<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Ltd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011222</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Dublin 20</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Claire.Nash@stewartscare.ie">Claire.Nash@stewartscare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Stewarts Care Ltd</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Gerry Mulholland</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Claire Nash</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Noelene Dowling</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Maeve O'Sullivan;</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>175</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>5</td>
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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 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 4 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
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<tr>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<tr>
<td>Outcome 13: Statement of Purpose</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

This monitoring inspection was unannounced and took place over four days, one section of which was undertaken out-of-hours in the late evening. The inspection reviewed nine outcomes. As part of the monitoring inspection the inspectors met with residents, staff and members of the management committee. Inspectors observed practices and reviewed the documentation available such as care plans, medical records, accident logs, policies and procedures and staff files.

A triggered inspection of this centre had taken place in December 2013 following notifications of allegations of abusive behaviours by staff. The provider had instigated an independent review of the allegations. The interim report had been made available to the provider and the Authority prior to this inspection and the final report was expected to be available by the week of March 10 2014. Safeguarding actions undertaken by the provider following these allegations included additional supervision in the centres and reallocation of employees while awaiting the outcome. However, as the findings of this report demonstrate improvement is still required in the systems for management of allegations and the monitoring of care practices.
The campus based service is comprised of 24 resident houses catering for persons with moderate to profound levels of intellectual disability. The diversity and range of service users needs is significant. All houses were visited at various times for the purpose of this inspection.

There were four actions identified following the inspection in December 2013. Two of these had been satisfactorily addressed. Actions not yet addressed were the assessment of need for the use of methods of restraint and interventions to physically assist residents. The time-frames for these actions had not elapsed however.

The findings of this report indicate that the provider has committed to and commenced a process to implement systems and practices to ensure compliance with the regulations and standards required for registration. The provider demonstrated an awareness of the requirements and of any current deficits in the implementation of them.

The inspection found that there had been considerable work in the development of the required policies, good medication management practices, and range of on-site multidisciplinary and allied services including psychiatry and behavioural supports were available. Work was evident in the development of risk management processes, and good fire safety management systems in-terms of the mechanisms available. The findings of the report indicate some good practices and areas where there was inconsistent application of the care required.

Improvements were required in the consistent development and implementation of meaningful personal plans and reviews for residents, the development of cohesive strategies for risk management and challenging behaviours, and documented healthcare assessments.

The numbers and skill mix of staff was also found not to be sufficient, with particular emphasis on night time supervision of care, monitoring of care practices and training pertinent to the resident population staff. Training in fire safety was also not satisfactorily addressed and written evidence of compliance with the requirements of the statutory fire Authority will also be required for registration of the centre.

Improvements were also required in the overall management of complaints including time-frames for completion, identifying situations of abusive behaviours and reporting of them. Significant issues of concern were the accommodation of children in adult houses and the mixed gender dormitories. The provider has revised the plans to register the campus as one designated centre. In view of this the management structure and areas of responsibility will also alter in order to provide better implementation of the required care standards and supervision of care across the entire campus.

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 (as amended) 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 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

Judgement:
Non Compliant - Moderate

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

Findings:
A number of factors influence the findings in relation to compliance with this outcome including the size of the agency, the complexity of the service user’s needs and some factors in the premises themselves. However, work has commenced in developing systems which could support service user’s rights and consultation processes in a more comprehensive manner. There was a user friendly pictorial policy on the rights of service users.

There is no appropriate advocacy service available suitable to the needs of the majority of the residents. The person in charge stated that that key workers are identified to act as advocates for their individual residents. There was some evidence of this in records where for example, key workers had identified the need for a resident to have a holiday and this was being pursued. The personal plans reviewed did not demonstrate consistent involvement or consolation of the residents or relatives. In practice staff did know their preferences, in terms of familiar objects, preferred clothing, meals and day-to-day routines. A resident’s council meeting takes place monthly. A review of the minutes indicates that that small numbers of residents who can participate, discuss issues such as outings, complaints food and activities. There was also reference to residents expressing concern that staff were being moved across houses which disrupts the continuity of care for residents. It is planned to record the meetings and distribute the minutes across the houses for other residents, relatives and staff. There is a visiting policy and no restrictions are placed on visitors.
A complaint policy, including an appeals process has recently been introduced but this has not being fully disseminated across the campus as yet as demonstrated by the fact that not all staff were familiar with it. Some residents stated that they would go to the identified staff if they had a complaint. Practices in the individual houses differed in how complaints were managed. For example, in one house regardless of the policy there was no record maintained of day-to-day complaints which had evidently been raised by individual residents. A review of the records maintained of complaints indicated that complaints if recorded, were addressed and the complainant was consulted but time-frames and the process were not adhered to.

