Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Ash Services
Centre ID:	OSV-0004055
Centre county:	Galway
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Ability West
Provider Nominee:	Breda Crehan-Roche
Lead inspector:	Thelma O'Neill
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
24 January 2017 09:00	24 January 2017 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this designed centre. This follow-up inspection was carried out to monitor compliance with the regulations and to review the action plan issued following the last inspection by the Health Information and Quality Authority (HIQA).

How we gather our evidence:

During the inspection, the inspector, spent time with the 11 residents living in this centre and reviewed documentation such as personal plans, fire records, risk management documentation, policies and procedures and residents' health and medication records. The inspector also met staff members and senior managers and reviewed all of the actions from the previous inspection.

On the day of inspection, the inspector found that there was no person in charge managing the centre. The previous person in charge had left on long term leave three weeks previously. An immediate action was issued to the provider during the inspection to appoint a new person in charge. By the end of the inspection a new person in charge was appointed to manage the centre.

Description of the service:
This centre provided full-time residential and respite services in two houses, which were located in a town in Co. Galway. Six residents lived in the residential house and five residents were accessing the respite house. In addition, another 12 individuals availed of respite services.

Each house contained communal areas and private accommodation for the residents. Residents living full-time in the centre, had their own bedrooms that were suitably decorated with their own furniture and personal possessions. Residents' were provided with keys to their bedroom doors, which ensured their privacy and dignity. There were adequate bathroom facilities and these were shared among the residents.

All residents had active lives. They attended day services or work placements Monday to Friday and also participated in social activities and goals in the evenings, and at the weekends, as they wished. They were well-supported by staff to achieve their personal goals.

Overall Judgment of our findings:
On the last inspection, two immediate actions were issued relating to fire safety management and safeguarding of residents. These actions were reviewed as well as the 20 actions issued following the last inspection. On review, the inspector found that seven actions were complete or partially complete and 13 actions not complete.

Some improvements had been made since the last inspection, with additional staff support available for the supervision of residents in the centre both during the day and at night. This had improved the safety of residents. However, as identified on the previous inspection the safeguarding of residents from peer to peer abuse, and the management of this abuse, continued to be restrictive, which was impacting on all of the residents' freedom of movement around their home. The compatibility of two residents living in this centre required review, to assess their long term suitability for the service. There was evidence that this service was not meeting their or the other residents needs, and assessments to determine whether an individualised service would be more appropriate, had not been completed.

Fire safety management and evacuation procedures had improved since the last inspection, however, there continued to be issues of concern. The inspector also found that there continued to be inadequate oversight by management of these issues and practices.

The findings of this inspection are discussed in more detail in each of the outcomes in the report. The action plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The inspector found residents' privacy and dignity was respected. Residents were consulted regularly about how the centre was managed on a day-to-day basis.

There were two actions issued following the last inspection, one action was complete and the second action was not complete. The incomplete action related to residents' freedom to exercise choice and control in their lives. The inspector found that the increased staffing had resulted in improvements with regard to residents' rights and consultation in the centre. However, residents' rights to freedom of movement around the houses continued to be restricted at times, as a means of safeguarding the residents from their peers.

The inspector found that staff were discussing choices around social activities that were being scheduled and the food menu for the evenings or weekends with the residents. In addition, staff discussed the procedures available on how to make a complaint if they wished, and how such complaints would be managed. Complaints management had improved since the last inspection and there were no open complaints at the time of inspection.

Staff members were familiar with residents' needs, and were able to describe to the inspector individual residents likes and dislikes. They spoke about residents with respect and discussed positive aspects of the service provided, in particular, improvements in staffing since the last inspection.

Judgment:
Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
On this inspection, the inspector reviewed the written agreements in place for respite residents.

The inspector found that there was no evidence in the residents' files of a needs assessment tool being used by the provider to assess the individualised need, or priority of need for respite services, by the residents or their families.

The written agreements in place for respite users did not detail the actual level of service that would be provided to residents or their families, such as, the number of nights respite they would receive or the frequency of the respite that could be offered. Therefore, residents or their families had no assurances that they would receive any respite services from month-to-month regardless of need.

The inspector found that the charges for one resident, who was receiving only an evening time respite for a couple of hours, were not proportionate to the level of service being provided.

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

Findings:
The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs in a comfortable and homely way.

Two actions were issued following the last inspection. The first action related to a lack of equipment being provided to one resident, which had impacted on the resident being offered overnight respite care. This service and equipment was recommended by members of the multi-disciplinary team. This action was not complete and the equipment has still not been made available to the resident. The second action related to the requirement to replace a hallway carpet. This was complete.

