

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Group C - Community Residential Service Limerick
<b>Centre ID:</b>	OSV-0003941
<b>Centre county:</b>	Limerick
<b>Type of centre:</b>	Health Act 2004 Section 38 Arrangement
<b>Registered provider:</b>	Daughters of Charity Disability Support Services Ltd
<b>Provider Nominee:</b>	Michelle Doyle
<b>Lead inspector:</b>	Mary Moore
<b>Support inspector(s):</b>	Noelle Neville
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	11
<b>Number of vacancies on the date of inspection:</b>	3

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

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

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

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

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

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

**The inspection took place over the following dates and times**

From:	To:
05 April 2016 09:00	05 April 2016 18:30
06 April 2016 09:15	06 April 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 03: Family and personal relationships and links with the community
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 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This inspection was the second inspection of the centre by the Authority (a previous monitoring inspection had taken place in one of the three houses) and was undertaken to follow-up on the findings of the previous inspection completed on the 10 and 11 March 2015. Failings were identified and actions issued from eleven of the eighteen Outcomes inspected in March 2015; one major, nine moderate and a substantial non-compliance issued from that inspection.

The centre consists of three separate houses located in the community where residential services and supports are provided to fourteen residents.

Over the course of this two day inspection, inspectors met with all of the residents in each of the houses, with the person in charge, the nominated provider and frontline support staff. As evidenced at the time of the last inspection, inspectors found evidence of good practice. Residents were engaged and led full and active lives.

Residents welcomed inspectors into their homes, recalled the previous inspection and spoke openly and willingly with inspectors. There was evidence that equally residents engaged openly with staff and with the provider on matters of concern to them in relation to the supports and services provided to them. Residents were clearly comfortable with the staff on duty and the interactions and practice observed by inspectors between residents and staff were equitable, respectful, professional and empathetic.

There was evidence of steps taken by the provider to address the failings identified at the time of the last inspection. Ultimately however unsatisfactory progress had been made by the provider particularly in relation to the unsuitable location of one of the houses and the failure to complete required fire safety upgrading works. Despite the fact that residents continued to clearly articulate dissatisfaction with the quality of some of the services provided to them, their complaints had not led to a satisfactory resolution for them. Further and additional failings were identified in failing to ensure that adequate staffing arrangements were in place at all times; this had resulted in the closure of one of the houses on Christmas Eve 2015 and the relocation of the residents to other centres in a manner that compelled the residents to subsequently complain to the provider.

Of the thirteen outcomes reviewed by inspectors the provider was judged to be compliant in five, in moderate non-compliance with six and in major non-compliance with two; fire safety measures and adequate and suitable staffing arrangements.

Elements of the response to the action plan were not accepted by HIQA and were addressed further in meetings and correspondence with the provider. The action plan response now reflects the most recent provider response as to the actions taken and in progress to address the identified failings.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

Inspectors saw that residents lived full and active lives and were busy and engaged throughout the inspection process. Inspectors were satisfied that improvements had been made since the previous inspection carried out in March 2015 in relation to access to community based activities. It was noted that residents had access to a range of community and group based activities; residents still continued to engage with their peers and utilise the facilities on campus. Residents participated in tai chi, pottery, woodwork, basketball, floor ball, tag rugby, hill walking, swimming, horticulture, music therapy, drama, literacy classes, needlework, cinema, bowling, shopping and dining out. Residents also visited with friends and family, attended mass and participated in the Special Olympics.

As outlined in the previous inspection report of March 2015, there was evidence that residents were consulted about how the centre was run. Inspectors again saw that residents engaged freely with staff and went about their daily routines with enthusiasm; there was ongoing communication between staff and residents on all matters pertaining to the daily routine. Minutes of residents' meetings were available for review and agenda items considered matters such as general welfare and complaints. Inspectors were informed that resident meetings should be held approximately every four weeks. However, as evidenced at the time of the last inspection this was not happening in practice as minutes evidenced that meetings were held approximately every two months in most cases since the previous inspection.

Whilst it was clear that residents were consulted about how the centre was run, there

were still opportunities to enhance this process. The current house meetings were a stand-alone process and as a result did not capture and reflect informal discussions with residents regarding issues such as activities, meal planning and shopping for example. In addition, it was not clear if actions resulting from issues raised by residents at their meetings had been satisfactorily resolved. For example, as noted in the previous inspection findings, the unsuitable location of one house was presenting on-going difficulties for residents in terms of noise disturbance and had been documented in each of the four house meetings of this house since the previous inspection in March 2015.

