

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Group B - St Anne's Residential Services
Centre ID:	OSV-0003945
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Louisa Power
Support inspector(s):	Noelle Neville
Type of inspection	Announced
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
27 July 2016 09:00	27 July 2016 18:00
28 July 2016 08:15	28 July 2016 15:25

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

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

Summary of findings from this inspection

Background to the inspection:

This was an 18 outcome inspection carried out to monitor compliance with the regulations and standards and to inform a registration decision.

How we gather our evidence:

Inspectors spent time with five residents; two residents were with family on holidays at the time of the inspection. Some residents did not use verbal communication. Residents with whom inspectors spoke were very complimentary of staff and the house manager.

Residents described that they were facilitated to be active members of the local community and were very happy living in the centre. Inspectors observed that residents were comfortable in the presence of staff. Staff were very familiar with all residents' means of communication.

Assistance and support was provided in a dignified and respectful manner. Residents were observed to be offered meaningful choice and their choices were respected.

Inspectors met and spoke with staff members. Inspectors observed practices and reviewed documentation such as plans of care, medical records, accident logs, policies and procedures.

Inspectors spoke with two residents' relatives during the inspection and reviewed resident and relative questionnaires submitted to the Health Information and Quality Authority (HIQA) post inspection; their feedback is included in the report.

Interviews were carried out with the person in charge, house manager and person nominated on behalf of the provider.

Description of the service:

The provider must produce a document called the statement of purpose that explains the service they provide. Inspectors found that the service was being provided as it was described in that document.

The centre comprised two adjoining two storey semi-detached houses located in a modern housing development. The housing development was in the outskirts of a large town and was within walking distance of local amenities. The centre provided single occupancy en-suite bedrooms for the residents as well as communal living facilities. The service was available to adult men and women with moderate, severe or profound intellectual disabilities. The centre supported residents with a variety of sensory, health and physical care needs including epilepsy, autism and mental health.

Overall judgment of findings:

Overall, inspectors found that residents had a good quality of life in the centre and the provider had arrangements in place to promote their rights and safety. Inspectors found major non-compliances in two core areas. Inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre. Management systems were not adequate to support and promote the delivery of safe and effective services.

Inspectors were satisfied that the provider had put systems in place to ensure that the regulations were being met in many areas. The person in charge and person nominated on behalf of the provider demonstrated adequate knowledge and competence during the inspection and inspectors were satisfied that both were fit persons to participate in the management of the centre.

This resulted in positive experiences for residents, the details of which are described

in the report.

Good practice was identified in the following areas:

- strong links with family were promoted (outcome 3)
- admissions were safe (outcome 4)
- robust safeguarding practices (outcome 8).

Improvements were required in the following areas:

- development, implementation and review of healthcare plans (outcome 11)
- inconsistent medicines management practices (outcome 12)
- review of staffing levels in line with residents' needs and interests (outcome 17).

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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:

Residents with whom inspectors spoke and interacted with stated that they felt safe and spoke positively about their care and the consideration they received. Interaction between residents and staff was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance.

Systems were in place to promote the involvement of residents and their representatives in the centre. Regular monthly house meetings took place. Minutes of these meetings were reviewed by an inspector. Items discussed included menu choices, day trips, holidays, community activities and personnel changes. The meetings were also used as a forum to educate residents in relation to making a complaint, their rights, safety, money management and healthy eating. Minutes indicated that the house meeting was a meaningful and effective forum with each resident given the opportunity to communicate their views.

Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their daily routine, meals, assisting residents in personalising their bedrooms and their choice of activities. Residents were encouraged to choose their activities. Inspectors saw that steps were taken to support and assist residents to provide consent and make decisions about their care and support.

Inspectors observed that residents were supported in a dignified and respectful manner. Residents' capacity to exercise personal independence was promoted. For example, residents' ability to perform tasks in relation to personal hygiene and dressing was

identified and residents were encouraged to perform these tasks.

Residents were encouraged to maintain their own privacy and dignity. Staff were observed to knock on bedroom doors before entering. An en-suite shower room was provided for each resident. Shared bathrooms were provided on the first floor which offered residents the choice of a bath if they wished. Suitable locks were provided on the doors of sanitary facilities to facilitate residents to adequately maintain their privacy and dignity.

The intimate care policy, dated May 2015, outlined how residents and staff were protected. An intimate care check list was completed for each resident which informed the plan of care in relation to intimate care. The intimate care plan was reviewed regularly. The plan outlined in detail the supports required and the resident's preference in relation to the gender of staff delivering personal care.

Residents' personal communications were respected. Residents reported that they could access the telephone provided in the centre at all times. Some residents had their own mobile telephone which they used to communicate with family and friends. Wireless internet was provided throughout.

There was a complaints policy which was also available in an accessible format and had been reviewed in February 2015. The complaints policy identified the nominated complaints officer and also included an independent appeals process. The policy was displayed prominently throughout and inspectors saw that the complaints procedure was discussed with residents individually and at house meetings. Residents' relatives with whom inspectors spoke outlined that they were aware of the process if they wished to make a complaint. An inspector reviewed the complaints log detailing the investigation, responses and outcome of any complaints. The complaints form also recorded whether the complainant was satisfied. The investigation undertaken in response to complaints was thorough, comprehensive and prompt. Learning from complaints was clearly identified to prevent recurrence. Complaints were reported and discussed at weekly management meetings.

Residents were encouraged and facilitate to retain control over their own possessions. There was adequate space provided for storage of personal possessions. Records in relation to residents' valuables were maintained and updated regularly in line with the centre-specific policy. Residents were supported to do their own laundry if they wished and adequate facilities were available.