On the day of inspection renovation work was ongoing and new flooring was being installed in a bedroom and sitting room in this house.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
Fire safety and risk management had improved since the last inspection; however, some actions remained incomplete.

The inspector reviewed the current management of risks in the centre. The operational risks were identified on the centre's risk register and residents' individual risk assessments were also maintained in their individual files. However, these were found to be incomplete, as they did not identify all of the risks posed in the centre. For example: environmental risks requiring restrictive practices or seclusion, risks in using the centre's transport and the use of medical equipment such as oxygen, were not included. In addition, the centre had a safety statement in place, but it was not reviewed since 2013.

The inspector also reviewed the arrangements for the safe evacuation of residents from

the centre in the event of a fire. The fire evacuation plan required review as it did not promote the fastest possible evacuation of residents from the centre. For example, one personal evacuation plan (PEEP) showed that a resident was advised to use a walking frame to evacuate the building in the event of a fire. Furthermore, the evacuation plan and the fire drill report omitted to note that the person using this walking aid could delay other residents' evacuation from the building, in the event of a fire. An alternative mobility aid such as a wheelchair had not been considered.

The inspector found suitable fire safety equipment was provided in the centre. There was adequate means of escape, fire exits were unobstructed and regular monitoring of fire escapes was in place. Equipment was regularly serviced and fire drills completed regularly. However, eight staff members did not have up-to-date fire safety training completed.

Environmental seclusion continued to be used in this centre. While the practice had significantly reduced since the last inspection, the use of seclusion without proper guidance or protocols, which had previously been raised with the person in charge, was again noted by the inspector . In particular the location of the room where "seclusion" was taking place put other residents at risk when they wished to access their bedrooms. Staff members told the inspector that residents to had to walk through the seclusion room, to access their bedrooms, when the room was being used for environmental seclusion. This put residents at risk of being assaulted.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspector reviewed the actions taken since the last inspection and found that improvements had been made to the safety of residents since the last inspection. However, some residents living in this centre continued to not feel safe in the centre.

The inspector found staff members were caring and supportive to the residents in this centre, but two residents living in this centre had complex behaviour needs which were impacting on the other residents' quality of life in the centre. Some residents displayed aggressive or challenging behaviours and these behaviours frightened their peers. As a result, environmental restrictions were put in place for protection of residents, however, as a result, residents' rights to exercise choice and control in their life was restricted.

Since the last inspection a complete review of the safeguarding needs of each resident had taken place. As a result all residents living in this centre had safeguarding plans in place to safeguard them from peer-to-peer abuse. In addition, all staff members had received training in safeguarding and positive behaviour support.

The inspector found staff members on duty on the day of inspection were aware of the procedures to follow if they witnessed peer-to-peer abuse, or if an allegation of abuse was reported to them. Furthermore, residents that displayed behaviours that challenge had their support plans reviewed and updated. However one resident's support plan did not clearly outline the protocols staff should use, when implementing restrictive practices. This had led to inconsistencies in the use of restrictive practices in the centre.

On the last inspection, there was an immediate action issued relating to the use of restrictive practices and environmental seclusion. The inspector had found this practice was not being appropriately monitored or reviewed by the person in charge or the multidisciplinary team. In addition to the immediate action, four other actions were issued relating to safeguarding concerns identified in the centre.

The inspector reviewed these actions and found that two actions were complete and two actions were partially complete.
The two actions related to the lack of arrangements in place to keep residents safe and to effectively manage the use of restrictive practices and environmental "seclusion" in the centre, were found to have not been addressed during this inspection.

In addition, staff members were continuing to lock internal and external doors and wardrobes to protect residents from injury to themselves or from their peers, but there were no protocols, or records kept to record or guide the use of these restrictive practices. The inspector also found that although the human rights committee had agreed to the locking of one resident's wardrobe in November 2014, this restriction had not been reviewed to assess if the restriction was still necessary,

A review of the safeguarding plans for some residents found that the risks present were not identified and did not include the rationale for restrictive practices such as a locked door. In addition, safeguarding plans were not signed or dated. In one file viewed the resident's behaviour support plan did not provide guidance to staff as to the behaviours, or risks that prompt the use of seclusion. The inspector found from speaking to staff, that the absence of guidance had led to a variance in staff interpretation on what constituted a rationale for environmental restraint, or chemical restraint.

It was clear that the suitability and compatibility of residents living together in this centre required review. There was no evidence of such reviews taking place in the residents files or of the impact on residents of the restrictions being used to keep them

safe.

