Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	The Comhar Centre
Centre ID:	OSV-0001816
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	St Joseph's Foundation
Provider Nominee:	Conor Counihan
Lead inspector:	Julie Hennessy
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
13 October 2016 08:00	13 October 2016 16:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
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:
This was the third inspection of this registered centre by the Health Information and Quality Authority (HIQA). The purpose of this inspection was to monitor on-going compliance with the regulations.

Brief description of the service:
The centre provides residential and respite accommodation for adults with an intellectual disability. Two of the beds in the centre were used at the weekend for respite purposes. The centre itself was a purpose-built spacious single-storey bungalow located in a quiet residential estate. Residents told the inspector that they liked the location as it's proximity to the nearby town meant that they could be easily facilitated to walk to and from their day service and into the nearby town. The house was spacious and bright and overall, in good condition. Residents were involved in maintaining the garden, outdoor area and plants.

How we gathered our evidence:
The inspector met briefly with or spoke with the six residents present on the day of the inspection, the seventh resident was away on holiday. The person in charge was on long-term leave at the time of the inspection and a social care leader was

deputizing in their absence. The social care leader facilitated the inspection and the inspector also met with other staff members during the day. The provider representative attended for periods of time over the course of the inspection. A nurse coordinator and area manger attended the feedback meeting at the close of the inspection. The inspector observed interactions between staff and residents and reviewed documentation including personal plans, audits, training records, fire-related and medication-related records.

Overall judgment of our findings:
Residents said that they felt safe in the centre and they knew who to talk to if they had a concern. Where residents had moved from another service, they told the inspector that they were delighted with this move. Staff were observed to support residents' expressed choices and preferences and to meet any support requirements. The provider representative was actively involved in the running of the centre and had put in place a range of auditing and oversight mechanisms.

However, Outcome 7 health safety and risk management was found to be at the level of major non-compliance for two reasons. First, it was not demonstrated that all residents could be evacuated and brought to a place of safety in the event of a fire. Second, information was not available in the centre to demonstrate that appropriate action had been taken following two significant incidents that had occurred in the centre in July 2016.

Other improvements were required in relation to medicines management, privacy arrangements and the approval of restrictive practices. Finally, the arrangements relating to the person in charge required review. These findings are outlined in the body of the report and required actions can be found in the action plan at the end of the report.

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

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

Theme:
Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Aspects of this outcome were inspected on foot of observations and findings by the inspector that related to privacy and dignity and opportunities for new experiences.

While support was provided in a way that respects residents' privacy, the inspector observed that there were two rectangular glass panels on bedroom doors that did not protect residents' right to privacy and dignity. A net curtain had been fitted to the upper panel, however, the inspector observed that one could see through this netting. In the majority of bedroom doors (six of seven), the lower glass panels were uncovered.

Residents accessed facilities in the local community, including the local library, café, church and attended events in the wider community, such as going to concerts, on day trips and overnight stays. A small number of examples were provided whereby residents regularly participated in activities in the community, such as in a choir and in work experience. Residents had access to a range of facilities, services and courses run by the service provider. These included arts and crafts, swimming, horse-riding, a gym, computers, life skills training. However, it was not demonstrated that the option to access such facilities, services and courses in the community had been explored with residents.

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

Findings:
The inspector reviewed a sample of residents personal plans.

At the previous inspection improvements were required to personal plans. At this inspection, a system was in place to complete an assessment of needs. Some assessments were under development at the time of inspection. Where residents had transitioned to the service, an assessment of needs had been completed with input from healthcare professionals. A record of the outcome of the assessment was completed, which identified areas in which residents may require support. Short- and long-term goals and on-going life goals had been identified by the resident and their circle of support. The action arising from the previous inspection had been addressed and personal plans now specified the names of those responsible for supporting the resident to achieve their goals and the timescales for the objectives.

Personal plans had been reviewed within the previous 12 months or to reflect changing circumstances or needs. The inspector reviewed a sample of recently reviewed personal plans. However, there was some variation in the effectiveness of the review. For example, key persons involved in providing support to individual residents were not always invited to or involved in the review process e.g. the social worker or psychologist

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

No actions were required from the previous inspection.