Residents had easy access to personal monies and, where possible, control over their own financial affairs in accordance with their wishes. Money competency assessments were completed annually for each resident which outlined the supports and training needs, if any, required. Staff outlined a transparent and robust system for the management of residents' finances who required support in this area. An itemised record of the all transactions with the accompanying receipts was kept in a ledger. Each resident was noted to have their own ledger with corresponding receipt book. The ledger balance matched the actual balance of funds available and the ledger was noted to be signed by two members of staff at each transaction. The ledger balance was checked twice daily by staff. The house manager informed inspectors that staff complete

a monthly reconciliation sheet and submit this to the finance department for review. A reconciliation sheet was viewed by inspectors. The house manager confirmed that there were never any discrepancies or issues with residents' finances.

Residents are facilitated to exercise their civil, political and religious rights. Easy read information was provided to residents in relation to their rights. Residents were afforded the opportunity to vote. Residents were supported to access religious services and supports in line with their wishes.

Judgment:

Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were facilitated to communicate in line with the centre-specific policy, reviewed in July 2015. Residents had diverse communication needs; some residents did not use verbal communication. Inspectors observed that staff were aware of each resident's individual communication needs and facilitated residents to communicate effectively at all times.

A comprehensive assessment of each resident's individual communication needs was completed annually and this informed the plan of care developed for this area. In addition, some residents had access to specialist input from speech and language therapists, in line with their needs, who completed comprehensive communication assessments.

Residents were facilitated to access assistive technology, aids and appliances to promote their full communication capabilities.

Visual aids and picture books were available to facilitate communication with residents, in line with the recommendations from the speech and language therapists.

A sample of personal plans was reviewed. The plans of care reviewed in relation to communication were comprehensive and outlined individual requirements, interventions and goals in relation to effective communication. However, inspectors noted that the recommendations from the speech and language therapist dated February 2016 were not comprehensively integrated into one resident's care plans to ensure that all staff

were aware of and implemented these recommendations.

The centre was part of the local community and residents had access to radio, television and wireless internet. Local and national newspapers were available to residents.

Judgment:

Substantially Compliant

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to develop and maintain personal relationships and strong links with the wider community. Families were encouraged to be involved in the lives of residents. However, improvements were required to ensure that community access was facilitated for all residents in line with their interests.

Positive relationships between residents and family members were supported. Residents were supported to spend time with family including overnight trips at weekends and holidays. At the time of the inspection, two residents spent time away with family on holidays. Residents were facilitated to keep in regular contact with family through telephone calls and family members were made welcome when visiting. There were adequate facilities for each resident to receive visitors and a number of areas were available if residents wished to meet visitors in private. Residents' relatives reported that they were always made to feel welcome when they visited.

Residents' relatives confirmed that they were kept informed of residents' well being on an ongoing and informal basis. Records confirmed that families and residents attended personal planning meetings and reviews in accordance with the wishes of the resident.

There was policy in relation to visitors and the policy had been reviewed in June 2014. The policy outlined that visitors were 'valued and supported in line with the wishes of individual residents'.

Residents were supported to participate in a range of activities in the local and wider community including meals out, music lessons, walks, trips to local amenities, exercise classes, Special Olympics training and events, shopping and cultural events. Residents were encouraged to shop, dine out, attend religious services and use services such as barbers, hairdressers and beauticians locally. A resident with whom inspectors spoke

had recently returned from an annual pilgrimage abroad with the local diocesan group.

However, inspectors saw and family members reported that social outings for a resident were restricted due to the changing needs and interests of peers. For example, staff and family members outlined that a resident was unable to attend a local music festival on the weekend before the inspection as staff were unable to facilitate the activity. This was discussed at length with the house manager who acknowledged the negative impact on the resident's quality of life and social inclusion.

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

The policy on admissions, transfers and discharge of residents, which had been reviewed in October 2015, was made available. The policy outlined the transparent criteria for admission and took account of the need to protect residents from abuse by their peers. Residents' admissions were seen to be in line with the statement of purpose.

A written contract was in place which dealt with the support, care and welfare of the resident in the centre and included details of the services to be provided. The fees and additional charges were included.

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):

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

Findings:

A sample of residents' plans was reviewed. An assessment of the health, personal, social care and support needs of the resident was completed annually and the information recorded as part of the assessment was individualised and person centred. The assessment formed the basis of an individual plan of care. A plan of care had been developed for each resident. The plan of care outlined residents' needs in many areas including communication, comprehension and decision making, eating and drinking, mobility, personal care, safe environment, sensory needs, spirituality and relationships. The resident and representatives were consulted with and participated in the development of the plan of care.

Goals and objectives were clearly outlined. There was evidence of resident involvement in agreeing/setting these goals. There was also evidence that individual goals were achieved for many residents. The goals outlined were based on residents' individual wishes including attending specific social events, building family links, attending art classes and holidays abroad. A goal tracking template was used to identify the resources required, steps need to plan, any obstacles encountered and the completion of goals. The person responsible for supporting the resident in pursuing these goals and the timeframe for completion was clearly identified.

However, inspectors noted that goals were not based on residents' assessed needs to ensure that personal development was maximised. For example, inspectors noted that a financial needs assessment identified that a resident would benefit from skills teaching in this area but a goal had not been developed in relation to this.

Staff and the person in charge outlined that the plan of care was subject to a review on an annual basis or more frequently if circumstances change. There was evidence that the review was carried out with the maximum participation of the resident. The review did assess the effectiveness of the plan and reviewed the goals/aspirations that had been identified.

However, inspectors saw that one plan of care had not been reviewed and updated where a diagnosis of a condition that could have a potentially major impact on quality of life and independence had been made eight months previously. The house manager confirmed that planned goals for this resident had been suspended since this diagnosis. The house manager and person in charge confirmed that a review of the resident's personal plan was planned for 10 August 2016.

There was evidence of multi-disciplinary team involvement for all residents, in line with their needs, including psychiatry, speech and language therapy, general practitioner (GP), optical, audiology and psychology services. However, the review of the plan of

care was not multidisciplinary in all plans of care seen during inspection.