Inspectors noted that the complaints procedure was now displayed in a prominent location in each house as required by the regulations. A new duplicate form to record complaints was in place in each of the houses as committed to in the provider's response to the last action plan. This new form facilitated capturing all of the information required by the regulations including the outcome of the complaint and whether or not the complainant was satisfied with the outcome. Several complaints were seen by inspectors, in particular in relation to staffing and the unsuitable location of the house mentioned above. Inspectors acknowledged that the culture of the centre and staff/resident relationship meant that residents felt comfortable making complaints, staff gave credence to their complaints, the provider nominee met with residents and there was no evidence that residents were adversely affected by virtue of having made complaints. It was however evidenced that residents were not satisfied with the outcomes of these complaints, measures that had been taken were not sufficient to address the matter complained of, it was not resolved and the issue of noise disturbance remained for residents.

As outlined in the previous inspection report of March 2015, residents were seen to be treated respectfully by staff and interactions were appropriate, kind and friendly. However, inappropriate and disrespectful commentary was seen to be used by some staff when describing residents' inherent personality and mannerisms. If there was a requirement for change on behalf of the resident it was not clear to inspectors from the record seen and what staff said that this was understood by staff so as to support the resident in an evidence based manner. A further record seen in another file described an antecedent to behaviours that challenged as "jealousy"; this is discussed again in Outcome 8.

The number of shared bedrooms in the houses had been reduced to one since the previous inspection due to reduced occupancy. The provider nominee told inspectors that at every opportunity shared bedrooms would be reduced to single occupancy but this was not formalised or reflected in the maximum number of residents to be accommodated in the centre as outlined in the statement of purpose and function. An occupant of the remaining shared bedroom informed inspectors that she was happy with the arrangement, had a good relationship with the other occupant and that they would each miss the other if separated. Staff said that a mobile screen was available to promote privacy if required, for example in the event of illness.

As stated in the provider's response to the action plan the bathroom in one house had been refurbished and a universally accessible shower had been installed. Residents were very pleased with their new facility and confirmed that they did not now have to access the facilities in the en suite of another resident's bedroom.

Inspectors saw that some but not all residents had provision (a key) to lock their bedroom doors; some residents expressed a wish to have this to inspectors. In addition, inspectors noted that there was no lock on bathroom and toilet doors which was evidenced to have the potential to impact on residents' privacy and dignity. When reviewing the required action due regard is required by the provider of the guidance provided in the fire safety audit undertaken of the centre in July 2014.

Inspectors noted that some residents had access to internal and external advocacy services. The provider nominee confirmed that access to external advocacy was arranged through referral from the centre. However, there were other residents and specific matters that inspectors believed would have benefited from similar referral, particularly where these residents had complained and advocated on their own behalf but where their efforts had not resulted in a satisfactory solution. This was discussed with the provider nominee and the person in charge who agreed to make this referral on behalf of these residents.

**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):**

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

**Findings:**

Inspectors were satisfied that residents were supported to enjoy ongoing family contact, links with the community and with their peers. On the days of inspection residents accessed their structured day services, employment, education, sports activities and evening group activities; others enjoyed a walk in the locality.

Staff spoken with had a sound knowledge of each resident's support network and there was evidence that the provider strove to establish and maintain positive communication with families. Most support plans outlined how staff would support residents in organising and facilitating home and family visits, social outings and visits to peers.

Residents spoke of their friendships outside of the centre and how staff supported them to maintain contact; photographic evidence was also seen.

The relationships that developed and the sense of community that residents enjoyed in the centre was particularly evident during this inspection due to the unexpected death of

one resident in the days preceding the inspection. Residents spoke fondly of the deceased resident, spoke with ease of their own loss and how she would be missed. Residents were supported by staff to attend the relevant ceremony in the community to express their condolences to the bereaved family.

**Judgment:**

Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

Inspectors reviewed a sample of support plans in each house. Improvement was noted but inconsistency was also noted in the standard of the support planning process. Inspectors based on their observations were of the view that the standard of documentation did not reflect the supports that staff actually delivered to residents on a daily basis.

The process consisted of an assessment of needs and ability and a plan of support where a need was identified. Some support plans were very detailed, demonstrated staff knowledge of residents and provided good guidance on the supports required by the resident, what worked and what did not work for them. However, at times where a need for a support plan had been identified there was no corresponding support plan or the required supports were broad and vague such as "staff support" or "requires staff reassurance". An example was the absence of detailed communication plans where there was a clear communication difficulty; other communication plans were very detailed with clear evidence of speech and language input. A further example was the requirement for a plan to support residents while grieving; there was no explicit plan of support. However, inspectors saw good practice in both of these areas with staff and residents engaging freely and without difficulty. Staff were seen to practically support residents to express their feelings at the very recent loss of a loved peer.

The participation of the resident was evidenced in their signing of agreed support plans;

the accessibility of the plan to the resident was enhanced by the use of photographic and pictorial cues.