Findings:
The provider failed to demonstrate that there were adequate arrangements in place for evacuating residents in the event of a fire. Overall, the inspector found that the combined failings relating to fire drills and emergency evacuation procedures as outlined below were at the level of major non-compliance. In addition, information was not available in the centre to demonstrate that appropriate action had been taken following two safeguarding incidents that had occurred in the centre.

There were arrangements in place for preventing, detecting, containing and extinguishing fires. However, the arrangements in place for testing fire equipment, providing staff with adequate instruction or evacuating residents required improvement. Servicing records demonstrated that the fire alarm was checked on a quarterly basis and fire equipment on an annual basis. Records in place for checking of emergency lighting pertained to annual tests and not quarterly, as required.

The inspector was told that emergency lighting was checked on a quarterly basis, the documentation available for review at the time of inspection pertained to annual checks only. Subsequent to the inspection, records of quarterly checks completed were submitted to HIQA and were found to be in order.

There was a fire evacuation plan and floor plan visibly displayed in the centre. A personal emergency evacuation plan (PEEP) was in place for each resident. However, it was not demonstrated that there was a plan in place to evacuate each individual resident in the event of a fire. In addition, other aspects of an evacuation plan reviewed required amendment as it referred to wedging a fire door open, leaving a resident unsupervised in the event of an emergency and also contained information that the social care leader said was out of date.

Fire drills were held at regular intervals. However, a review of fire drill records demonstrated that all fire drills had taken place during day-time hours. No drill had taken place that simulated night-time conditions or night-time staffing arrangements. Also, some improvements were required to fire drill documentation to demonstrate the effectiveness of drills that did take place. For example, the residents present at the time of the drill and whether all parts of the emergency plan worked effectively were not recorded (e.g. did the keypad-operated front door automatically open when the fire alarm was activated and did the fire doors automatically close). While staff had all received fire safety training, the social care leader confirmed that due to staff changes in the house, not all staff working on night shift had received instruction on how to use fire aids and appliances (such as a fire evacuation sheet).

Other arrangements were in place in relation to health and safety. There was a risk register in place and individualized risk assessments had been completed. Incidents were recorded in the incident book. Incidents were reviewed by the social care leader and the health and safety officer. However, learning from serious incidents involving residents was not consistently demonstrated. In particular, where there had been two significant incidents (in July 2016), the social care leader was unable to articulate what follow up action had been taken.

Procedures were in place for the prevention and control of infection. Alcohol hand gels, plastic aprons and disposable gloves were available. Staff had training in the correct hand washing technique and there were Health Service Executive (HSE) leaflets on the procedure placed strategically near the sinks. There were coloured coded systems in use for cleaning and food preparation. The centre was clean and tidy on the day of inspection.

Staff had up to date training in relation to moving and handling training, infection control and the management of actual and potential aggression.

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:
Overall, arrangements were in place to protect residents from abuse or harm in the centre. Improvement was required to ensure that the staff team would have the information that they required to implement any positive behaviour support recommendations. In addition, improvements were required to the management and oversight of restrictive practices in the centre.

Residents told the inspector that they were happy and felt safe in the centre. The inspector saw evidence that staff and residents were comfortable in each other's company. Staff interacted with residents in an appropriate and warm manner.

There was a designated liaison person within the service to deal with allegations of abuse and a nominated complaints officer. Details of advocacy series were also visible and readily available. Contact details and pictures of those persons were displayed in the hallway. Staff had received training in relation to the management of abuse. Supervision meetings took place between the social care leader and staff team members on approximately a six-weekly basis. Regular staff team meetings were held and resident meetings also took place, during which any issues could be raised and discussed.

Residents had access to psychology and psychiatry where required. However, based on a conversation with the social care leader, it was not demonstrated that the staff team would be provided with the information they required to implement any positive behaviour support recommendations or to ensure that interventions would be reviewed as part of the personal planning process. This was discussed with the provider during the feedback meeting.