Changes in circumstances and new developments were included in the personal plan and amendments were made as appropriate. Residents reported that their personal plan had been made available in an accessible format in line with their needs.

A booklet ('hospital passport') was available for staff to record relevant and important information in the event of a resident being transferred to hospital. The hospital passport was completed in advance and contained comprehensive information in relation to the needs of the resident including communication, personal care and healthcare.

However, the hospital passport was not accurate for one resident. The resident did not communicate verbally and the hospital passport did not clearly indicate the resident's means of communication. The resident required assistance to eat and drink; this was not clearly outlined in the hospital passport.

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):

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was in line with the centre's statement of purpose and met residents' individual and collective needs in a homely and comfortable way. However, there were some areas that required attention including maintenance and inadequate storage.

The centre comprised two adjoining domestic two-storey houses located in a modern housing development. The centre was located in the suburbs of a large town close to local amenities and transport links.

The centre contained nine bedrooms; two bedrooms were located on the ground floor and seven bedrooms were located on the first floor. One of the bedrooms on the first floor was for staff use and doubled up as office space. An additional dedicated office was also provided. Adequate sanitary facilities were provided with en-suite shower

facilities in all bedrooms, two toilets downstairs and two bathrooms on the first floor.

There was adequate private and communal space for residents. Bedrooms were personalised with the resident's choice of soft furnishings, photographs of family and friends and personal memorabilia. Ample storage space was provided for residents' personal use. Apart from the residents' own bedrooms, there were options for residents to spend time alone if they wished with two large sitting rooms and two kitchen/dining areas provided. All rooms were of a suitable size and layout for the needs of residents.

The centre was suitably decorated throughout. The residents had input into the décor of the centre and the centre was decorated to reflect residents' tastes and preferences. There was suitable heating, lighting and ventilation and the centre was free from major hazards. There were suitable and sufficient furnishings, fixtures and fittings. Suitable adaptations such as grab rails were provided where appropriate.

However, inspectors noted that some aspects required upgrade and maintenance. The wooden flooring downstairs and carpet on the stairs were damaged and scuffed; this had been identified during the most recent unannounced visit by the registered provider. Areas of paintwork in a ground floor bedroom required attention as the paint was chipped and scuffed in areas. A handle was missing from a resident's wardrobe.

Inspectors noted that there was a clear system of regular cleaning in place in the centre. A comprehensive cleaning schedule was in place. Staff reported that adequate cleaning equipment was provided. The centre was visibly clean. However, storage space for cleaning equipment including mops was limited and could lead to cross contamination.

Each premises had a separate kitchen that was fitted with appropriate cooking facilities and equipment. Adequate laundry facilities were provided and residents were supported to launder their own clothes if they so wish. A contract was in place for the disposal of waste. However, inadequate storage was available and inspectors saw clothes drying equipment and an ironing board stored in a downstairs toilet.

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):

No actions were required from the previous inspection.

Findings:

There was a health and safety statement in place which outlined general aims and

objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy, last reviewed in July 2015. The risk management policy had been updated since the last inspection to include the process for reporting incidents. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk.

The risk register was reviewed by an inspector who saw that there was a system to identify and review hazards on an ongoing basis. The risks identified specifically in the regulations were included in the risk register. There was evidence that risk assessments had been implemented in practice and were kept under continual review. However, inspectors noted some risks that were not included in the risk register including unrestricted windows on the first floor and unrestricted access to latex gloves.

Individualised risk assessments were developed for each resident. The risk assessments identified the individual hazards and controls in place to mitigate the risks. Inspectors saw that the controls in place were implemented and there was evidence of ongoing review in line with residents' changing needs. Residents were facilitated to take reasonable and positive risks such as walking independently in the local area and using public transport unaccompanied. However, one risk assessment in relation to safety contradicted a risk assessment in relation to a resident who went on independent walks and could potentially impact on this resident taking positive risks.

A comprehensive emergency plan was in place, dated May 2014, which covered events such as natural disasters and utility failure. Provision was made to cover an event where the centre may be uninhabitable.

An inspector reviewed a sample of incident forms and saw that accidents and incidents were identified, reported on an incident form and there were arrangements in place for investigating and learning from accidents. The inspector noted that the improvements identified were implemented in a timely fashion. Incident forms were reviewed by a member of the management team in a timely manner and were discussed at weekly management meetings.

Suitable fire safety equipment was provided throughout the centre. Fire safety equipment was to be serviced on an annual basis, most recently in October 2015. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation in event of fire was displayed in a number of areas. However, inspectors noted that inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre. Due to the potential catastrophic impact of a fire, this outcome was judged to be at a level of major non-compliance.

The fire panel and emergency lighting was serviced on a quarterly basis, most recently in July 2016. Records of daily and monthly fire checks were kept. These checks included inspection of the fire panel, escape routes, emergency lighting and evacuation procedure.

Staff demonstrated good knowledge in relation to fire safety and the procedure to follow

in event of a fire. The training matrix confirmed that fire safety training and regular refresher training was mandatory for all staff. However, the training matrix indicated that one staff member required refresher fire training.

Fire drills took place at least every month. Residents and staff reported that they had all attended a recent fire drill. A detailed description of the fire drill, duration, participants and any issues identified was maintained for many fire drills. However, it was noted that fire drills only simulated day time conditions and the associated staffing levels. In addition, two fire drill records since January 2016 did not record the number of residents present at the time of the drill. Therefore, it could not be demonstrated that the fire evacuation procedures in place were adequate to evacuate all residents safely at all times.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. However, the PEEP only outlined whether a resident was ambulant or non-ambulant. Inspectors noted that, for five fire drills from March to July 2016, one resident required assistance due to declining mobility. Staff with whom inspectors spoke were aware of the assistance required but the resident's PEEP did not reflect the assistance required.