Support plans seen were all dated as reviewed in mid to late 2015. However, it was not always clear that the review of the support plan was multidisciplinary (MDT) where there was MDT involvement or should have been MDT involvement.

The support plan process incorporated the identification of personal goals and objectives. Deficits were identified in this process. There was a need to individualise residents' goals and to demonstrate that goals were developed with a view to residents' achieving personal progression rather than a once off target. This is discussed again in more detail in Outcome 10.

**Judgment:**

Non Compliant - Moderate

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

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

**Findings:**

The location of one of the three houses that comprised this designated centre was not suited to its stated purpose and function.

There was no change noted to the observations and findings of the last inspection. The house was situated in a compact area in which students predominantly resided. The inspectors observed that the surrounding area was unpleasant, untidy and poorly kept by neighbours with discarded rubbish including glass and beer cans littered about. The other houses were generally unkempt with excessive car parking on kerbs and grassed areas noted.

Residents told inspectors at the time of the last inspection that this location presented a difficulty for them in terms of intermittent noise disturbance; this was also documented in the pre-inspection questionnaires that the residents completed. At that time the provider nominee acknowledged that this was an issue for the residents and that a long-term plan was in place to facilitate a move to a more suitable location.

However, there was no ostensible change to the residents' unsatisfactory situation and it

was clear residents' needs would be better met, and residents would be happier, in a different location. Unprompted, residents repeated their concerns to inspectors and clearly told inspectors that they wanted to move from this house. Staff said that the complaints of the resident were perfectly reasonable and pertained in particular to late evening and night-time disturbance when they were unable to sleep; this was also impacting negatively on the staff sleepover arrangement.

Inspectors saw eight complaints made by residents in relation to this matter in the period since the last inspection; four through the residents' committee meetings and four through the provider's complaints process. The provider had communicated with the residents and with other parties in an attempt to resolve matters; residents had received a gift and a letter of apology from one group of students. While appreciated, staff and residents said that the student cohort changed, the problem was cyclic and not restricted to any one house.

Ultimately, the continued use of this house did not facilitate the provider in meeting the stated aims and objectives of the service or the needs of the residents.

In contrast inspectors found the other two houses that comprised this designated centre to be pleasantly and appropriately located, homely and welcoming on sight and suited to their stated purpose and function.

**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:**

In July 2014 the provider had commissioned an external competent person to undertake a fire risk assessment of the premises; recommendations assigned a medium or high priority were issued. In this regard and further to the inspection of March 2015 the Authority did not accept the action plan response to Regulation 28(1) with the provider despite affording the provider two attempts to submit a satisfactory response. In the most recent updated response requested in March 2016 and also during the inspection itself, the nominated provider again confirmed that with the exception of works to the fire detection and emergency lighting systems, the other recommended works had not been completed.

A fire register was maintained in each house. The inspector saw that fire detection systems, emergency lighting and fire fighting equipment were inspected and tested at the prescribed intervals and most recently in February 2016 and May 2015 respectively. Staff implemented and recorded inspections and testing of escape routes and the fire detection system. Simulated evacuation drills were convened regularly, adequate evacuation times were recorded; residents confirmed their participation in the drills.

However, contrary to what was stated in the response received from the provider to the effect that an upgrade of the fire alarm and emergency lighting systems had been completed, inspectors saw no evidence of emergency lighting in one house. The person in charge and staff on duty confirmed that there was no emergency lighting. Escape routes were not clearly indicated in this house.

Some but not all final fastenings on exit doors had been replaced to facilitate timely egress with internal thumb turn devices; however, there were residual, manual key operated locks.

**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:**

At the time of the last inspection in March 2015 a major non-compliance was identified in relation to safeguarding and safety as the provider had not satisfactorily ensured that all residents were protected from injury or harm by their peers. There was evidence that individual residents were being subjected to injury and harm by their peers on an intermittent but on-going basis. The level of non-compliance was due to: the duration of the situation (since 2013); the impact the situation was having on specific individuals who were adversely affected by such behaviours; that the situation was current and on-going and finally; there was no concrete plan in place to resolve the situation.

During this current inspection it is reasonable to state that matters had improved in so

far as that there were no reported or recorded incidents of physical harm or injury to residents by their peers. A number of steps had been taken by the provider to address the situation including: staffing levels had been increased at key times of the day (i.e. the provision of 1:1 support in the evenings); there was evidence of on-going review and; consultation with all of the involved residents had taken place with support provided to all residents concerned. Also, potential underlying causes to the behaviours had been explored and identified. Alternative accommodation had also been explored but this had not progressed for specific reasons.

However, while the issue was managed it was clearly not resolved and in the interest of all residents required further review and intervention.