The manner in which residents were addressed by staff was seen to be appropriate and respectful. Individual rooms were personalised in most but not all houses. There was evidence that staff tried to maintain resident’s dignity and respect when carrying out personal care. However, the policy on intimate care was vague and while staff were able to articulate the procedures there were insufficient guidelines available for staff to follow. Other factors which mitigate against adequate privacy and dignity is the shared gender dormitories in three houses, with female residents sharing cubicles with male residents. Some staff correctly articulated their discomfort with these arrangements. Other factors included the lack of suitable locks on toilet and bathrooms doors with two showers contained in one bathroom and the use of inappropriate utensils for eating. Inspectors noted that in some instances tables for meals were nicely laid and the crockery used was appealing and attractive. This was not a consistent finding however, with some mealtimes observed as being frugal in terms of crockery or laying of tables. In the inspectors view this cannot be entirely explained by the resident’s behaviours, dependency levels or the need for assistive crockery. In a significant number of houses residents records were not stored securely but were located in unlocked cabinets in hallways or in day rooms.

Residents retained their own possessions’ and some had significant amounts of photographs and belongings which they invited inspector to see. Although laundry is done centrally clothing was seen to be clearly and securely marked.

**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

**Judgement:**
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
The findings in relation to this outcome vary greatly in their compliance with the requirements across all houses and the inspectors acknowledge that the process of change in relation to this is ongoing. The change includes the implementation of a computerised documentation programme. Records were therefore in transition between hard and soft copy. Some of the findings may be influenced by this factor. There was evidence of appropriate multidisciplinary involvement in resident’s personal plans. Individualised supports such as communication cards, personal passports, massage, and assistive devices to support mobility were evident with good effect. In most houses staff demonstrated insights into the communication needs of residents and were observed to use these insights to guide care.

A suitably qualified team of staff had been assigned to support the development of an assessment framework and the subsequent development of personal plans, goals and outcome reviews which currently were not consistently evident. Where residents had capacity to communicate and express their choices there was evidence that this influenced their care and routines with access to training or education, life skill supports and social integration. Where this was not possible staff demonstrated a knowledge of the residents preferences and acted on this knowledge. There was little evidence that relatives or other significantly important people were actively involved in the development of the personal plans for residents who could not participate themselves. Some residents informed inspectors that they had choices and that staff helped them with tasks and their views were listened to.

The quality and detail of the personal plans differed greatly. For example, some were very person-centred and demonstrated a very in-depth knowledge of the resident’s preferences. These were followed through to ensure that they were implemented. For example, one resident did not like to be woken early and preferred time away from the group. Inspectors observed this being implemented. Others dealt with behavioural issues, while others were primarily activity focused and did not fully review outcomes for residents. Some residents had access to day services and meaningful occupation. This was not a consistent finding however. The day activity service had been reconfigured prior to December 2013 and therefore some residents were no longer able to access this. In an effort to compensate for this staff had been assigned to specific houses to provide activities. These were interesting and included access to the on-site swimming pool, trips to various parks, cinemas, or shopping centres. There are seven campus based suitably adapted vehicles available for this purpose. Each resident therefore has an outing of this type weekly and residents were observed out walking or being supported to mobilise on the campus.

A number of houses have a music or quite room with relaxing lighting. However, inspectors did not see this being used often during the period of the inspection. In one instance the room was also used to house spare furniture which greatly diminished the overall atmosphere. Apart from the organised activities there were significant periods of time where residents, in particular the more dependant residents were observed to be supervised but with no meaningful activity or structure and in the inspectors view some
of this was dictated by staffing limitations. Practices in relation to the continued development of independence was limited, hindered somewhat by the structures such as central catering and laundry services. There were a number of residents being prepared to leave the campus and go to the community based houses with suitable supports and life-skill development plans in place.

Children’s personal plans were found to be detailed and regularly reviewed. They have access to safe and suitable external play areas. The bedrooms of both young people were seen to be personalised although one house was sparse in terms of décor suitable for such a young person. The long term plans for these individuals have not been firmly decided upon but it is acknowledged that children should not be resident in the same units as young or older adults. One of these houses is used for respite purposes which also means that there is a continuous movement of residents with little continuity or stability for the child. Residents were supported and encouraged to maintain familial and community links but there was limited contact with the local community evident in some instances.

### Outcome 07: Health and Safety and Risk Management

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

**Theme:**
Effective Services

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
There was a signed and current health and safety statement available. Each house had an individual health and safety statement. No overall audit of the campus and individual houses had been undertaken. Inspectors were informed that a site specific review which will incorporate risk management had been developed and will be implemented. Inspectors did observe that the lighting in the grounds at night was extremely poor.

