

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St Raphael's Centre
Centre ID:	ORG-0008616
Centre county:	Cork
Email address:	SuzanneR.Moloney@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Moloney
Person in charge:	Susan Wall
Lead inspector:	John Greaney
Support inspector(s):	Breeda Desmond
Type of inspection	Announced
Number of residents on the date of inspection:	53
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 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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
29 April 2014 09:30	29 April 2014 18:30
30 April 2014 10:30	30 April 2014 17:00

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

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

Summary of findings from this inspection

This was a first monitoring inspection of this Health Service Executive (HSE) centre for adults with disabilities in which 18 outcomes were inspected against. The inspection was announced and took place over two days. As part of the inspection process inspectors met with residents, the nominated provider, nursing management, and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, policies and procedures and staff files.

Overall inspectors were not satisfied that there was an adequate level of compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for

Persons (Children and Adults) with Disabilities) Regulations 2013. Governance arrangements were unclear due to proposed retirement of some senior personnel, which also had implications for the management of other designated centres.

The premises was old, institutional in design and layout and some care practices were also institutional in nature, as exemplified by the absence of choice of food at mealtimes, the absence of person-centred care planning and the limited integration and interaction with the community.

Other improvements identified by inspectors to enhance the quality of life and care for residents in the centre, included:

- consultation with residents in relation to decisions about care and in relation to the running of the centre
- multi-occupancy dormitory style bedrooms
- contract of care
- risk management practices and policies
- design and layout of the centre
- reviews by allied health/specialist services
- choice of food at mealtimes
- medication management
- access to resources
- personnel records
- adequate staffing
- staff training

The action plan at the end of the report identifies improvements necessary 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 2013.

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 - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was no systematic process for consulting with residents in relation to routines and practices in the centre. There were no residents' meetings or no surveys of residents or their relatives in relation to the quality and safety of the service provided.

The centre has a named independent advocate but the advocacy service is not adequately promoted to ensure that all residents and/or their relatives are aware that it is available.

The centre had a complaints policy dated September 2013, however it did not specify who was responsible for dealing with complaints, an independent appeals process or a person responsible for ensuring that all complaints are adequately addressed. There was a notice on display identifying the complaints officer and there were separate notices on display outlining the complaints process, but not prominently, in adequate detail or in an accessible format. A complaints log was reviewed that contained only one complaint. However, based on the record available it was not evident that the complaint was adequately investigated, whether the complainant was informed of the outcome of the investigation or if the complainant was satisfied with the outcome of the complaint.

Based on observations of staff interacting with residents, it was evident that staff had good knowledge of the residents. As will be discussed in Outcome 6, there were significant shortcomings in the structural design and layout of the premises that directly impacted on the ability of staff to support the privacy and dignity of residents.

Routines and practices did not support residents to maximise their independence or enhance the quality of their lives. For example, as discussed in Outcome 11, residents were not offered a choice of food at mealtimes even though choice was available from the kitchen. Records were not available identifying, likes and dislikes of residents or preferences in relation to participation in activities. A religious service was available in a church on site each week and all religious preferences were facilitated.

There was a policy on residents' personal property and possessions and records were maintained of residents' personal finances, however, there were no records maintained of other personal property and possessions. Residents clothing was laundered in an external laundry.

There were limited opportunities for residents to engage in activities and it was not possible to determine, based on available records, if the activities available suited the residents' need, interests and capacities. Activities available included massage and aromatherapy, however, there was minimal organised activities taking place on the days of the inspection. A number of residents attended day activation units within the grounds of the centre, however records were not available to determine if the activities/occupation programme available in these units met the needs and preferences of residents. While a number of residents were elderly and had significant co morbidities making it difficult for them to participate in activities in the community, a number of residents would have benefited from visits to shops and cafés, this was not facilitated. Inspectors were informed by staff that there were insufficient staff numbers to accompany residents on trips out of the centre.

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There were televisions available in communal areas and each unit had access to telephones.

There was no policy on communicating with residents available in the centre on the days of the inspection. A number of residents had significant communication needs and a number of residents were non-verbal. While staff members appeared to be aware of non-verbal cues from residents, from a sample of care plans viewed by inspectors, communication needs were not highlighted or addressed in care plans. There were no

records of staff training in communication with residents. There was poor access to speech and language services and many residents either had no assessment or were overdue a review.

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

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

Theme:

Individualised Supports and Care

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

Based on discussions with staff and relatives, relationships with families were facilitated and supported and families were kept informed of resident's well-being. A number of residents only had minimal contact with family members, however, based on records viewed by inspectors, it was evident that where families were in regular contact with residents, they were not included in the development and review of personal plans.