Procedures were in place for the prevention and control of infection. A comprehensive infection prevention and control policy was available, dated July 2015. The centre was visibly clean throughout. A colour coded cleaning system was in place to prevent cross contamination. Staff confirmed that personal protective equipment such as gloves and aprons were available. A robust procedure was in place for the safe handling of laundry and alginate bags were available for the safe handling and segregation of soiled laundry. The training matrix indicated that all staff members had completed infection prevention and control training.

The training matrix confirmed that moving and handling training and refresher training was mandatory for all staff. Safe moving and handling practices were observed.

Vehicles were available and records confirmed that the vehicles were roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

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):

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

Findings:

Systems were in place to protect residents from being harmed or suffering abuse. A restraint-free environment was promoted. Supports were in place to ensure that residents were provided with emotional, behavioural and therapeutic support that promoted a positive approach to behaviour that challenges.

There was a policy and procedure in place in relation to the safeguarding of vulnerable adults, reviewed in January 2016. The policy identified the designated safeguarding officer and their deputy. The policy and procedure were comprehensive, evidence based and would effectively guide staff in the reporting and investigation of incidents, allegations or suspicions of abuse. The policy included a reporting pathway if the allegation was made against a member of the management team.

Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. Staff were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. However, the training matrix indicated that all staff required refresher training in line with the safeguarding vulnerable adults at risk of abuse national policy.

Residents with whom inspectors spoke confirmed that they felt safe in the centre and that they knew who to talk to if they needed to report any concerns of abuse. Residents' relatives confirmed that they believed their family members were kept safe from abuse and would report any concerns of abuse to the house manager or the person in charge.

The provider and person in charge monitored the systems in place to protect residents and ensure that there are no barriers to staff or residents disclosing abuse. A robust recruitment and selection procedure was implemented, all staff received ongoing training in understanding abuse and staff stated that there was an open culture of reporting within the organisation.

Inspectors noted that there had been no incidents, allegations and suspicions of abuse since the last inspection. The person in charge and the person nominated on behalf of the provider outlined the steps that would be taken to ensure that any incident, allegation or suspicion of abuse was appropriately and comprehensively recorded, investigated and responded to in line with the centre's policy, national guidance and legislation. Residents, relatives and staff confirmed that they believed that the house manager and the person in charge would act appropriately if there was an incident, allegation or suspicion of abuse.

A policy was in place to support residents with behaviour that challenges, reviewed in September 2014. The policy was comprehensive and focussed on understanding the function of the behaviour, responding and communicating appropriately and identifying

triggers for the behaviour. Training records confirmed that training was provided to staff in the management of behaviour that is challenging including de-escalation and intervention techniques.

An inspector reviewed a selection of plans to support residents with behaviour that challenges and spoke with staff. Residents and their representatives were involved in discussions and reviews that had been arranged to support residents to manage their own behaviour. Clear strategies were in place to support residents to manage their own behaviour and staff were able to describe the strategies in use. Protocols were in place and evidence based tools were used to validate that the strategies outlined were effective.

The policy in relation to restrictive practices was made available. The policy had been reviewed in July 2014, was comprehensive and was in line with evidence-based practice. Staff with whom inspectors spoke were knowledgeable in relation to the policy and outlined that physical and environmental restraint was not in use in the centre at the time of the inspection. The inspector noted that a resident was prescribed a medicine to be used 'as required' as a chemical restraint. Medication administration records indicated that this medicine was used very infrequently. The positive behaviour support plan contained comprehensive information to guide staff in relation to appropriate administration and monitoring of this medicine.

Judgment:

Substantially Compliant

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:

A comprehensive record of all incidents was maintained. Notifications to HIQA were made in line with the requirements of the regulations.

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):

No actions were required from the previous inspection.

Findings:

There was a policy in place on access to education, training and development which had been reviewed in April 2016. Residents outlined that their education, training and development needs were met through attending a day service run by the organisation locally on week days. A number of day services were available to residents in line with their needs and transport was provided. Some residents outlined that they had paid employment in local businesses or establishments run by the organisation. At the time of the inspection, residents were on holidays from their day service.

An assessment of resident's educational, training and employment goals was undertaken as part of the comprehensive assessment. The assessment tool gathered information in relation to education history, current training/employment, literacy, time recognition and numeracy. The assessment formed the development of a plan of care. The assessment and plan of care were seen to be comprehensively completed for many residents. However, for two residents, areas of the assessment were left blank including education history, numeracy, literacy, time recognition and independence. A plan of care in relation to one resident's education, training and employment goals had not been developed.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents were supported on an individual basis to achieve and enjoy best possible health. However, improvements were required in relation to the documentation of each resident's wishes in relation to care and support during times of illness and access to

specialist services.

Residents' healthcare needs were met through timely access to health care services and appropriate treatment and therapies. A medical practitioner of their choice was available to each resident and an "out of hours" service was available if required. Access to a medical practitioner was facilitated regularly. There was clear evidence that where treatment was recommended and agreed by residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Inspectors noted that plans of care had been developed in line with residents' individual health care needs such as diabetes, epilepsy, cardiac needs, mental health, nutrition and mobility. However, inspectors noted that some plans of care were contradictory. A care plan in relation to nutrition for one resident contained a low fat high fibre eating plan dated June 2015 and an extra calorie eating plan dated June 2014. One plan outlined that 0% fat dairy products be offered and the other plan outlined that full fat dairy products be offered. The house manager confirmed that the resident was on a low fat high fibre eating plan. A health check care plan had not been updated following updated recommendations from the dietician in relation to frequency of weight checks; the nutrition care plan had been updated.