Firstly the fundamental issue of unsuitable placement was unaltered. It was clearly stated in a needs assessment for residential placement that one resident required accommodation with a smaller group of peers of similar ability and functioning. It was clearly stated that the resident was challenged when accommodated with peers with good verbal and social skills and hence this personal challenge manifested in behaviours that were a risk to particular residents. It was further reported that the resident had no reported incidents of such behaviours in another service accessed by them on a daily basis.

Secondly the current behaviour management plan was functional in its approach and lacked a sound clinical therapeutic approach; the focus was on segregation of residents and routines, for example the use of different entrances and staggered mealtimes. There were two copies of the management plan seen by inspectors. One was signed as having psychology input in February 2014; the ongoing reviews and the most recent update (February 2015) were not. Staff said that the plan was having an effect as demonstrated in the cessation of physical incidents, as did the 1:1 staff support at key times and the increased consistency of the staff allocated to provide these supports.

However, there was evidence of ongoing but perhaps different consequences for all residents as the known antecedent while being managed by the plan was still very much present on a daily basis. Residents told inspectors that while the incidents of physical injury had ceased there were verbal incidents, residents said that the unpredictability of behaviours was an ongoing cause of "worry" and concern to them and that they "dreaded" certain events. Residents said that some staff, but not all staff told them that they had to stay in their rooms while the other resident was in the house and that "this is not right, this is our home". The person in charge told inspectors that this was not correct but segregation of the residents was a theme of the management guidelines in place. There was no explicit safeguarding plan for two residents that set out for staff any required approved interventions and their duration; for example any requirement for residents to stay in their bedrooms.

Further more, while there were no reported incidents of peer to peer physical harm and injury since October 2015, staff had completed ABC (antecedent, behaviour and consequence) charts. Inspectors reviewed the 13 charts completed between December 2015 and the 22 March 2016 and saw that staff had identified the known antecedent (the presence of two particular residents) as a trigger to 11 of the 13 incidents of self-injurious behaviours. It was also recorded at the MDT meeting in November 2015 that

these behaviours highlighted the unsuitability of the resident's current placement.

There was evidence of MDT input predominantly nursing, psychiatry, speech and language therapy and support staff; there was evidence of past psychology input. However, there was no clear evidence of timely and current psychology review. Inspectors saw a reference to psychology input made by psychiatry in April 2015, there was a referral form dated October 2015 and while acknowledged within three days of receipt the resident was stated to be on a waiting list. Other than the behaviour plan signed in February 2014, while the person in charge said that there had been input from psychology, there was no evidence available to inspectors of psychology review and input from April 2014 to the time of this inspection in March 2016.

The provider nominee and the person in charge confirmed that the service did not employ a behavioural therapist. As stated previously the behavioural management guidelines were functional in approach and focussed on physical segregation and segregation of routines. It was of concern that a risk assessment informing the guidelines and dated November 2015 stated that there were no known triggers to the behaviours and that "jealousy" was a descriptor utilised; there were clearly two known and recorded antecedents; particular peers and their level of functioning and the expectations of other relevant parties.

Staff providing direct supports to residents with behaviours that challenged or posed risks to others and themselves demonstrated and articulated insight, understanding and skill in supporting residents. However, staff said that they had not received formal training in responding to and supporting residents to manage their behaviour.

**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):**

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

**Findings:**

A record was maintained of accidents and incidents that occurred in the centre and/or to residents while in other locations such as leisure activities; inspectors reviewed these records in each house. The submitted notifications reflected the accident and incident records seen during the inspection.

However, the provider nominee confirmed that a change to the persons participating in

the management of the centre (PPIM) had taken place in September 2015 and the notification required by Part 7 (3) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 had not been submitted to the Chief Inspector. This failing is addressed and actioned under Outcome 14 Governance and Management.

**Judgment:**

Compliant

**Outcome 10. General Welfare and Development**

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

**Theme:**

Health and Development

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

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

**Findings:**

There was a need to individualise residents' goals and to demonstrate that goals were developed with a view to residents' achieving personal progression rather than a once off target.

It was evidenced that residents were leading full and active lives; residents relayed to inspectors how they planned to spend their day and their week and it was clear that what was planned was eagerly anticipated by them. All residents spoken with confirmed their participation in activation, education, training and/or employment.

Inspectors noted a balance between community and group based activities as discussed in Outcome 1. Inspectors reviewed a large sample of goal assessments and plans for residents; the completion of the assessment was inconsistent. While it was noted that residents were facilitated to achieve goals and did in fact achieve several, there appeared to be a shared theme among these goals for some residents. For example, residents had a shared goal of travelling independently on a train, of planting a plant, making home-made produce and attending a concert.

As evidenced at the time of the last inspection all articulated goals were not included in the goal plan; for example one resident discussed with staff and inspectors how she would love to go to see a rugby match but this was not included in her agreed goals.