The environment of the individual houses differs significantly. Some were very homely, comfortable and personalised while others were not. All areas were extremely clean and there was an effective system for clinical waste disposal and infection control with guiding policies available. Staff were observed taking appropriate precautions where necessary and protective equipment including gloves, aprons and sanitizers was evident. Overall flooring, lighting and heating in the houses was satisfactory. Residents were observed to have suitable assistive equipment for mobilising. Training in transporting of residents had been undertaken and the staff had appropriate food safety management training.
Inspectors reviewed the fire safety register and saw that fire drills had been carried out in each of the individual houses twice yearly and residents were included in these drills. Fire safety management equipment including the fire alarms, emergency lighting and extinguishers had been serviced quarterly and annually as required. Records however indicated that there was a shortfall in the number of staff who had undergone fire training, with 143 listed as having attended between 2012 and 2013 out of circa 850 staff. Works was being carried out to upgrade the fire safety system in order to provide documentary evidence of compliance with the Fire Authority by a competent person.

Fire evacuation procedures for individual residents were available in each house. Some of these were very specific as to the specific support/either physical or cognitive required for residents in such an event. For example, the resident was to be transported in bed if the incident occurred at night. Others were generic and simply stated that support would be needed but did not give specific details in cases where this would be required. In a number of houses torches were available but in four cases the torches failed to work.

The current risk management policy is not satisfactory in that it does not address the identification of risk as outlined in the Regulations or system of review to support learning and improvement. It is augmented by an emergency plan which included an integrated generator in the event of such an emergency. Maintenance personnel and emergency numbers are easily assessable for other emergencies. Each resident has an overall risk assessment undertaken and where relevant this included the risk of pressure areas or manual handling which were very detailed. However, there was also a document entitled “risk assessment and management plan” which was found to be generic in most instances and did not correlate with the risk identified in the specific risk assessment undertaken. In addition to this, inspectors noticed overall inconsistencies in the identification of and management of risk. For example, all residents had a generic assessment of being at risk from unauthorised persons entering the house. The action to mediate this risk was that all entrance doors were to be locked. However, in a number of houses inspectors found back doors and fire doors open to public and easily accessible areas. This contradicted the actions taken in locking the front doors. Night staff were issued with walkie-talkies which also acted as personal alarms. Not all staff however were observed to be using them or to have them easily accessible. Inspectors noticed that a significant number of keys were utilised and staff were not always sure which keys opened which doors, including fire escape doors. This factor and the subsequent risk had not been addressed in any risk management strategy. Risks in relation to staffing levels at night had not been identified or addressed. The missing person plan did not adequately cover the location, size of the campus or the staffing levels at night.

Vehicles owned by the organisation to transport residents had evidence of road worthiness and insurance and companies contracted to provide such services are required to produce evidence of fitness. Equipment used for resident comfort and safety including hoists and specialist beds was serviced and maintained regularly.

There is a corporate governance risk manager and a risk management committee whose function is to undertake a review of incidents in conjunction with the risk management committee which meets fortnightly. There is no specific clinical risk audit or review
undertaken although this committee does review incidents of challenging behaviours. On examination of this data inspectors found that the specific type of behaviour was not identified and reviewed which diminished the value of the review and any subsequent actions. A revised incident report form had been developed but not yet implemented which was found to be detailed and precise in the information sought. A multidisciplinary committee also reviews restraints used and incidents’ in relation to them. This committee meets circa four monthly. Appropriate actions were identified to mediate risk for example, some younger residents were able to open the seat belts in the transport vehicles and the appropriate remedial action identified was to source specialised clips to ensure this could not occur.

There were again significant differences across the campus in how risk was identified and managed with in some instances little knowledge of the content of the risk assessment or any planning in relation to this. For example, inspectors requested to know the type of restraint identified in one residents plan. The technique was described significantly differently by members of staff. This placed both residents and staff at risk of injury. Despite the committees involved with various aspects of risk may, in the inspectors view, a strategic and cohesive procedure for the management of risk is not translating into practice across the houses.

**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

**Judgement:**
Non Compliant - Major

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

**Findings:**
The inspector reviewed policies and procedures for the prevention, detection and response to allegations of adult abuse and found that they were satisfactory and included a designated person to oversee any allegations of this nature. The provider also uses the HSE “Trust in Care” policy to guide practice. Staff working with children had access to Children First training and were knowledgeable on the reporting mechanisms and their own responsibilities. This information is included in the brochure which has been recently devised for residents and relatives. Records demonstrated that all current staff have received training in the prevention of and response to abuse between 2012
and 2013. Staff were able to articulate their understanding and responsibilities in relation to this. As required following the inspection in December 2013 a revised reporting form had been included in the procedure. The final report into the investigation of allegations made in 2013 has not yet been received. It is of concern that the interim and final report have exceeded any agreed or expected time-frames, notwithstanding the actions taken by the provider.