Staff with whom inspectors spoke outlined adequate knowledge of residents' healthcare needs and the associated interventions as outlined in the plans of care. However, inspectors saw that a plan of care in relation to high blood pressure was not implemented as the plan of care outlined that blood pressure was to be recorded twice per month and staff confirmed that blood pressure was recorded monthly.

Where referrals were made to specialist services or consultants, staff supported residents to attend appointments. In line with their needs, residents had ongoing access to allied healthcare professionals including psychiatry, audiology, dental, dietetics, optical and chiropody. However, inspectors saw that there was a delay in accessing psychology and physiotherapy. A referral had been made for one resident to review the positive behaviour support plan in March 2015 and again in March 2016. Staff confirmed that the referral was still outstanding at the time of the inspection. In addition, a referral had been sent for physiotherapy for a resident in February 2016 and staff confirmed that the referral was outstanding at the time of the inspection.

The end of life policy was made available which described the procedure to be followed in the event of a sudden or unexpected death. A comprehensive and sensitive discussion had taken place with residents and their representatives to residents' views in relation to loss, death, dying and end of life. A plan of care for end of life was developed based on this discussion. However, much of the information contained in the plan of care related to care after death. Staff confirmed that an individualised plan of care had not been developed in relation to care at times of illness for each resident. Therefore, information would not be available to guide staff in meeting all residents' needs whilst respecting their dignity, autonomy, rights and wishes.

The management of epilepsy was in line with evidence-based practice. Residents were supported to attend regular reviews in relation to epilepsy management. Staff were conversant in the management of epilepsy and seizures. Where 'rescue' medicine was

prescribed, inspectors that the medicine was available at all times and staff had been trained in the administration of this medicine. Individualised epilepsy care plans had been developed for all residents with a diagnosis of epilepsy which outlined type of epilepsy, description of seizures, identified triggers, medicines prescribed, frequency of review, 'rescue' medicines prescribed and management of seizures.

The management of dementia was guided by a clinical nurse specialist who reviewed each resident with dementia at least annually or in line with their changing needs. Recommendations as a result of this review were implemented by staff. A comprehensive and individualised plan of care was developed for each resident with dementia which was person centred and focussed on residents maintaining independence and autonomy. Inspectors observed the interaction between staff and residents with dementia and saw that staff endeavoured to provide individualised and flexible support to residents. Residents were facilitated to be independent in completing their daily routines and staff were observed to ensure that residents were supported to maintain their functional abilities for as long as possible. However, where a recommendation had been made by the clinical nurse specialist to ensure robust assessment and response to pain, inspectors saw that this had not been fully implemented. A pain assessment tool had been placed in the resident's plan of care but no guidance was given in relation to the application of and response following the use of the tool to ensure timely response to pain.

Residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control and healthy eating. Residents were encouraged to be active through swimming, walking and participating in team sports. Staff with whom inspectors spoke outlined that residents were supported to access a clinical nurse specialist in nutrition, a dietician or speech and language therapist in line with their needs.

Residents were encouraged to be involved in the preparation and cooking each meal. Residents reported that a choice was offered for each meal. The meals outlined by staff and residents were nutritious and varied. A healthy choice of cereals, hot beverages, toast and yoghurt were available for breakfast.

There were ample supplies and choice of fresh food available for the preparation of meals. Outside of set mealtimes, residents had access to a selection of refreshments and snacks and residents were encouraged to prepare their own refreshments and snacks. There was adequate provision for residents to store food in hygienic conditions.

Residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. Health information specific to residents' needs was available in an easy read format.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Medicines for residents were supplied by a local community pharmacy. Staff confirmed that the pharmacist was facilitated to meet his/her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

There was a centre-specific medicines management policy and had been reviewed in July 2015. The policy detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. Staff demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. The training matrix indicated that training had been provided to staff in relation to medicines management.

Inspectors noted that medicines were stored securely throughout. Staff stated and inspectors confirmed that medicines requiring refrigeration or additional controls were not in use at the time of the inspection.

A sample of medication prescription and administration records was reviewed by an inspection. Medication prescriptions records contained the required information. Medication administration records identified the medicines on the prescription and allowed space to record comments on withholding or refusing medicines.

The practice of transcription was in line with guidance issued by An Bord Altranais agus Cnáimhseachais. The signature of the transcribing nurse and the signature of the second nurse who independently checks the transcribed record were present and the records were co-signed by the prescriber.

An individualised medicines management plan of care had been developed for each resident to guide staff in relation to the administration of medicines to each resident and the associated monitoring of medicines for effectiveness or side effects. Staff with whom inspectors spoke were knowledgeable in relation to each individual plan of care.

An inspector observed medicines administration on the second day of the inspection and saw that staff did adhere to many aspects of the medicines management policy and best practice. However, the staff member did not check the labels and contents of the compliance aid before administering the medicines to ensure that the medicines in the compliance aid corresponded to the prescription. The contents were checked by the inspector who confirmed that medicines were administered as prescribed. The practice posed a potential risk of residents not receiving their medicines as prescribed.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines. Staff with whom inspectors spoke confirmed that no residents were self-administering medicines at the time of inspection. A comprehensive and individualised risk assessment was available which took into account cognition, communication, reception and dexterity.

Staff outlined the manner in which medicines which were out of date or dispensed to a resident but were no longer needed are stored in a secure manner, segregated from other medicinal products and were returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

Staff confirmed that there was a checking process in place to confirm that the medicines received from the pharmacy correspond with the prescription records. A system was in place for reviewing and monitoring safe medicines management practices. The results of the most recent medicines management audit in July 2016 were made available. Inspectors confirmed that actions had been completed.

When residents left the centre for holidays or days out, a documented record was maintained of the quantity and medicines given to the resident and/or their representative. This record was signed by staff and the resident and/or their representative. A similar record was maintained when the resident returned to the centre and the quantities were reconciled by staff.

A sample of medication incident forms were reviewed and inspectors saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for

residents. The statement of purpose was made available to residents and their representatives.