In addition goals and objectives appeared to be once-off occurrences and targets, lacked a developmental focus and consequently did not demonstrate how, when successful they contributed to improved and sustainable quality of life outcomes for

residents in their daily life such as enhanced independence . For example one resident told inspectors that she had successfully travelled independently on a bus and hoped that she "might do it again". Likewise where goals were not successfully achieved and where staff had identified potential barriers, there was no clear plan or learning from this to ensure that future goals were matched to individual resident skills and ability to ensure success and achievement.

These areas requiring improvement are actioned under Outcome 5 in respect of Regulation 7 (c).

**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):**

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

**Findings:**

The failings identified at the time of the last inspection were substantially addressed.

The person in charge who was a member of the drugs and therapeutic committee confirmed that the medication management policy had been revised further to the last inspection findings. The inspector reviewed this policy dated July 2015 and saw that it did now outline the procedures for;

- staff referral to and the use of the community residential medication management policy and procedure
- the policy, procedure and controls for the administration of PRN (as required) and over the counter medications
- the frequency of medication review to ensure that each resident's medication was subject to an appropriate review in a timely manner.

The practice described by staff particularly in relation to the administration of PRN medication was as outlined in the revised policy.

Formal records of the quarterly review of medications were seen in resident's medical files.

A risk assessment, assessment of capacity and management plan had been completed for residents who took responsibility for their own medication; residents described for inspectors the controls outlined in the plan to support them and safely guide this

practice.

The community pharmacist who supplied medications to the centre had completed a detailed audit of medication management systems in June 2015; an action plan had issued and there was evidence of the follow-up of the action plan. The person in charge had completed a further audit in December 2015 but confirmed that the action plan had not yet issued to staff.

However further areas requiring improvement were identified on this inspection.

Inspectors noted that some of the handwritten prescriptions were illegible; the person in charge agreed. The medication management policy did not clearly stipulate the requirements and responsibilities for the generation of a prescription including its legibility. Given that some prescriptions were illegible it was unclear how staff reconciled what was supplied with that was prescribed in line with the five rights of medication administration.

The system in place for the security of medications held by residents themselves was not sufficient and did not restrict potential access by persons other than the resident for whom the medications were prescribed.

**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):**

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

**Findings:**

A revised statement of purpose was submitted and accepted by the Authority subsequent to the inspection of March 2015.

**Judgment:**

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:**

Inspectors only reviewed the Regulation 23 (2) (a) and (b) aspect of this Outcome. The provider nominee had undertaken an unannounced visit to the centre on the 4th March 2016; the report was made available to inspectors. Inspectors were satisfied that this was a comprehensive review; it acknowledged core issues such as the unsuitable location of one house and the complaints made by residents. Inspectors were satisfied as to the transparency of the process as many of the findings of the visit reflected these inspection findings such as the deficits in the support planning and goal setting process and access to advocacy. Thirty six actions issued, responsible persons were identified as were completion timeframes; these timeframes had not elapsed.

A failure to comply with the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 discussed in Outcome 9 is actioned under this Outcome.

**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:**

There was no evidence to support a definitive failing at the time of the last inspection, however, staff did tell inspectors at that time that there had been some challenges to

ensuring continuity of care and support to residents as a result of the use of agency and relief staff. Staff repeated these observations to inspectors on this current inspection, staff said that the required staff supports were not always in place and on occasion staff without the required skills such as the ability to drive, were deployed. Staff also said however that they noted improvement of late with an increased consistency of the relief and agency staff allocated to each centre.

However, on reviewing complaints lodged by the residents of one house it was of concern to inspectors that the provider had failed to ensure that appropriate staffing arrangements and appropriate contingencies were in place to meet residents' needs with consequent self-reported negative outcomes for residents.

Staff confirmed that this particular house did not normally close for Christmas and that all of the four residents spent some or all of the Christmas period in the house. Records indicated that Christmas was a difficult time for some residents. Due to unplanned staff absence a decision was made to close the house on Christmas Eve 2015; the nominated provider told inspectors that it had not been possible to source staff. Residents were relocated to other designated centres and returned to their home on the 26th December. In addition to the requirement for residents to leave their home at this time, the complaint indicated the closure was not appropriately managed as presents/gifts residents had purchased were left behind in the house and residents did not have access to them until their return.

A further complaint record indicated that again due to inadequate staffing on the 2nd January 2016 residents had to vacate the house between the hours of 07:00hrs and 22:45hrs.

Failings have previously been identified to the provider in this regard, that is staffing levels, contingency plans for responding to unexpected staff absences and the negative impact on residents and their routines, in another of its designated centres. Reassurances were received from the provider at that time that measures would be taken to address such failings and prevent reoccurrence. However, these current findings would not substantiate those reassurances.

**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):**

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

**Findings:**

Overall, inspectors were satisfied that the actions that had emanated from the last inspection were satisfactorily addressed.