Policy states that personal care will be provided by staff of the same gender and if this is to be deviated from consultation and consent will be sought, although the policy does also state that this practice may not always be possible taking staffing into account. However, in practice, inspectors found that this was not in any way adhered to. Consultation to deviate from the practice was not evident and staff confirmed this finding.

As stated in Outcome 1 there were brief procedural guidelines on the provision of personal care but these were not sufficiently detailed to guide practice and responsibilities of staff. Inspectors did not see such guidelines detailed in personal plans. As detailed also in Outcome 1, the physical layout of the mixed gender wards and the bathrooms in some houses do not support good practice in protecting residents.

Inspectors reviewed the documentation in relation to two incidents which had been reported in 2013 and were outside of the allegations currently being investigated. One was investigated by an external consultant. The findings indicated that the allegation was unfounded but did note that staff had failed to document or report adequately as they did not believe the allegation. The report also made reference to the poor staffing arrangements in one house. In another instance of verbal abuse which was reported there was a significant delay in the response to this. The role of the designated person and the provider in its resolution was not clear. There was no evidence that this was satisfactorily resolved or completed. Inspectors also saw a significant incident report on a resident’s file which on enquiry had not been reported to the resident’s family. The reasons given were that that such reporting was considered based on the view of the severity of the incident. These findings indicate that despite training and policy development adequate governance and overview of the practices in these areas is not in place.

There is an up-to-date policy on the management of behaviour that is challenging and on the use of restrictive procedures which is in line with HSE policy. A multidisciplinary restraint review group meets regularly to discuss ongoing systems for the use of restrictive measures and clinicians also review episodes of challenging behaviours and devise guidelines for staff. Restrictive measures are prescribed for by the consultant psychiatrist and any medications used for these purposes are regularly reviewed. A significant number of such procedures are utilised, including body suits and locked doors in some houses. As required following the inspection of 2013 the use of some locked doors has been altered so as not to restrict the freedom of movement of other residents. A significant number of lap belts were also used. However, in the majority of cases the use of such procedures was clinically prescribed to support residents. A policy on the use of restrictive measures was in place. Inspectors noted that there was no evidence of consultation in regard to the use of such systems and risks associated with restrictive procedures in themselves were not adequately documented. Additionally,
staff gave conflicting information in regard to the reasons for the restraint, in particular the all-in-one suits which are worn day and night by a significant number of residents. While there was clinical assessment, clear rationale and protective factors apparent for their use in some instances this was not consistently evident. For example, inspectors were informed that the suits were used because single staff at night could not be available to see to personal care needs. In another case inspectors were informed that the lap belt on an ordinary wheelchair was to prevent a resident getting up and falling. However, the risk of the resident falling with the chair as observed by inspectors had not been considered.

Inspectors noted that various levels of challenging behaviours were evident and recorded. In some instances very restrictive measures had been implemented yet residents were facilitated to leave the houses and appropriate safety arrangements were in place to allow freedom of movement and to protect other residents. Guidelines and plans for behaviour management were available and there was evidence that staff actively sought to understand the behaviours and find appropriate responses to alter patterns. This was augmented by the work of the behavioural specialist and psychology department. These findings however were inconsistent and inspectors were concerned that the governance in some houses did not contribute to such review, monitoring of these practices and consideration of alternatives which are also significant factors in the protection of residents.

The inspector saw that amounts of pocket monies were made available and kept in the houses for residents. These were utilised to support activities or the purchasing of necessary sundries. Inspectors saw that transactions were detailed and counter signed using double signatures of staff. The senior nurse in each house was responsible for auditing the figures and returning of the receipts. Written receipts were forwarded to the accounts department for all purchases made on residents’ behalf. However, the items or reason for expenditure were not detailed in the records maintained in the houses making it difficult for transparent accounting and the provision of this type of information to residents or relatives.

<table>
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<tr>
<td>Residents are supported on an individual basis to achieve and enjoy the best possible health.</td>
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**Theme:**
Health and Development

**Judgement:**
Non Compliant - Moderate

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.
Findings:
A local general practitioner (GP) service is primarily responsible for the health care of residents. Overall the records reviewed demonstrated that there was regular access to this service and out-of-hours service is available. There was evidence from documents, interviews and observation that a range of allied health services is available and accessed. This included occupational therapy, dietician services, physiotherapy, psychiatric and psychological services a number of which are linked directly to the organisation which is suitable to the diverse needs of the resident population. Guidance of these specialists was evident and was seen to be known and adhered to by staff. There was no policy on end-of-life care although in two instances inspectors found evidence of altered care plans, symptomatic support, and good monitoring systems for residents whose needs were assessed as palliative.