The statement of purpose contained all of the information required and inspectors found that the Statement of Purpose was clearly implemented in practice. The statement of purpose had been last reviewed in July 2016.

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:

There was evidence of a defined management structure that identified the lines of authority and accountability, specified roles, and details of responsibilities for all areas of service provision. However, a review of the management systems was required to ensure effective governance, operational management and administration of the centre.

The person in charge was employed full time by the organisation. The person in charge was a registered nurse in intellectual disabilities (RNID) and had worked in the service since 1990. The person in charge was observed to be familiar with the residents, their health and social care needs and community inclusion. The person in charge was aware of any complaints or adverse incidents in the centre.

The person in charge was also appointed as the person in charge in three other centres. A house manager was appointed in the centre to ensure the effective governance, operational management and administration of the centre. The house manager demonstrated an in-depth knowledge of the residents, their achievements, likes/dislikes and their support needs. Residents were observed to be comfortable and familiar with the house manager. Residents and their relatives were very complimentary of the house manager and the support she provided. Staff confirmed that the house manager was approachable and supportive. The house manager confirmed that the person in charge was accessible at all times. A good working relationship was observed between the person in charge and the house manager.

However, the house manager was appointed as house manager in another centre and therefore spent a maximum of 19.5 hours in the centre per week. The report from the annual review by the provider in 2015 identified that a review of the governance was required and that there were no supernumery hours for the house manager. The house manager acknowledged to inspectors that it was a challenge to ensure adequate oversight in this centre due to competing priorities and the changing needs of the residents. Relatives with whom inspectors spoke reported that they had encountered difficulties in contacting the house manager as she may be in the other centre.

Inspectors concluded, based on the findings of this report and the potential negative impact on residents, that the management systems at the time of the inspection did not support and promote the delivery of safe and effective services. There was evidence of inadequate oversight which had led to the failings outlined in this report including inconsistent medicines management practices, lack of psychology services, inadequate fire safety measures, limited access to the community for some residents, aspects of maintenance which required attention and gaps in the care planning processes and procedures. An action identified at the previous inspection in relation to inadequate levels and skill mix of staff, which resulted in negative outcomes for residents, had not been satisfactorily addressed.

There were established regular weekly management meetings attended by the persons in charge in all centres, clinical nurse managers and the person nominated on behalf of the provider.

The provider had arranged for an unannounced visit to the centre in the last six months to assess quality and safety of the care and support in the centre. The most recent unannounced visit which had been completed in January 2016. There was evidence of progress against the action plan.

The annual review of the quality and safety of care in the centre was made available. The review was comprehensive and based on the standards and regulations. Areas for improvement were identified and actions completed in a timely fashion. There was evidence of ongoing quality assurance and improvement through regular audits in key areas such as infection prevention and control, fire safety, medicines management and risk management. An annual survey of residents/representatives had been completed in October 2015. The audits identified areas for improvement and audit recommendations. Improvements were brought about as a result of learning from audits.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

<p>Theme: Leadership, Governance and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There had been no periods where the person in charge was absent from the centre for 28 days or more since the commencement of the Regulations and there had been no change to the person in charge.</p> <p>The provider was aware of the obligation to inform the Chief Inspector if there is any proposed absence of the person in charge and the arrangements to cover for the absence.</p> <p>Inspectors were satisfied that suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. The house manager was nominated as the person responsible for the management of the centre in the absence of the person in charge with support from two clinical nurse managers.</p>
<p>Judgment: Compliant</p>

<p>Outcome 16: Use of Resources <i>The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.</i></p>
<p>Theme: Use of Resources</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The centre was adequately resourced to ensure the effective safe and effective delivery of care and support in accordance with the Statement of Purpose. Sufficient resources were available to support residents to achieve the goals. Inspectors observed that there was sufficient transparency in planning and deployment of resources in the centre. The facilities and services available in the designated centre reflected the Statement of Purpose.</p>
<p>Judgment: Compliant</p>

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

There was a planned and actual staff roster in place which showed the staff on duty during the day and the sleepover staff on duty at night. At the previous inspection, staffing levels required review. The actions required were not satisfactorily implemented and the proposed timescale in the provider's action plan had passed. The house manager and staff confirmed that there were times when residents' activities were dictated by staffing levels, especially at weekends. This was further compounded by residents' changing needs and their associated increased requirement for support. Residents and their relatives reported that opportunities to access the community for activities, personal shopping or meals out were sometimes limited due to staffing constraints. In addition, residents' relatives outlined that agency staff and recent staff moves to other centres had resulted in an inconsistency of staffing which had caused residents some distress.

Staff files were kept centrally at the organisation's head offices and were not examined as part of this inspection. There was evidence of effective recruitment and induction procedures; in line with the centre-specific policy, last reviewed in June 2014.

Staff were observed to be supervised appropriate to their role on a formal and informal basis. Regular staff meetings were held and items discussed included policies and procedures, audit results, training, arrangements for residents' finances, activities, advocacy, risk management, complaints, staffing levels and infection control.

Staff were able to articulate clearly the management structure and reporting relationships. Copies of both the regulations and the standards had been made available to staff and staff spoken with demonstrated adequate knowledge of these documents.

Staff training records demonstrated a proactive commitment to the ongoing maintenance and development of staff knowledge. Training had been completed in food safety by all staff since the last inspection. However, the training matrix indicated that dementia training had not been completed by four staff in line with residents' needs. In addition, the training matrix indicated that three staff had not completed training in communication.

Volunteers received supervision and vetting appropriate to their role and level of involvement in the centre.

Judgment:

Non Compliant - Moderate

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:

The records listed in Schedules 2, 3 and 4 of the regulations were maintained in the centre. However, the directory of residents was not complete as the marital status was not recorded for all residents and the date of admission was not recorded for three residents.