There were no physical restrictions in use in the centre. However, improvements were required to the overall management and oversight of other restrictive practices in the centre. Staff were unable to articulate the process in place for the approval of restrictive practices (as described by the provider representative at the feedback meeting). The inspector found that multidisciplinary input had not been sought when planning a restrictive practice for a resident that involved restricted access to food. In addition, it was not demonstrated that the use of a keypad on the front door had been assessed by the multi-disciplinary team as being the most appropriate measure and as a result, it was not clear whether or not it was a restrictive practice for some residents. Also, a rationale for the keypad was not provided, as the social care leader told the inspector that no resident was at risk of absconding from the centre.

There were measures in place for the day-to-day management of residents' finances and there were records in a register of financial transactions made by and on behalf of residents. All transactions contained the signature of the resident and the staff member. Any withdrawals of monies were signed by two staff members and overseen by the finance department. Internal audits were completed by the finance department and the inspector reviewed a report by an external financial auditor in December 2015.

Judgment:
Non Compliant - Moderate

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:
Notifications had been made to HIQA in line with the regulations. This included notifications regarding the absence of the person in charge from the centre and a report of incidents that occurred in the centre on a quarterly basis. However, the inspector found that not all restrictions had been included in the quarterly report, including a keypad on the front door and a restricted access to certain types of foods that impacted

on all residents.

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:
Overall, residents' healthcare needs were supported by access to medical, nursing and allied health care.

Residents had access to the general practitioner (GP) services and allied health care services, such as, the dentist, psychologist, dietician, occupational therapist, physiotherapist and speech and language therapist. An assessment of residents' healthcare needs had been completed. The inspector reviewed a recent assessment that had been completed with input from an appropriate healthcare professional as required by the regulations. Healthcare support plans were in place based on this assessment, for example, in relation to epilepsy, weight loss, wellbeing, continence, oral hygiene and pain management. Healthcare checks were maintained if required, for example in relation to weight, blood pressure or personal care supports.

Residents were supported to access health information and to make healthy living choices. Residents were involved in meal planning and staff accompanied residents to go shopping. A small number of residents were involved in cooking meals. A healthy life-style was supported and residents were encouraged to walk to their workplace and to go for walks with staff after work.

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 was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications. However, improvements were required in relation to the management of medication errors, the medication policy and the receipt, storage during transport and safe return of medication for residents availing of respite.

The inspector reviewed residents' files and found that individual medication plans were reviewed as part of the personal plan review process. Prescription charts and administration charts were completed in line with relevant professional guidelines and legislation. All medications were individually prescribed. The maximum dosage of PRN ("as required") medicines was stated and all medicines were regularly reviewed by the prescriber. There were no controlled medicines in use at the time of inspection. Residents did not require their medicines to be crushed. Where appropriate, residents had been assessed in relation to self-administration of medication and were being supported in accordance with the outcome of that assessment. A dedicated fridge was available for use if required. Unused and out of date medicines were segregated from other medicinal products, as required by the regulations and a record of returns to pharmacy was maintained.

However, a number of improvements were required, in particular for residents availing of respite. The social care leader explained the arrangements in place for the management of medications when residents arrived to or were discharged from the centre. However, these arrangements were not outlined in any policy or procedure. Medications were checked, counted and recorded. The inspector observed that such medicines were in their original container/packaging with original labels attached or were provided from the pharmacy in a monitored dosage system. However, the medication reconciliation system at admission for residents attending on respite was not in accordance with the guidance issued by HIQA to ensure that residents were provided with the correct medicines during their stay.

In addition, improvements were required in relation to medication reconciliation on admission. It was not verifiable whether the prescription was the current prescription as medications were not accompanied by a current script, prescription or letter. In addition, practices on discharge of residents from the centre required review. When residents were returning to their family home, staff members outlined that medicine pods were removed from the original monitored dose system and placed in an envelope. This practice of 'secondary dispensing' placed residents at risk as the original monitored dose system contained additional labelling information as required by legislation to ensure that medicines were administered as prescribed.