However, there was a lack of composite healthcare assessment documentation available. While there is considerable documentation in relation to the primary diagnoses of intellectual disability the concurrent physical conditions present and development were not clearly documented. This is especially evident in the documentation in regard to the annual health check. A pro-forma document is completed primarily by the nursing staff and signed annually by the GP. In some instances the information is scant, and for instance, for older female residents the section for breast check had not been completed in some cases. The staff could not confirm to the inspector whether this review was completed following an actual clinical review of the resident by GP or multidisciplinary team. While all clinical assessments including speech and language were reviewed annually or more often as required there was no evidence of cohesive multidisciplinary review taking all factors into account.

Examination of the records concerning two residents who had passed away did not clearly demonstrate the monitoring of their health care status, symptoms and appropriate responses in the days preceding the events. Inspectors could not ascertain with accuracy whether the resident had been seen by the medical practitioner or whether a consultation by phone had taken place. Nursing records on two occasions stated that the resident was to see the GP and on one occasion that he had been reviewed. However, there is no corresponding record in the medical notes. Despite the information of concern in the nursing notes for two days prior to an emergency admission to acute care there was no GP consultation evident. The decision or timing of admission to acute care was not recorded in the residents records. The person in charge informed inspectors that no overall review of the incident had been undertaken.

The diverse needs of the residents were addressed in the dietary supports available. There was evidence of assessment and directions from speech and language therapists and dieticians in each house and in the catering department. Overall the food appeared to be nutritious and readily available. With the exception of three houses there were no arrangements for the preparation of their own food. Overall residents who required support were supported appropriately and in an unhurried manner. The mealtime experience differed across the houses however, in-terms of the support and interaction residents received from staff during it and the manner in which the meals were served to residents.
Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Minor

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

Findings:
There was a centre-specific policy on the prescribing and administration of medication which included the safe storage and safe return of medication. The records available indicated that resident’s medication was reviewed regularly by the GP and on occasion in consultation with other relevant specialists.

Overall practices were found to be in line with legislation and guidelines with some improvements required. Routes for the administration of medication were clearly documented on the administration record. The maximum dosage of PRN (as required) medications was not consistently detailed on the prescriptions and some medications stored were not identified for the resident to whom they were to be administered. No transcribing practices were used and a review of a number of medication records did not indicate any significant errors or incidents. Some medication errors had been reported. These were managed appropriately by the person in charge with actions including additional training for staff had been implemented and clinical consultation in regard to the residents concerned. No resident was self-administering and the policy did not allow for this event. Psychotropic medication was reviewed annually or as required and a monthly audit of medication takes place.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.
Findings:
There is a current statement of purpose available. However, this requires amendment as it does not satisfactorily address the requirements of the Regulations. As the provider is currently considering a review of the designate status of the campus a revised statement is required. An information booklet detailing the services is available to be introduced to residents or prospective residents.

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

Judgement:
Non Compliant - Moderate

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

Findings:
The governance structure had recently been revised. The board of management holds regular meetings and there is a monthly visit by a designated board member to identified houses which may be in the community or the campus. A brief report is submitted to the board by the visiting member. Aside from the residents forum meetings there are however no other mechanisms evident for reviewing the quality and safety of care as required by the Regulations.

The current person in charge is a suitably qualified and experienced nurse and is engaged full-time in the management of the centre. A suitably qualified assistant director of nursing is available for periods of absence of the person in charge and functions as part of the management team. Governance is supported a range of systems including corporate risk and development. A variety of nursing grades have been assigned to oversee care practices in a number of the houses. However, these arrangements differ significantly across the campus, with some grades responsible for two houses and others for three houses. Staff were clear on the management structure.

The inspectors fully acknowledge the diversity and complexity of the service and also the significant changes which the provider has made and is planning to make to order to support good governance. The overall findings of the report however, indicate that the current management structure is not sufficient and does not demonstrate effective governance and monitoring of care practice. The provider has concurred with these findings and has indicated that changes will be made to allocate specific responsibilities
within a more manageable structure to ensure functions can actually be carried out.

**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

**Judgement:**
Non Compliant - Moderate

**Findings:**
The inspectors were not satisfied from observation and records available that the numbers and skill mix of staff were satisfactory for the needs of the residents on a 24 hour basis. While this was especially pertinent at night it was also found to impact on the availability of staff to provide care and activation to some residents during the day. There is an actual and planned rota available in each house.

Staffing at night was found to be significantly depleted. In total three nurses and one night nurse manager was available from 8pm to 8am with one care staff in each house, with the exception of one house where there are two care staff at night. The nurses have specific duties such as undertaking medication rounds across various houses and availability for emergency medical responses. This effectively means there were significant periods with one health care assistant in each house which in some instances are two story buildings. At 8.30pm on one night, inspectors observed a lone staff removing the television from a room in order to prevent injury. We were informed that this event was not unusual. However, taking the needs of the resident population into account it diminishes the capacity of the staff to provide care and supervision to the remaining residents. This staffing level also impacts on the ability of the provider to adequately supervise and monitor practices.

