered the roster for sick leave purposes, but held an administrative role all other times, to allow her to have sufficient oversight of the centre. The team leader and the person in charge met formally each week to discuss issues concerning the centre. The person in charge and national service manager held regular telephone meetings and had one-to-one meetings to discuss the operations of the centre. The person in charge informed the inspector that the revised governance structure has had a positive impact on the running of the centre and that it afforded her the capacity to fulfil the duties of her role. Regular staff meetings were held in the centre to ensure staff were maintained aware up-coming changes to practices. These meetings were attended by both the person in charge and the team leader for the centre.

The centre had a number of action plans in place which were developed from the findings of the last HIQA inspection report, six monthly provider unannounced visits and from internal audits. These action plans were reviewed by the inspector and were found to be completed within their specified timeframes. An annual review of the service was also completed.

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):

No actions were required from the previous inspection.

Findings:

Overall, residents received continuity of care through the monitoring of the centre's rostering practices. No actions were required from the centre's previous inspection findings. However, improvements were required to the maintenance of Schedule 2 documents and to the centre's staffing arrangements.

A planned and actual roster was in place for the centre which outlined the names of staff members on duty both day and night. Relief staff members were allocated to the centre as required and the inspector observed continuity in the rostering of these staff members. On the day of the inspection, the inspector found some staff members were rostered for night duty without having received adequate training in fire safety. This was brought to the attention of the person in charge who reviewed the night time roster on

the day of the inspection to ensure staff were not rostered for this shift until they had received training in fire safety.

The inspector noted that some residents had recently been reviewed by an allied health professional, who recommended that additional staffing arrangements be put in place to support residents assessed at high risk of falls. The person in charge informed the inspector that meetings were being held to propose a business case to be submitted to secure these additional staff hours. In the interim, the person in charge informed no interim staff support arrangement was in place to meet the assessed needs of these residents.

A sample of staff files were reviewed by the inspector and gaps were identified in the maintenance of Schedule 2 documents for all staff.

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:

Anne Marie Byrne
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 Peter Bradley Foundation Limited
Centre ID:	OSV-0001516
Date of Inspection:	26 April 2017
Date of response:	29 May 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The provider failed to ensure that:

- all complaints made were recorded in accordance with the centre's complaints recording process
- the complainants satisfaction level was recorded following the outcome of the complaint

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

1. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

All minor concerns will be forwarded to the PPIM and PIC and will be kept in the Complaints Folder.

The satisfaction outcome for the complainant will be detailed in the investigation outcome.

Proposed Timescale: Completed since 2.05.17

Proposed Timescale: 02/05/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

The provider failed to ensure that recorded recommendations arising out of each personal plan review included:

- up-to-date information on residents' progress towards achieving their personal goals
- the names of those responsible for supporting residents to pursue the objectives of their personal goals

2. Action Required:

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

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

The IRP Action Plan will refer to personal goals to state if they have been reviewed and Progress Report for updated information on goals, review/completed date and the staff that are supporting the Resident with their personal goals'.

The Goals and Progress Report will state the staff member supporting the Resident with their goals.

The PIC has completed a flow chart to show how the process works from the Initial Assessment, IRP action Plan, client/keyworker meetings, 3 monthly GPR and the Annual GPR, this will show where/how the goals are reviewed.

Proposed Timescale: Completed since 16.05.17

Proposed Timescale: 16/05/2017

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 provider failed to ensure that the risk management policy included the measures and actions in place to control the risks identified.

3. Action Required:

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

The Risk assessments will be reviewed and extra measures and controls will be identified in the Risk Management Assessment.

Proposed Timescale: Completed since 16.05.17

Proposed Timescale: 16/05/2017

Theme: Effective Services

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

The provider failed to put systems in place for the management and on-going review of risk to include:

- clarity on what control measures were in place to mitigate identified risks within the centre
- risk assessment of the use of door clasps in the centre to mitigate falls and its management in relation to fire containment
- the risk register did not guide on the date risks were last reviewed or when they were next due for review.

4. Action Required:

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

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

The door clasps are no longer in use in the house and all Residents have been assessed and are supported on opening the doors. The PIC has ordered door guards for both houses – 1 x double door in the corridor and 1 x single door to the kitchen, these are called the Shuttle and they work by learning the sounds from the fire alarm and then

automatically closing when the fire alarm sound goes off.

The Evacuation Procedure includes the closing of all fire doors and these are now ticked off as all fire doors in the house are closed until the door guards have been installed.

The PIC The Local Risk Register will identify all Local Risks with review dates and next date for review.