Medication errors were recorded in the critical incident report book. These were reviewed by a nurse coordinator attached to the centre. However, there was no arrangement in place to ensure that errors were discussed between the coordinator and social care leader and/or staff team. The outcome of errors was not recorded on the

corresponding medication error report form. Learning from errors was not demonstrated.

Medication audits were completed. Staff had undergone training in relation to medication management and a competency assessment programme was in place.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Overall, while there were systems in place for reviewing the quality and safety of care in the centre, the arrangements relating to the post of the person in charge required review.

There was a governance and management structure in place which was in accordance with the structure outlined in the Statement of Purpose for the centre. However, the post of the person in charge was being filled by a deputizing arrangement over the course of the previous two years. This was discussed with the provider who said that this arrangement was in the process of being formalized.

The social care leader was identified as a person participating in the management of the centre and was deputizing in the absence of the person in charge. The social care leader post was full-time. The social care leader's working day began at 16:00hrs. She was able to attend residents' personal planning and multidisciplinary meetings by agreeing to attend such meetings outside of her normal working hours. The social care leader held an appropriate qualification in health and social care and was experienced in supporting persons with an intellectual disability. The social care leader demonstrated that she knew residents, their likes and dislikes well.

As part of the provider's visits, the provider had implemented a system of reviewing aspects of quality and safety of care provided in the centre. This system involved input from a range of suitably qualified and experienced personnel, who reviewed different

aspects of the quality and safety of care provided in the centre. For example, finances were reviewed by the finance officer and health and safety by the health and safety officer. Other audits were also completed in the centre, such as audits of personal plans, infection control and hand hygiene. However, as indicated under outcomes 7, 8 and 12, aspects of the auditing system required review as findings identified on this inspection had not been identified in audits. An independent financial audit had been completed in December 2015. The provider gave verbal reassurances to the inspector in relation to issues raised by the auditors in that audit. An annual review had been completed and was informed by consultation with families.

Judgment:
Non Compliant - Moderate

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, the numbers and skills mix of staff on the day of inspection met the support requirements of residents.

A sample of staff files reviewed by the inspector complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. The inspector viewed the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures.

Records reviewed indicated that staff had attended a range of training to include the mandatory training required by the regulations. As previously addressed under outcome 7, staff required instruction in the use of emergency evacuation aids and appliances.

Staff were supervised according to their role. While the inspector was present the residents received attention and care in a respectful and timely manner. The daily care notes viewed by the inspector indicated that the night staff were also responsive to any care and welfare issues which occurred on their shift. Rosters were arranged to meet the needs of the residents. The inspector viewed the roster and the planned roster for the following week. Staff had access to a copy of the Regulations and the National

Standards for the sector.
Judgment: Compliant

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:

Julie Hennessy
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by St Joseph's Foundation
Centre ID:	OSV-0001816
Date of Inspection:	13 October 2016
Date of response:	13 January 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:
Glass rectangular panels on bedroom doors did not protect residents' right to privacy and dignity.

1. Action Required:
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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

dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
To comply with Regulation 09 (3) which The Registered Provider will ensure that each resident's privacy and dignity is respected in relation to glass panels which do not currently protect their privacy and dignity by installing opaque film to the glass panel on the lower part of the doors.

proposed Timescale: Completed 21/10/2016

Proposed Timescale: 21/10/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the option to access facilities, services and courses in the community had been explored with residents.

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

Please state the actions you have taken or are planning to take:
Under Regulation 13 (2) (b) the Registered Provider will ensure that opportunities are provided for residents to participate in activities in accordance with their interests, capacities and developmental needs through the provision of information regarding local events, training opportunities etc by provisiding local papers, newsletters etc. highlighting what is available in their local community. The Registered Provider will ensure that community opportunities will be discussed at the residents weekly house meetings and records of same will be kept.

Proposed Timescale: Completed 09/12/2016

Proposed Timescale: 09/12/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Key persons involved in providing support to individual residents were not always

invited to or involved in the review process e.g. the social worker or psychologist

3. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
Under Regulation 05 (6) (a)the Person in Charge will ensure that all relevant multi-disciplinary team members will be involved in the review process for personal plans by issuing team member timely invitations and affording them opportunities to review the necessary documentation.
This processed will be scheduled by the Person in Charge over the next two months.