There was a centre-specific policy on recruitment and selection of staff. A significant number of agency staff were being utilised at the time of this inspection. The person in charge had correctly identified that this could impact on the continuity of care and was negotiating with the recruitment agency to identify a specific number of agency staff who would be available for regular work. The person in charge also stated that they had reviewed their practices in relation to procuring the relevant documentation for agency staff and would be insisting that they had access to the information held by the agencies on the staff been allocated to them. The current system was not satisfactory in that the person in charge did not have access to this information before the person commenced which does not support safeguarding.
A review of the recruitment processes and personnel files indicated that while there was overall compliance, some of the required documentation was not available. Missing documentation included photographic identification and one file did not contain any references. Evidence of registration with relevant bodies was available for staff who required this. The person responsible informed the inspector that all personnel files were currently being reviewed to ensure they were compliant. Inspectors were informed that no volunteers are currently used in the service.

Training records were held centrally which outlined the planned and actual training for all staff. Actual training provided in 2013 included fire safety training but a significant number of staff have not received this training with 143 listed as having attended.

The provider stated that the basic training requirement for new entrants was FETAC Level 5. To support this, an internal programme had been implemented for a three year period. Not all of the current staff had this level of training. There was no evidence and the person in charge confirmed that staff did not have training in challenging behaviours or cognitive impairment. The training schedule for 2104 includes intellectual disability awareness training. However, this is a two hour slot which also includes key worker training. Taking account of the resident population and the diversity of needs evident this is insufficient. A system of crisis intervention training has been undertaken internally with key staff trained to provide this. A supervision and performance management system had been devised but not yet commenced for staff pertinent to their role, which does not support care practice or safeguarding systems. A documented handover system is used to ensure information is passed to staff coming on duty.

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

**Report Compiled by:**

Noelene Dowling  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider's response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Stewarts Care Ltd</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0011222</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>24 February 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>10 April 2014</td>
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</table>

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

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:
Some practices did not take account of the gender and age range of all residents in order to ensure their care was appropriate to their assessed needs and their right to privacy and dignity.

Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
• A plan has been devised to address the shared gender dormitories in the 2 houses. This plan will be implemented by 31st May 2014.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
• A plan has been put in place for alternative accommodation for the service users in the 3rd house. This plan will be costed by Friday the 25th and presented to the Chief Executive on Monday 28th for approval. Implementation will commence as soon as practicable following approval.
• A long term plan has been developed for the relocation of all service users living in dormitory accommodation to purpose built houses. However funding for this project is currently not available.
• Plans have been submitted for refurbishment of bathroom facilities in the area with 2 showers. This plan will be submitted to the Chief Executive on the 28th April 2014, once a costing has been received. In the interim protocols are in place to promote and maintain the dignity of the service users.
• The current locks on toilet and bathroom doors will be reviewed by our technical services team to ensure that suitable locks will be in place. (31st May 2014).
• The policy on intimate care will be revised to include specific guidelines to all aspects of intimate care. (June 2nd 2014).
• The use of “inappropriate utensils for eating” will be reviewed by each CNM2/1/staff nurse of their own areas. Each person will review the current eating utensils in relation to their appropriateness for the service users. They will in consultation with the person in charge address any issues arising. (31st May)

**Proposed Timescale: 02/06/2014**
**Theme: Individualised Supports and Care**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All residents care needs could not be demonstrated as being sufficiently assessed and met.

**Action Required:**
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

**Please state the actions you have taken or are planning to take:**
The assessment tool which is currently been rolled out across the service will continue and will be used to identify the needs of the service users. The findings will be used to guide the personal support plans ensuring that all residents care needs will be sufficiently assessed and met 31st October 2014.

**Proposed Timescale: 31/10/2014**
**Theme: Individualised Supports and Care**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
No suitable and appropriate advocacy service was available for residents.
**Action Required:**
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

**Please state the actions you have taken or are planning to take:**
- The registered provider will link with advocacy service to source an appropriate advocacy service for residents.
- An advocacy service has been identified. There is a commitment for advocacy services to commence from 16th July 2014 and will be on-going on a personalised basis.

**Proposed Timescale:** 16/07/2014

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures in relation to complaints were not consistently implemented in some houses and there were delays in the timing of responses to complainants.

**Action Required:**
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

**Please state the actions you have taken or are planning to take:**
- The complaints procedures within the houses will be reviewed as per policy to ensure consistency.
- Both complaints received at local level and the procedures for dealing with them will be a standard item agenda at house meetings.

**Proposed Timescale:** 10/04/2014

**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:**
Some residents assessed needs were not adequately met in terms of access to suitable activities and accommodation.