Records in respect to each resident, as required under Schedule 3 of the Regulations were maintained in the designated centre and retrieved as requested by inspectors.

While there were ongoing issues in relation to resolving complaints the provider had as committed to in the response to the action plan implemented a new complaint recording template.

All of the policies required under Schedule 5 of the Regulations were available in the centre and were current.

**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:***

Mary Moore  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
<b>Centre ID:</b>	OSV-0003941
<b>Date of Inspection:</b>	05 and 06 April 2016
<b>Date of response:</b>	29 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:**

There were residents and specific matters that inspectors believed would have benefited from referral to independent advocacy, particularly where these residents had complained and advocated on their own behalf but where their efforts had not resulted in a satisfactory solution.

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

**1. Action Required:**

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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

The Person In Charge will make a referral to the Independent Advocacy Services to have the views of each of the four residents represented by an external source

Updated Response:

This has been completed – The referral to the independent advocacy Service was completed. The independent advocate has met with the residents on 08/08/16 and was satisfied with the progressions of actions in selling the house and sourcing alternative accommodation for the four residents.

**Proposed Timescale:** 27/09/2016

**Theme:** Individualised Supports and Care

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

Inappropriate language was viewed by inspectors in residents' personal information as completed by staff.

Some but not all residents had provision (a key) to lock their bedroom doors; some residents expressed a wish to have this to inspectors.

Inspectors noted that there was no lock on bathroom and toilet doors which was evidenced to have the potential to impact on residents' privacy and dignity.

**2. Action Required:**

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The person in Charge addressed this matter with staff on the 26.4.2016 in relation to the use of appropriate language when completing documentation. The documentation has been reviewed and will be amended in her care plan by the 13.5.16.

The nominee provider circulated a memo to all designated centres on the 19.4.16 asking residents of their wish to have locks installed on their bedroom doors. A list has been compiled and locks will be installed where requested.

The nominee provider will ensure that locks will be installed on all bathroom doors

Updated response: This is completed

**Proposed Timescale:** 31/05/2016

**Theme:** Individualised Supports and Care

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

The current house meetings were a stand-alone infrequent process and as a result did not capture and reflect informal discussions with residents regarding issues such as activities, meal planning and shopping for example. In addition, it was not clear if actions resulting from issues raised by residents at their meetings had been satisfactorily resolved.

**3. Action Required:**

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

The person in charge has spoken to the managers in this centre to document all consultations with residents, not just those occurring at house meetings. A recommended agenda and standardised template for recording minutes circulated previously will be re-circulated by the nominee provider. The person in charge will ensure that meetings occur more frequently and minutes are circulated to all staff. The scheduling of the team meetings will be delegated to all staff in the centre. The person in charge will monitor the recording of consultations.

Updated response: This is completed

**Proposed Timescale:** 13/05/2016

**Theme:** Individualised Supports and Care

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

Residents were not satisfied with the outcomes of their complaints, measures that had been taken were not sufficient to address the matter complained of, it was not resolved.

**4. Action Required:**

Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

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

The nominee provider and the Service has committed to the residents to the sale of this house and the purchase of alternative accommodation. This proposal was discussed with HIQA on the 11.4.16

Updated Response: The house in question has been sold and the sale of the property is

with the service and purchasers solicitors for sign off. It was the intention to seek alternative accommodation to rent in the interim until an appropriate house could be purchased. However, due to the lack of availability of appropriate rental accommodation locally, the possibility to rent has not been feasible to date. Since then the service has applied for a capital assistance scheme to fund alternative accommodation. The service has received verbal confirmation that this application is successful but the service is still awaiting official documentation on this from the County Council.

It is proposed that a house to be vacated within the service would provide more suitable accommodation for the residents in the house of contention as it is placed in a more appropriate residential area. It is anticipated that this action will be completed by 31/07/2017. The service will review this plan for the existing residents once more definitive actions occur. All residents and their families have been informed of the proposed developments. The residents' will remain in this house as tenants until this is actioned or an appropriate rental accommodation becomes available.

**Proposed Timescale:** 31/07/2017

#### **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:**

it was not always clear that the review of the support plan was multidisciplinary (MDT) where there was MDT involvement or should have been MDT involvement.

**5. 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:**

The person in charge will ensure all plans of care in this centre are reviewed by key worker and MDT where they are involved. The recommendations of the MDT will be reflected in the plans of care. Where there is no MDT involvement for the individual an MDT review of the plan of care will be scheduled. Training for staff on care planning and Person centred planning was completed on 26.4.16 and will be repeated until all staff have received same.

Updated response: This is completed

**Proposed Timescale:** 31/08/2016

**Theme:** Effective Services

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

Where a need for a support plan had been identified at times there was no corresponding support plan or the required supports were broad and vague such as "staff support" or "requires staff reassurance".