Judgment:
Non Compliant - Major

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 healthcare needs were generally well met in this centre.

Access to health care services such as a general practitioner, psychiatrist, dentist and behaviour support specialists were clearly documented. Residents' had been referred to specialist services such as a speech and language therapist, dietician, and in a timely manner, and where required, recommendations from specialist assessments had been included and addressed within the residents' health care plans.

Residents' participated in choosing their evening mealtime menu options and had the opportunity to eat their meals in pleasant surroundings. The dining and kitchen facilities met the needs of residents. There was space to engage in the preparation of meals and snacks. There was a good supply of food in the centre. For example, fridges and presses had a good supply of frozen and fresh produce. There was a good choice of condiments for the preparation of fresh meals. Dining facilities were spacious and relaxing.

Residents' nutritional risks were assessed using a nutritional risk assessment tool. Eleven residents receiving a service in this centre were identified as requiring a special diet. Staff members were aware of the appropriate food to provide to the residents, including their preferred foods. However, some staff required training in the management of residents' difficulties in feeding, eating drinking, and swallowing (FEDS). The inspector also found that a dietician had recommended that one resident should keep a food diary of their nutritional intake, however, on review the diary was not completed to give a full view of the resident's food intake over a period of days.

Residents were encouraged and enabled to make healthily living choices. Residents were provided the opportunities to make choices about meals. Meal choices were provided in a pictorial format for some residents with a sensory impairments, to enable them to choose which meal they could have on a daily basis. All meals were prepared in the centre by the staff. There was an adequate amount of fresh, canned or dried foods available in the fridge, freezer and cupboards in the kitchen.

Judgment:
Substantially Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
There was a policy and procedure in place relating to the ordering, prescribing, storing and administration of medication to residents. However, the procedures in place did not ensure that the organisational medication policy was effectively implemented.

There was one action issued following the last inspection that was not complete.

On the last inspection, the inspector found that there was a lack of governance and oversight by management around the use of chemical restraint in this centre. On this inspection, the inspector reviewed the use of chemical restraint for some residents and found discrepancies between the resident's medication administration sheet and the PRN recording sheet. The inspector found there was a lack of protocol around the use of chemical restraint and inadequate oversight or review of the frequency that chemical restraint was used.

On this inspection, and during the last inspection, the inspector found discrepancies in the prescribing and administering of medication. The systems in place for safe medication management, including the monitoring and reviewing of stock control or medication administration to residents continued to be ineffective. In response to the previous action plan, the provider stated that medication audits would be completed to review medication practices in the centre. While medication audits had taken place, the audits did not identify a medication error, which had been written on the residents' prescription sheet since September 2016.

The centre used two different medication management systems for the recording and administration of medication. The use of two medication recording and ordering systems was found to be confusing, and there was no guidance documents or procedure for staff to follow, when using these medication systems. This risk was not identified as such on the centre risk register.

The inspector also reviewed the use of oxygen in the centre. Oxygen cylinders were

stored insecurely in the centre and there were no records available to show that the oxygen cylinders or the oxygenator had been serviced. There was also no evidence that support staff were trained in the correct use and administration of oxygen and that all the fire safety precautions were strictly adhered to when oxygen was in use.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
On the day of inspection, there was no person in charge of this centre. The previous person in charge had left on the 5 January 2017 on planned long-term leave. An immediate action was issued to the provider and a new person in charge was in place before the end of the inspection.

There were three actions issued following the last inspection, one action was complete. Two actions were not complete, these related to putting appropriate management systems in place for the delivery of a safe service and the requirement for a six monthly unannounced review and report to be completed by the provider.

The inspector found that despite the absence of the person in charge for the previous three weeks, there was improvement in the governance and management of the centre. Additional staffing during the day and at night had been funded by the provider, which had resolved some of the safeguarding concerns in the centre. This was an action from the last inspection that was now complete. In addition, a significant amount of multidisciplinary team support had been provided to the staff team over the past few months, which included all residents having a review by the HSE safeguarding team.

A review of residents' placements had commenced, and one resident was relocated to the other house in this centre to provide a more stable environment for the resident.

Renovation works to the centre had also occurred, including repair works to the flooring

in the hallway of one house. This was an action completed since the last inspection.

Staff also told the inspector that management and multidisciplinary support had improved since the last inspection and that they felt the additional staffing had made significant improvements to the delivery of services in the centre.

However, the inspector found that although the provider had implemented additional staffing and safeguarding measures to protect residents' safety, an assessment of the suitability of the environment and compatibility of residents living together in this centre was not completed and this continued to place residents at risk. The provider had stated in their previous action plan response that a review of the services by an external body would take place, the report for this review was not complete or available on the day of inspection. The annual review of the quality and safety of the service provided and the six monthly unannounced visit report, completed by the provider, was not available on the day of inspection.