**Action Required:**
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
- A dependency levels / staffing analysis is currently ongoing. This review will consider the structure in order to support resident’s access their preferred activities.
- Every Resident through their personal support plan will have identified suitable activities that they wish to access. (30th September 2014)
• A plan has been put in place to relocate one of the children currently living in an adult house to a children’s house. (31st October 2014)
• The second child: a long term plan is currently been developed. In the interim changes will be made to the child’s current accommodation to provide the child with her own personal space in addition to her own bedroom. (31st October 2014)

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The development and amendment of personal plans, goals and outcome reviews based on the health and social care needs of residents was not consistently evident.

**Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
On the 29th of April a meeting of the trainers of the personal support plan is taking place in order to ensure a consistent approach to development and evaluation of personal plans, goals and outcome reviews of the health and social care needs of residents. Following this meeting, on-site training will be implemented to ensure a consistent approach.

**Proposed Timescale:** 31/08/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not completed in conjunction with residents or other significantly important people for those residents who could not participate themselves.

**Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
- A PATH system will commence to make personal plans available in an accessible format for all residents and their significantly important people. This system will commence in June 2014 and will be implemented on a planned phased basis over the next 2 years.
- In the interim, personal support plans will be made accessible through the use of
other means, such as pictures and photographs. (30th September)
- Also as the Personal Support Plans are been reviewed service users and their families/friends or representatives will be invited to participate. (30th June 2015)

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

<table>
<thead>
<tr>
<th><strong>Outcome 07: Health and Safety and Risk Management</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>There was no risk management policy which governed the procedures for the identification and management of risk throughout the centre in accordance with Schedule 5 and included systems for hazard identification.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The risk management policy will be reviewed and updated to comply with the regulatory requirements.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 10/06/2014</td>
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<tr>
<th><strong>Theme:</strong> Effective Services</th>
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<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The risk management policy did not address the risk of self-harm.</td>
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<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The risk management policy will be reviewed and updated to comply with the regulatory requirements.</td>
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<td><strong>Proposed Timescale:</strong> 10/06/2014</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>There were no systems to ensure procedures used did not negatively impact on the residents quality of life inadvertently.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 10/06/2014</td>
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**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 management policy will be reviewed and update to comply with the regulatory requirements. (10th June 2014)
- A manager has been identified to systematically coordinate risk and set up and oversee adequate risk management systems. (31st December 2014)

**Proposed Timescale:** 31/12/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy which identified the measures to control risks identified.

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

**Please state the actions you have taken or are planning to take:**
The risk management policy will be reviewed and update to comply with the regulatory requirements.

**Proposed Timescale:** 10/06/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The unexpected absence of a resident was not included in the risk management policy.

**Action Required:**
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

**Please state the actions you have taken or are planning to take:**
The risk management policy will be reviewed and updated to comply with the regulatory requirements.

**Proposed Timescale:** 10/06/2014
<table>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>There was no risk management policy to manage accidental injury to resident’s visitors or staff.</td>
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<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>The risk management policy will be reviewed and update to comply with the regulatory requirements.</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>There was no risk management policy to guide practice in relation to self-harm.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The risk management policy will be reviewed and update to comply with the regulatory requirements.</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>There was no effective system to identify and learn from untoward events.</td>
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<tr>
<td><strong>Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>- A manager has been identified to systematically coordinate risk and set up and oversee adequate risk management systems. (31st of December 2014)</td>
</tr>
</tbody>
</table>
| - A process has commenced at house levels to identify and assess risks and this will be
done with the assistance of the risk manager. Commence Immediately and on-going)
- There will be on-going review of risk at both management and at house meetings and
this will allow for learning from, recording and investigation of serious incidents or
adverse events. (Commenced on 10th April 2014 and will remain on-going)

**Proposed Timescale:** 31/12/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Arrangements for exiting the premises in the event of a fire were not consistently satisfactory, particularly in relation to some fire doors.

**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:**  
- Individual fire evacuation plans will be reviewed to ensure they are sufficiently detailed. This will be completed by 23rd May 2014.
- A Review of the keys used on fire escape doors by the CNM2/1 and staff nurse will take place to ensure they are easily identifiable to staff. (16th May 2014)

**Proposed Timescale:** 23/05/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Staff did not have training in fire prevention and evacuation and fire management techniques.

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

**Please state the actions you have taken or are planning to take:**  
All Staff will now receive annual fire training. Commencing 31st of May 2014 records of fire evacuation on-site training will be evidenced on staff training files.

A schedule for the fire evacuation training is available. Fire Evacuation practice drills take place bi-annually and a planned schedule is available of same.

**Proposed Timescale:** 31/05/2014
### 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:**
Staff did not consistently demonstrate sufficient knowledge and up-to-date training the management of behaviour.

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

**Please state the actions you have taken or are planning to take:**
- As part of the daily handover process any prescribed physical restrictive techniques will be demonstrated and practiced by the staff on duty to ensure consistency. (24th April 2014)
- A staff resource will be identified who will work with staff and Service users to identify and train staff in the management of behaviours that challenge. This will commence on 1st May 2014.