**6. 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:**

The person in charge will ensure all plans of care in this centre are reviewed by key worker and MDT where they are involved. The person in charge will audit plans of care to ensure that up to date plans of care detailing exact supports required are documented. Training for staff on care planning and Person centred planning was completed on 26.4.16 and will be repeated until all staff have received same.

Updated Response: This is completed and ongoing.

**Proposed Timescale:** 31/08/2016

**Theme:** Effective Services

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

There was a need to individualise residents' goals and to demonstrate that goals were developed with a view to residents' achieving personal progression rather than a once off target. Where goals were not successfully achieved and where staff had identified potential barriers, there was no clear plan or learning from this to ensure that future goals were matched to the support plan, to individual resident skills and ability to ensure success and achievement.

**7. 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 person in charge will ensure all plans of care in this centre are reviewed by key worker and that goals are developed according to the individual needs and wishes. The person in charge will audit plans of care to ensure that up to date plans of care detailing exact supports required for each goal are documented.

Training for staff on care planning and Person centred planning was completed on 26.4.16 and the nominee provider will ensure this is repeated until all staff have received same.

Updated response: This is completed and ongoing.

**Proposed Timescale:** 31/08/2016

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The continued use of this house does not facilitate the provider in meeting the stated aims and objectives of the service or the needs of the residents. There was no ostensible change to the residents' unsatisfactory situation and it was clear that they and their home did not belong in this location. Unprompted, residents repeated their concerns to inspectors and clearly told inspectors that they wanted to move from this house.

**8. Action Required:**

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

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

The nominee provider and the Service has committed to the residents to the sale of this house and the purchase of alternative accommodation. This proposal was discussed with HIQA on the 11.4.16

Updated Response: The house in question has been sold and the sale of the property is with the service and purchasers solicitors for sign off. It was the intention to seek alternative accommodation to rent in the interim until an appropriate house could be purchased. However, due to the lack of availability of appropriate rental accommodation locally, the possibility to rent has not been feasible to date. Since then the service has applied for a capital assistance scheme to fund alternative accommodation for residents in another centre. The service has received verbal confirmation that this application is successful but the service is still awaiting official documentation on this from the County Council.

It is proposed that a house to be vacated within the service would provide more suitable accommodation for the residents in the house of contention as it is placed in a more appropriate residential area. It is anticipated that this action will be completed by 31/07/2017. The service will review this plan for the existing residents once more definitive actions occur. All residents and their families have been informed of the proposed developments. The residents' will remain in this house as tenants until this is actioned or an appropriate rental accommodation becomes available.

**Proposed Timescale:** 31/07/2017

## 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:**

In July 2014 the provider had commissioned an external competent person to undertake a fire risk assessment of the premises; recommendations assigned a medium or high priority were issued. In this regard and further to the inspection of March 2015 the Authority did not agree the action plan response to Regulation 28(1) with the provider despite affording the provider two attempts to submit a satisfactory response. In the most recent updated response requested in March 2016 and also during the inspection itself, the nominated provider again confirmed that with the exception of works to the fire detection and emergency lighting systems, the other recommended works had not been completed.

Contrary to what was stated in the response received from the provider, inspectors saw no evidence of emergency lighting in one house. The person in charge and staff on duty confirmed that there was no emergency lighting. Escape routes were not clearly indicated in this house.

Some but not all final fastenings had been replaced with internal thumb turn devices; there were residual manual key locks.

### **9. 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:**

The nominee provider will ensure that emergency lighting and exit signposting will be installed in the house identified.

Updated Response: Internal thumb turn devices have been installed on the final exit doors in this house

Emergency lighting and exit signposting has been completed. The service has enlisted the services of an external fire consultant who has issued a letter of fire assurance for the houses in this centre which has been forwarded to HIQA by the Provider Nominee on 29/06/2016. Manual Keys have been removed.

**Proposed Timescale:** 31/05/2016

## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

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

The behavioural management guidelines required review to ensure a therapeutic focus, an evidence base, and that any restrictions including physical segregation were with the

informed consent of all residents.

It was of concern that a risk assessment informing the guidelines and dated November 2015 stated that there were no known triggers; there were clearly two known, particular peers and their level of functioning and the expectations of other relevant parties.

There was no clear evidence of timely and current psychology review.

**10. 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:**

The person in charge will ensure the behaviour support plan for this resident is reviewed and updated by the MDT to reflect all triggers and supports required. An MDT meeting will be scheduled by the 31.5.16.

The person in charge will review and update the risk assessment to reflect triggers as identified through the MDT and plans of care. The plans of care will be updated.

The person in charge will pursue the psychology referral to confirm a date for review and source input from CNS in behavioural support from within another part of the organisation.