Judgment:
Non Compliant - Major

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
On the day of inspection, there was no person in charge of the centre. The previous person in charge of this centre was absent since the 5 January 2017, on planned long-term leave. In such cases the provider is required to notify HIQA of the absence and what arrangement would be in place to cover this absence. This had not occurred.

An immediate action was issued to the provider to nominate a person in charge for this centre. The provider responded by the end of the inspection and named another person in charge that would take on the role, until a new person in charge could be appointed.

Judgment:
Compliant

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
Significant improvements had occurred in the staffing of this centre since the last inspection.

There were three actions issued under this outcome following the last inspection. One action was complete and two actions were not complete. The actions that were found incomplete related to inadequate staff training in managing risks, such as, fire training, safe moving and handling training, safe medication practices, risk management and behaviours that challenge. A review of staff training on this occasion showed that staff working in this centre continued not to have the required mandatory training.

The provider had taken action to improve the staffing levels in one of the houses, following significant safeguarding risks being identified on the last inspection. As a result three staff now worked in this house during the day and at night there was now waking night staff available to support and supervise the residents.

There was a planned staff roster in place in both houses, however, the actual staff roster was only kept in one house in this centre. Therefore it was difficult for residents in the second house to know what staff were actually going to support them on a daily basis, as they did not have access to the this information.

A review of staff files showed that some staff members did not have details of the position the person held, the work they performed and the number of hours they were employed, as required by schedule two documents.

Judgment:
Non Compliant - Moderate

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:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Ability West
Centre ID:	OSV-0004055
Date of Inspection:	24 January 2017
Date of response:	06 March 2017

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents freedom to exercise choice and control in their life was limited due to environmental restrictions put in place to protect them from their peers.

1. Action Required:
Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the

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

freedom to exercise choice and control in his or her daily life.

Please state the actions you have taken or are planning to take:
Protocol for use of environmental restrictions has been put in place for one person with detailed criteria; each incident when the restriction is used is detailed on a log, along with impact in terms of safeguarding. This has been put in place in consultation with multidisciplinary team support.

Proposed Timescale: 21/02/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Written agreements did not detail the actual level of service that would be provided to residents or their families, including the number of nights respite residents could receive monthly or the frequency of the respite offered.

2. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
A copy of the monthly respite offered to each resident is available in the Directory of Residents at the service.

Proposed Timescale: 01/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Charges for different levels of service were not clear or proportionate

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

Please state the actions you have taken or are planning to take:
A contract of care for respite provision has been issued to the family which reflects the reduced charge for current services.

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The criteria used to determine the basis for the admission for respite services was not clear in the residents' files or in accordance with the statement of purpose.

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

Please state the actions you have taken or are planning to take:
Service is provided on the basis of current need and in the event of specific requests from families they are managed by the Respite and Community services co-ordinator in conjunction with the Person in Charge; a Prioritisation Committee is in place for residents with regard to respite provision. A full planning process takes place for all new admissions to Ability West which includes an assessment to needs to ensure that the service has the capacity/resources available to provide a safe service to the individual.

Proposed Timescale: 28/02/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Equipment required to support a resident receiving a respite service was not provided.

5. Action Required:
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

Please state the actions you have taken or are planning to take:
With regard to this resident a business case has been put forward to appropriate health care funder on 09/02/2017, seeking funding in order to provide a 7 day residential placement for this person. Business case includes the equipment required.

Proposed Timescale: 09/02/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. The systems in place for the assessment, management and ongoing review of risk were not sufficient. Risks identified, such as, restrictive practices, the use of seclusion, risks associated with using the centre transport and the use of medical equipment such as oxygen were not appropriately identified or risk rated.
2. The centre's safety statement had not been reviewed since 2013.
3. Residents were at risk of being assaulted when they used the seclusion room to access their bedrooms.

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

Please state the actions you have taken or are planning to take:
1. Risk assessments have been reviewed in terms of ensuring that all risks identified as noted above are included.
2. Centre Safety Statement has been reviewed and updated.
3. Due to increased staffing and review of strategies, a seclusion area is no longer in use.

Proposed Timescale: 07/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' personal evacuation plans (PEEPS) were not effective in promoting a swift evacuation from the centre, in the event of a fire.

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

Please state the actions you have taken or are planning to take:
PEEPS have been reviewed and amended as necessary.