**Proposed Timescale:** 01/05/2014

### Theme: Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that the concerns of either the resident or their representative was sought in regard to the consistent use of methods of restraint and that these systems were reviewed.

**Action Required:**
Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

**Please state the actions you have taken or are planning to take:**
- Commencing immediately, where consultation has not already taken place, service users will be consulted in line with policy along with their family or representative on any prescribed restraints.
- Moving forward as a review of prescribed restraints take place in line with policy the service user and or their representative will be consulted on the use of the restraint.

**Proposed Timescale:** 12/05/2014
### Theme: Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Policy in regard to the use of restrictive procedures was not adhered to and the rational for their usage was not as described in accordance with policy and best practice.

**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:**
- As part of the handover protocol the rationale and the use of a restraint will be discussed. (Commence 16 April 2014 and on-going)
- Evidence will be in the personal support plans as to the rationale and use of a prescribed restraint. (Commence 16th April 2014 and on-going)

**Proposed Timescale:** 16/04/2014

### Theme: Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Governance and overview of the practices in systems for protection of residents was not robust.

**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:**
The newly appointed Designated Person will set up a system to oversee and track all allegations of abuse. (System in place by the 1st of June 2014)

The Designated Person reports on these issues monthly to the Chief Executive (Commence Immediately)

**Proposed Timescale:** 01/06/2014

### Theme: Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personnel plans and arrangements for the provision of intimate care were not consistently evident or in some cases adequate.

**Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such
assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
Personal hygiene/intimate care template has been developed and disseminated to all areas to support service users in line with their personal support plan. (This action has been completed.)

The intimate care policy is currently under review. This will be completed by the 6th June 2014.

Proposed Timescale: 06/06/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Record and assessment documentation did not consistently demonstrate the monitoring of, and response to residents health care status.

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:
- Documented evidence of the implementation of the Residents health care plan will be located in the health chapter of the personal support plan. This will commence on the 30th April and will be on-going.

Proposed Timescale: 30/04/2014

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no policy to guide practice at the end of residents lives.

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:
In consultation with our GP service and multidisciplinary team, a policy will be developed to guide practice for end of life care for residents.

Proposed Timescale: 30/06/2014
**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Arrangements for residents who may be able to be involved in the preparation of food was not evident.

**Action Required:**
Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

**Please state the actions you have taken or are planning to take:**
Arrangements are made to support the residents in so far as reasonable and practicable to buy, prepare, and cook their own meals as identified in their personal support plans.

**Proposed Timescale:** 30/09/2014

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### 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:**
Some practices in the prescribing and storing of medications were not satisfactory.

**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:**
- Contact has been made with the suppliers to ensure that the medications are identified for the resident to whom they are to be administered.
- A PRN protocol template is currently under development and will be implemented for all PRN medication. The medication safety and therapeutics committee will meet to discuss and approve the implementation of this protocol on the 9th June 2014.

**Proposed Timescale:** 09/06/2014

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### Outcome 13: Statement of Purpose

**Theme:** Leadership Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The statement of purpose did not comply with the regulations and clearly outline the nature of the services to be provided.
**Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:**
In line with the reconfiguration of the designated centres, new statement of purposes for individual designated centres will be developed in line with the regulations.

**Proposed Timescale:** 18/04/2014

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**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:**
Current management arrangements are not satisfactory given the size of the service and the complexity of the residents needs.

**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 reconfiguration of the designated centres has been undertaken and is due for submission by 18th April 2014 and will be implemented on the 1st of May 2014. As part of this process management arrangements have been reviewed.

**Proposed Timescale:** 01/05/2014

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The number and skill mix of staff was not satisfactory with particular reference to night time.

**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.
<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A dependency needs assessment is on-going. Following this, a review will be undertaken of the current skills mix and levels of staff.</td>
</tr>
</tbody>
</table>

**Proposed Timescale:** 31/07/2014  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Recruitment procedures did not ensure that all documentation required for staff had been sourced prior to commencement.

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

**Please state the actions you have taken or are planning to take:**  
All staff files have been audited. Appropriate documentation will be sought to ensure full compliance with Schedule 2 for all staff.

**Proposed Timescale:** 30/09/2014  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staff did not have sufficient training pertinent to the needs of the resident population.

**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 an analysis of the assessment of service user needs a training needs analysis is being developed and will be conducted for all staff pertinent to the needs of the resident. Commence 1st June Completed 31st December 2014.

**Proposed Timescale:** 31/12/2014  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
At the time of this inspection a staff supervision programme was not implemented.
**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
Training will commence on the 16th and 17th April 2014 for staff supervision and performance management. This will be rolled out across the service.

**Proposed Timescale:** 30/04/2015