Proposed Timescale:

- Door clasps have been taken off since 27.04.17
- Risk Assessments carried out 27.04.17
- Door guards to be installed by 02.06.17
- Update report of installed door guards by 6.06.17

Proposed Timescale: 06/06/2017

Theme: Effective Services

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

The provider failed to ensure adequate cleaning arrangements were in place for the centre.

5. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

A Deep Cleaning schedule has been updated and to be signed of following a spontaneous Inspection to take place by the PPIM every week.

Proposed Timescale: Completed since 15.05.17

Proposed Timescale: 15/05/2017

Theme: Effective Services

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

The provider failed to put in place effective fire safety management systems in relation to:

- adequate arrangements to ensure the containment of fire would be adequately managed in the centre.
- maintenance of residents' personal fire doors to ensure they are accessible to

residents in the event of an evacuation

6. 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:

- All outside doors have been serviced by Munster Joinery 2.05.17 and all doors are accessible for all Residents.
- Fire and Emergency Evacuation plan (section 2 H+S Folder) has been updated to include behaviour and high falls risk management during an evacuation.
- Fire drills will include the closing of fire doors and going forward by installing smoke sensors.
- Fire drills are planned to cover different times, staff will simulate a night time evacuation and one staff member will carry out the evacuation.
- All staff fire training was completed 28.04.17.

Proposed Timescale: 24/05/2017

Theme: Effective Services

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

The provider failed to ensure residents' personal emergency evacuation plans (PEEPS) clearly guided on:

- arrangements in place to support residents with behaviours that challenge in the event of an evacuation
- arrangements in place to support residents identified as a high falls risk in the event of an evacuation.

7. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

For the Resident that has challenging behaviour clear guidelines have been put in place and all staff have been informed of proposed process of the updated PEEPS.

For Residents that have a high falls risk clear guidelines have been included in their PEEPS.

The Evacuation Point has been moved further so that there will be no interference for the fire and rescue service and that no-one will be in any danger from falling debris.

Proposed Timescale: Completed since 16.05.17

Proposed Timescale: 16/05/2017

Theme: Effective Services

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

The provider failed to ensure that fire drills included all possible fire scenarios at times of minimum staffing levels.

8. Action Required:

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

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

The Fire Evacuation Drill to be carried out in May will be completed with one member of staff and will simulate a night time scenario.

Proposed Timescale: 31/05/2017

Theme: Effective Services

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

The provider failed to ensure all staff had received up-to-date training in fire safety

9. 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:

All staff received fire training on 28.04.17.

Proposed Timescale: Completed since 28.04.17

Proposed Timescale: 28/04/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

The provider failed to ensure the implementation of environmental restrictive practices was supported by an appropriate assessment

10. 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:

Where another Resident cannot use the shared ensuite a risk assessment has been carried out in agreement with the Resident and PPIM. The agreement is to keep the ensuite bathroom door locked as part of the Safe Guarding Plan dated 25.07.16. The Restraint Register has been completed and filed accordingly to reflect the locked door.

Proposed Timescale: Completed since 16.05.17

Proposed Timescale: 16/05/2017

Outcome 12. Medication Management

Theme: Health and Development

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

The provider failed to put appropriate and suitable practices in place relating to the administration of medicines to ensure that medicine is administered as prescribed to the resident for whom it is prescribed.

11. 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:

The Drug Prescription Book is to be part of handover in the mornings and evenings, the staff on duty is to go through the medications and to ensure that it has been administered and signed.

Medication administration is on the Handover Staff Sheet to prompt staff to ensure that all Residents are administered their medications and that they are signed for by Staff.

Medication administration is included in the Staff Supervision, if there is no signature for medication administered the PIC or the PIMM will meet with that Staff Member within the week.

The PIC will do spot checks every week to ensure that all medications are being signed for.

Proposed Timescale: Completed since 2.05.17

Proposed Timescale: 02/05/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

The provider failed to ensure that all information as outlined in Schedule 2 of the regulations was maintained for all staff

12. Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

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

All Relief staff are to have a staff file with all relevant documentation.

Proposed Timescale: 26/05/2017

Theme: Responsive Workforce

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

The provider failed to ensure that the number of staff is appropriate to the assessed mobility needs of the residents.

13. 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:

The PIC has reviewed the rota and has increased the staffing level to meet the support needs for this Resident as outlined in the Occupational Therapists Report.

The PIC met with the HSE re Occupational Therapist Report and a business case is to be put in re higher staffing levels to support the Resident; this will be completed and emailed to the HSE by 26.05.17.

Proposed Timescale: Completed since 5.05.17

Proposed Timescale: 05/05/2017