The person in charge will ensure a clear safeguarding plan will be put in to the plans of care for other residents affected to guide staff as to the supports required.

Updated Response: The resident plans of care and ABC charts has been reviewed by the Principal psychologist who in tandem with a consultation with the services of a CNS in behaviour have made minor adjustments to the resident's management plan. The resident and her management supports are reviewed by a regular MDT – last meeting occurred on 08/11/2016. The resident's independent advocate has returned to work following an absence and has had a meeting with the Provider Nominee and the PIC on 01/09/16. The independent advocate reviewed actions to date. Overall the independent advocate indicated at a meeting with the Provider Nominee happiness with measures in place and actions to date. The independent advocate continues to liase with the PIC and Provider Nominee on this resident.

**Proposed Timescale:** 10/06/2016

**Theme:** Safe Services

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

Staff said that they had not received formal training in responding to and supporting residents to manage their behaviour.

**11. Action Required:**

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

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

The nominee provider will ensure that all staff in this centre will receive additional training in responding to and supporting residents to manage their behaviour.

Updated Response: Completed and Ongoing

**Proposed Timescale:** 31/07/2016

**Theme:** Safe Services

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

While the issue was managed it was clearly not resolved and in the interest of all residents required further review and intervention.

The fundamental issue of unsuitable placement was unaltered. It was clearly stated in a needs assessment for residential placement that one resident required accommodation with a smaller group of peers of similar ability and functioning. It was recorded at the MDT meeting in November 2015 that self injurious behaviours highlighted the unsuitability of the resident's current placement.

**12. 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 nominee provider will continue to review all available vacancies in other designated centre to assess the suitability of those centres in meeting the needs of this resident and opportunity for internal transfer.

The person in charge will ensure the behaviour support plan for this resident is reviewed and updated by the MDT to reflect all triggers and supports required. An MDT meeting will be scheduled. The provider will make a referral to the CNS In Behavioural Support in another part of the organisation to assist with this process.

Updated Response: All actions completed. The resident was offered alternative accommodation as a vacancy arose in a house in the CRS. However, this offer did not progress due to the articulated views of the resident, her family and the residents in the proposed accommodation; the offer of this accommodation was transferred to another resident. The resident was reviewed by a CNS in behaviour and minor adjustments were made to the resident's plan of care in supporting her behaviour. Ongoing review

of the management of this resident is held and incidences have reduced. However the Provider Nominee will continue to explore alternative accommodation for the resident. This case has been discussed at the service Admission, Discharge and Transfer Committee and has also been highlighted with the HSE. The Provider Nominee has met with the resident several times and explained the process and also with the residents family on 28/10/16.

**Proposed Timescale:** 31/03/2017

## **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 system in place for the security of medications held by residents themselves was not sufficient.

Some of the handwritten prescriptions were illegible; the person in charge agreed. The medication management policy did not clearly stipulate the requirements and responsibilities for the generation of a prescription including its legibility.

Given that some prescriptions were illegible it was unclear how staff reconciled what was supplied with that was prescribed in line with the five rights of medication administration.

### **13. 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 person in charge discussed the issue of illegibility of prescriptions at the Service Medication and Therapeutic Committee on the 20.4.16. The medication policy will be updated to the requirements and responsibilities for the generation of a prescription including its legibility.

The key to the residents medication box has been stored separately and will be spot checked by the social care leader.

Updated Response: The residents kardex's are now issued typed from the pharmacy and were viewed by the Provider Nominee at the 6 monthly unannounced inspection on 01/11/2016 and were very clear and legible. The medication policy is currently being reviewed and this review is due to be completed by 16/12/2016. The review will include ensuring that the Medication policy clearly reflects the importance of legible prescriptions.

**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:**

A change to the persons participating in the management of the centre (PPIM) had taken place in September 2015 and the notification required by Part 7 (3) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 had not been submitted to the Chief Inspector.

**14. Action Required:**

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

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

The nominee provider has submitted the required notification NF31 and PPIM form to HIQA.

This is completed

Proposed Timescale: Complete

**Proposed Timescale:** 29/11/2016

#### **Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

The provider had failed on at least two known occasions to ensure that appropriate staffing arrangements and appropriate contingencies were in place to meet residents' needs with consequent self-reported negative outcomes for residents.

**15. 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 person in charge, PPIM and CNM3 in consultation with the residents will ensure there is a contingency plan in place for the designated centre in the event of sudden and unexpected absences of staff.

Interviews for the recruitment of additional relief staff was undertaken on the 22nd and 29th April 2016 by the nominee provider and this recruitment process has commenced.

Updated Response: Recruitment has occurred and additional relief staff have been provided. This is constantly being monitored by the Provider Nominee to ensure appropriate and consistent staff are available to residents.

**Proposed Timescale:** 31/07/2016