Proposed Timescale: 28/02/2017

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:
Learning from serious incidents involving residents was not consistently demonstrated.

4. Action Required:
Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

Please state the actions you have taken or are planning to take:
Under Regulation 26 (1) (e) the Registered Provider will ensure that there is learning from any serious incidents involving residents and any medication errors which occur through review of the incidents and through the promotion of reflective practice for staff. Additional documentation has been developed to support staff to review all incidents.

Proposed Timescale: Completed 30/11/2016

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, it was not demonstrated that there was a plan in place to evacuate each individual resident in the event of a fire and bring them to a safe location. In addition, other aspects of an evacuation plan reviewed required

amendment.

5. 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:
The Registered Provider will ensure Under Regulation 28 (3) (d) that all emergency evacuation plans are reviewed and amended in accordance with the advice received from the Hiqa Fire Officer to ensure each resident in the designated centre can be brought to a safe place in the event of fire.

Proposed Timescale: Completed 21/10/2016

Proposed Timescale: 21/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practice fire drills did not consider all likely scenarios, different times at which a fire may occur or night-time staffing conditions. In addition, improvements were required to fire drill documentation.

6. 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 Registered Provider Under Regulation 28 (4) (b) will ensure that fire drills will be simulated at varying times including night hours and that all staff and residents (where possible) will be aware of the procedure in the event of a fire.

Proposed Timescale: Commenced as of 22/11/2016 and willing be ongoing.

Proposed Timescale: 22/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed within the findings, improvements were required to the management and oversight of restrictive practices in the centre.

7. 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:
The Person in Charge Under Regulation 07 (5) will ensure that the current restrictive practice ceases and any further restrictive practices will be made as a last resort and all other efforts to alleviate behaviour are exhausted prior to a restrictive practice being implemented. Any restrictive practices being considered in the future will include input for the multi-disciplinary team members.

Proposed Timescale: Completed 14/10/2016

Proposed Timescale: 14/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
As detailed with the findings, it was not demonstrated that the staff team would be provided with the information they required to implement any positive behaviour support recommendations or to ensure that interventions would be reviewed as part of the personal planning process.

8. 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:
Under Regulation 07 (1) the Person in Charge will 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 through appropriate referrals to psychology, appropriate training for staff in this area and ongoing support of psychology or other relevant multi-disciplinary personnel.

Proposed Timescale: Completed 14/10/2016

Proposed Timescale: 14/10/2016

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:
Not all restrictions had been included in the quarterly report,

9. 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:
The Person in Charge (PIC) under Regulation 31 (3) (a) will insure that all information required to be submitted to the Chief Inspector will be included in the quarterly report.

Proposed Timescale: 31/01/2017

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:
It was not demonstrated that there were 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:

As detailed in the findings, a number of improvements were required to ensure that medications were administered as prescribed and in particular as they related to the safe management of medication on admission and on discharge from the centre.

In addition, practices to ensure safe receipt, storage and return of medicines as it related to residents availing of respite were not underpinned by the organisation's or centre's policy.

Also, the outcome of medication errors and any learning from same was not demonstrated.

10. 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:
Under Regulation 29 (4) (b) the Person in Charge will ensure that any improvements required to ensure the safe administration of medication and the safe management of medication on admission to and discharge from the centre will be implemented and any supporting documentation , changes to policy and procedure will be put in place as per HIQA guidance document.

Proposed Timescale: Completed 16/12/2016

Proposed Timescale: 16/12/2016

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 governance and management arrangements in the centre required review, for example,

- person in charge and deputizing arrangements required review;
- as identified under outcomes 7, 8 and 12, oversight of the system required improvement.

11. 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:
Under Regulation 23 (1) (c) the Registered Provider will 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. The system and documentation for auditing has been reviewed by the Registered Provider and HIQA template document will now followed for all future audits.
The position of the Person in Charge will be regularised.

Proposed Timescale: 30/01/2017