All of the key policies as listed in Schedule 5 of the regulations were in place. These policies were stored in the centre and were easily accessible for staff. A process was in place to ensure that policies and procedures were reviewed and updated to reflect best practice and at intervals not exceeding three years. However, the medicines management policy did not contain information to guide staff on the safe administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections. Inspectors noted that some residents were prescribed topical preparations and eye drops at the time of the inspection.

Records were kept securely, were easily accessible and were kept for the required period of time. A system was in place to store residents' records were stored securely. The system in place for maintaining files and records was very well organised. However, inspectors saw that correction fluid and pencil was used in some residents' records.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the regulations.

<p>Judgment: Substantially Compliant</p>

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:

Louisa Power
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0003945
Date of Inspection:	27 and 28 July 2016
Date of response:	28 October 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 02: Communication

Theme: Individualised Supports and Care

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

The recommendations from the speech and language therapist from February 2016 were not comprehensively integrated into one resident's care plans to ensure that all staff were aware of and implemented these recommendations.

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

1. Action Required:

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

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

The Person In Charge and Home Manager discussed the Speech and Language report of Feb 2016 for this service-user at a House Meeting on 13/10/16 and the recommendations were transferred to the service-user's care plan. All staff fully aware of the reviewed intervention plan.

Proposed Timescale: 13/10/2016

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

Theme: Individualised Supports and Care

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

Social outings for a resident were restricted due to the changing needs and interests of their peers.

2. Action Required:

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

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

This issue was discussed with all staff with emphasis on striving to facilitate individual activities of choice. Individual activity planners were reviewed in line with Person Centred Plans. Forward planning for events has been incorporated into the rosters, where an activity has been identified the required number of staff will be rostered on. The Home Manager and keyworkers will monitor this process to ensure community access is facilitated for all residents in line with their interests.

Proposed Timescale: 13/10/2016

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:

Goals were not based on residents' assessed needs to ensure that personal development was maximised.

Planned goals had been suspended for one resident.

3. Action Required:

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

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

Based on an assessment of needs service users Person Centred Plans were reviewed on 10/08/16. The goals identified were based on the recommendations of their assessments and were specific to the changing needs of the service users to maximise the quality of care and promote their independence and wellbeing. The plans will be reviewed in a timely manner by the Home manager and the Person in Charge. Any change in needs will be highlighted and reassessed by a CNS as required.

Proposed Timescale: 10/08/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

A plan of care had not been reviewed and updated where a resident had been diagnosed with a condition that could have a potentially major impact on quality of life and independence.

4. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

Following the service users Person Centred Planning meeting 10/08/16, the plan of care was reviewed by Home Manager and Person In Charge. The reviewed care plan reflected the recommendations of their assessment and the goals identified at her planning meeting. The plans of care will be reviewed in a timely manner with input from members of the Multidisciplinary Team as required.

Proposed Timescale: 10/08/2016**Theme:** Effective Services**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The review of the plan of care was not multidisciplinary in all plans of care seen during inspection.

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:

Following service users Person Centred Planning meeting on 10/08/16, the plans of care were reviewed by Home Manager and Person In Charge. The reviewed care plans reflected the recommendations of their assessments and the goals identified at the planning meeting. The plans of care will be reviewed in a timely manner with input from members of the Multidisciplinary Team as required.

Proposed Timescale: 31/12/2016

Theme: Effective Services

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

The hospital passport was not accurate for one resident.

6. Action Required:

Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

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

Following the HIQA inspection the Home Manager and Keyworker reviewed the Hospital Passport and updated the information to reflect the changing needs in the relevant areas for this service-user.

Proposed Timescale: 29/07/2016

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 wooden flooring downstairs and carpet on the stairs were damaged and scuffed.

Areas of paintwork in a ground floor bedroom required attention as the paint was chipped and scuffed in areas.

A handle was missing from a resident's wardrobe.

7. Action Required:

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

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

A repair form was submitted to the Maintenance Department and the handle was replaced on the resident's wardrobe door on 09/08/2016. New flooring and paint works are being completed by the maintenance department

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Storage was limited for cleaning and laundry equipment.

8. Action Required:

Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

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

The Service is currently sourcing a secure and accessible storing system for community residents.

Proposed Timescale: 30/11/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Some risks that were not included in the risk register including unrestricted windows on the first floor and unrestricted access to latex gloves

9. Action Required:

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

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

The risk register was reviewed and now includes the risk of unrestricted windows on the first floor and the unrestricted access to latex gloves.

Proposed Timescale: 15/09/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Contradictory risk assessments could potentially impact on positive risk taking.

10. 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:

The risk assessments have been reviewed by the Home Manager and the Person In Charge. The changes made reflect the support required to maintain the levels of independence and to promote positive risk taking.

Proposed Timescale: 10/08/2016

Theme: Effective Services

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

Personal evacuation plans were not reflective of the assistance required to evacuate each resident.

11. 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 personal evacuation plans were reviewed in line with the Mobility Risk Assessment by Home Manager and Person In Charge.

The changing needs of the service-user are now reflected in their personal evacuation plans.

This will be continuously monitored and reviewed based on changing needs.

Proposed Timescale: 17/10/2016

Theme: Effective Services

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

Inadequate measures were in place to contain fire as fire resistant doors were not installed in the centre.

12. 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 service had enlisted an external fire consultant agency in 2014 who completed a fire safety risk assessment. This consultant has been asked to review this risk assessment in light of works completed to ensure Group B meets fire safety compliance. A holding letter from the fire consultant agency was submitted to HIQA on the 28th October.

Proposed Timescale: 28/10/2016

Theme: Effective Services

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

The training matrix indicated that one staff member required refresher fire training.

13. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

The Home Manager reviewed the training matrix and identified a staff member requiring refresher fire training. The fire training has been booked for the 15/11/2016

Proposed Timescale: 15/11/2016

Theme: Effective Services

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

Fire drills only simulated day time conditions and the associated staffing levels.

Two fire drill records since January 2016 did not record the number of residents present at the time of the drill.

14. 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:

A fire drill was held on the 06/10/2016 within the house. The documentation now states the number of residents present at the time of fire drills

Proposed Timescale: 06/10/2016

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:

The training matrix indicated that all staff required refresher training in line with the safeguarding vulnerable adults at risk of abuse national policy.

15. Action Required:

Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

The Home Manager has submitted six staff names to the Training and Development Department to attend training in relation to the Policy for the Protection and Welfare of Vulnerable Adults and the Management of Allegations of Abuse which is currently being rolled out by the service. The training is to commence on 26/10/2016

Proposed Timescale: 22/11/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

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

For two residents, areas of the assessment were left blank including education history, numeracy, literacy, time recognition and independence. A plan of care in relation to one resident's education, training and employment goals had not been developed.

16. Action Required:

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

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

The Policy on Access to Education, Training and Development for Service-Users was discussed by Home Manager and Person In Charge at the House Meeting 13/10/16. Emphasis was placed on the importance of incorporating and accessing opportunities for education, training and development based on individual's needs. The residents identified in this inspection will have an individual assessment completed whereby their needs will be incorporated into their individual care plan and support will be provided by Keyworker along with guidance from the Quality and Risk Officer.

Proposed Timescale: 30/11/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

There was a delay in accessing physiotherapy and psychology services.

17. Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

Each service user has access to a physiotherapist who attends the service weekly. The organisation has contracted a Psychologist who is to commence in October / November 2016 for two days a week. Each service user will have access to this service.

Proposed Timescale: 30/11/2016

Theme: Health and Development

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

An individualised plan of care had not been developed in relation to care at times of illness for each resident.

18. Action Required:

Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

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

The Home Manager and Person In Charge will review the plans of care at times of illness for each service-user and updated the care plan appropriately. This plan of care will be reflective of the individual supports and wishes required during times of illness and or admission to hospital. The plan of care will also include the staffing support and or family involvement required to respond to the wishes of the service user to ensure their physical, emotional and spiritual needs will be met.

Proposed Timescale: 30/11/2016

Theme: Health and Development

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

Some plans of care were contradictory.

A plan of care was not followed in relation to blood pressure monitoring.

Recommendations in relation to pain assessment and management were not followed.

19. Action Required:

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

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

The Home Manager and Person In Charge reviewed this practice and the service-user's blood pressure is being recorded twice monthly and documented within their care plan. Recommendations in relation to pain assessment and management were followed up and linked the Abbey pain scale guidelines in service users care plan.

Proposed Timescale: 13/10/2016

Outcome 12. Medication Management

Theme: Health and Development

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

The staff member did not check the labels and contents of the compliance aid before administering the medicines to ensure that the medicines in the compliance aid corresponded to the prescription.

20. Action Required:

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

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

The medication management co-ordinator was informed of the drug error and the relevant drug error documentation was completed and submitted to co-ordinator. The staff member completed medication management training on HSEland.

Proposed Timescale: 15/08/2016

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 review of the management systems was required to ensure effective governance, operational management and administration of the centre.

21. 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:

A new PIC has been appointed to this designated centre. The house manager currently oversees two houses which are divided between the two centres. The PIC meets with the house manager on a daily / weekly basis. They have a direct link with a CNM3 who provides support and mentorship to them. There are weekly Governance and Management meetings which the PIC attends. The focus of these meetings is to give support and guidance to the PIC's and evaluate how they are managing and auditing their designated centres. The CNM3 will have individual supervision meetings monthly with the PIC.

Proposed Timescale: 30/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

A review of staffing levels was required to ensure that residents were supported appropriately at all times.

22. Action Required:

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

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

A full review of the centres rosters was carried out on the 18/10/2016 with the PIC, house manager, HR and Registered Provider. It was identified that there was a good level of skill mix. The PIC is supernumerary and provides additional supports when required. It was identified the two service users needs are changing, the PIC and house manager are submitting a business case to highlight the changing needs.

Proposed Timescale: 30/11/2016

Theme: Responsive Workforce

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

Agency staff and recent staff moves to other centres had resulted in an inconsistency of staffing which had caused residents some distress.

23. Action Required:

Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

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

A staff recruitment day was held in September 2016. A number of applicants who were successful have been placed and are due to be placed in the centre where there are current vacancies. This will reduce the need for any agency staff and will result in the consistency of regular staffing levels.

Proposed Timescale: 07/11/2016

Theme: Responsive Workforce

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

The training matrix indicated that dementia training had not been completed by four staff.

The training matrix indicated that three staff had not completed training in communication.

24. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Following the HIQA inspection two staff completed the dementia training on 22/09/2016

The remaining staff will attend the next dementia training session in 2017.

The Home Manager has submitted staff names to complete communication training on the 16th November 2016

Proposed Timescale: 17/11/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

The medicines management policy did not contain information to guide staff on the safe

administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections.

25. Action Required:

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

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

The Drugs and Therapeutic committee are currently reviewing the medications policy and including protocols to cover the safe administration of a number of dosage forms/routes including topical, inhalers, nebulisers, eye/ear/nasal drops and injections. The local pharmacy has provided training on injection administration to all nurses.

Proposed Timescale: 31/12/2016

Theme: Use of Information

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

The directory of residents was not complete.

26. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

The directory of residents has been completed by the Home Manager and the Person In Charge.

Proposed Timescale: 18/10/2016

Theme: Use of Information

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

Correction fluid and pencil was used in some residents' records

27. Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The Home Manager and PIC have discussed the prohibited use of correction fluid and

pencil on any documentation. All correction fluid has been removed from the centre.

Proposed Timescale: 05/08/2016