Proposed Timescale: 07/03/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

the following respect:
Restrictive procedures including physical, chemical or environmental restraint, including seclusion, were in use in this centre, but were not applied in accordance with national policy and evidence based practice.

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

Please state the actions you have taken or are planning to take:
A review of restrictive practices has taken place, resulting in removal of certain restrictive practices.

For remaining restrictive practices, a Restrictive Practices Protocol has been put in place, which includes an escalation pathway that outlines the criteria required for the implementation of restrictive measures. Ongoing logging of the utilisation of environmental and restrictive measures taking place. This logging also includes impact on service users of restrictions.

Proposed Timescale: 28/02/2017

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. Residents living in this centre were not safe from the risk of assault or intimidation on a daily basis.
2. Residents living in this centre were not provided alternative living options from the constant risk of physical and psychological abuse from their peers.
3. The control measures and restrictive practices in place to manage peer-to-peer abuse limited some residents' to choice and freedom to access their home whenever they wished.

9. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
1. Behaviour Support Plans are in place and have been reviewed, extra staffing resources have been made available on a 1-1 basis for an individual and it is anticipated that this will lead to a decrease in incidents of behaviours that challenge.
2. Contact has been made with the Social Work Department to ensure that residents from Ash Services are considered as part of the organisation's residential review group, which considers placements.
3. Alternative activities outside the service are being offered to an individual at key times which has improved the remaining residents' ability to choose their activities within the house. All residents can access their bedrooms at any time either on their own or with staff support.

Proposed Timescale: 28/02/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' food diaries were not maintained as required by the healthcare professionals.

10. 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:
Residents' food diaries are maintained in line with the healthcare professionals' advice. Audit of this is in place by the Person in Charge on a regular basis.

Proposed Timescale: 21/02/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff were not trained to support residents individual needs with their eating and drinking.

11. Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
FEDS Training for staff has been organised to take place on the 15/03/2017; in the meantime, staff have been requested to re-familiarise themselves with the Policy and Procedure on Management of FEDS.

Proposed Timescale: 15/03/2017

Outcome 12. Medication Management

Theme: Health and Development

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

1.Medications were not administered as prescribed.
2.There was no protocol in place around the recording or reviewing of PRN medication use in the centre.
3. Medication audits did not identify serious medication errors in the centre.
4. The use of dual medication systems in the centre was confusing and there was no clear protocol around the practices for managing these medication systems in the centre.
5. The management of oxygen in the centre was not in line with national policies and procedures.

12. 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:
1. Medication administration is being audited on an ongoing basis.
2. Protocols for PRN are in place, and in the correct designation.
3. Independent medication audit has been organised to be carried out by a healthcare professional and any actions required will be addressed and findings will be discussed at staff team meeting.
4. Management of medication is as per the organisation's policy and procedures and is subject to medication audit.
5. The management of oxygen has been reviewed and appropriate storage is being organised which will be in line with national policies and procedures and stored appropriately.

Proposed Timescale: 15/03/2017

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:
There were inadequate management systems in place to ensure that the service provided was safe, appropriate to residents' needs and that the service was consistently and effectively monitored.

13. 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:
There is now a Person in Charge in place; appropriate management systems are in place with the Person in Charge and Person Participating in Management. A number of

audit tools have been implemented to monitor service delivery on an ongoing basis. Provider Led Unannounced Audit took place on 09/11/2016, copy now available in service and actions are being addressed. External review of service has taken place.

Proposed Timescale: 28/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review completed of the quality and safety and support provided in the designated centre on the day of inspection.

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

Please state the actions you have taken or are planning to take:
A. External review of service has taken place, this was undertaken utilising the Annual Review template from HIQA. Completed
B. A further internal annual review is planned for Quarter 2 of 2017.

Proposed Timescale: 28/02/2017 (A) 30/06/2017 (B)

Proposed Timescale: 30/06/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A actual staff roster was not maintained in one of the houses in the centre.

15. Action Required:
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:
Staff rosters are now in place for both services under this designated centre.

Proposed Timescale: 20/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff files for two staff did not contain all of the required information.

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

Please state the actions you have taken or are planning to take:
Staff files have been reviewed and all have the required documentation, with individual checklists on staff records in place in this regard, available in the service.

Proposed Timescale: 01/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff working in this centre had not completed the required schedule of training as per previous action plan response. Training outstanding included, fire safety management, safe moving and handling training, FEDS training, and managing behaviours that challenge.

17. 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:
Training matrix has been completed to ensure that all staff working in the service are scheduled for mandatory training as it becomes available.

Proposed Timescale: 28/02/2017