As discussed in Outcome 1 and 6, due to the design and layout of the premises, there were not suitable facilities within the centre for residents to meet with visitors in private. There was insufficient evidence that residents were supported to integrate, socialise or to maintain links with the wider community. For example, residents that were physically capable of visiting shops and cafés had limited opportunities to do so.

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

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was a policy available detailing the process for admission to the centre, however, current practice is not to accept new admissions. Inspectors found, and the provider acknowledged, that the physical design and layout of the centre and access to multidisciplinary services are not suitable for the needs of the residents.

Residents did not have a contract of care, however, inspectors were informed that a contract of care is currently in draft.

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 - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

A template for recording the assessed needs of resident called "My Assessment" was available in each resident's care plan. The template included sections for recording residents' choice, education/learning, circulation and breathing, nutrition, mobility, communication, oral hygiene, men's/women's health and personal cleansing and dressing, however, these were only partially completed for a significant number of residents. Staff members had received minimal training in developing care plans and this was evident in the quality of care plans viewed by inspectors.

Care plans were developed based on residents' assessments, however these primarily focused on healthcare needs, were written from a staff perspective and there was variation in the quality of the care plans. Social care needs were not addressed in the plans and there was no evidence that residents or their relatives, where possible, were consulted in relation to developing the plans or if residents had declined to engage in the process. For example, the care plans did not address:

- information to guide staff on how to communicate with residents with communication difficulties
- goals identified by the residents, plans in place to enable goals to be met or who was responsible to help the residents achieve their goals

- education, lifelong learning and employment support services, where appropriate
- social care needs
- development, where appropriate, of a network of personal support
- transport services
- assistive devices and technologies
- the resident's wishes in relation to where he/she want to live and with whom
- the resident's wishes or aspirations around friendships, belonging and inclusion in the community
- the involvement of family or advocate. The role of the family and the support services to be provided were not documented in the care plans.

A copy of the plans was not available to residents and they were not in an accessible format.

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

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

This was a three-storey premises, however all resident accommodation was on the ground floor. The design and layout of the premises was institutional in nature, with large multi-occupancy dormitory style bedroom accommodation for the majority of residents. The centre comprised three separate units, two of which accommodated mostly elderly residents and the third unit accommodated residents with predominantly severe to profound disabilities.

The first unit accommodated 20 residents in one 10-bedded room, a 7-bedded room, a twin-bedroom and a single bedroom. There were accordion style screens fixed to the wall between each bed in the multi-occupancy rooms to facilitate the provision of personal care. Residents had a wardrobe for storing clothing, however not all of the wardrobes were proximal to the residents' beds. Some, but not all, residents had a bedside locker and where bedside lockers were present, they incorporated lockable storage. There was a sluice room that contained a sluice sink, bedpan/urinal washer, and while there were hand washing facilities within the room, it was evident that they were not routinely used as there were items stored in the basin. On the day of inspection the sluice room was unlocked and there were cleaning chemicals stored,

unsecured, on shelving in the room. The sluice room was also used to store cleaning equipment such as mops and buckets, and the mop heads were stored in buckets containing unclean water. Inspectors were satisfied that the storage of cleaning equipment in the sluice room and the manner in which it was stored, was poor infection prevention and control practice and had the potential to cause cross contamination.

Sanitary facilities consisted of a bathroom, a shower room and two toilet cubicles. The bathroom contained an assisted bath and the room was also used to store a linen trolley and a non-clinical waste bin. There was body wash, shaving foam and medicated powder in the bathroom that was not labelled for individual resident use. The shower room was en suite to the single bedroom and contained an assisted shower, a toilet and a wash-hand basin. Communal facilities comprised a conservatory that contained comfortable seating and a dining table that could only seat six people. The inspectors were satisfied that there were insufficient communal and dining areas for the residents.

The second unit accommodated 17 residents in one 12-bedded room and five single bedrooms. Some of the beds were very close together, there were no screens between the beds, however, mobile screens were available within the unit. Two of the single bedrooms were located in an area of the premises that was not immediately adjacent to the main part of the unit. This area also contained a small sitting room and a shower room containing an assisted shower and toilet. Additional sanitary facilities consisted of a bathroom with an assisted bath and a shower room with an assisted shower. There were three toilet cubicles. There was access to a secure garden.

The third unit accommodated 16 residents in one 14-bedded room and a twin bedroom. There were accordion style screens fixed to the wall between each bed in the multi-occupancy bedroom. Each resident had a bedside locker beside their beds and wardrobes that were not stored proximal to residents' beds. There was a bathroom with an assisted bath and a shower room with an assisted shower. There were four toilet cubicles for use by residents. Communal facilities consisted of a combined sitting room/dining room. There was access to a secure garden.

Inspectors viewed service records showing that hoists received preventive maintenance six-monthly, most recently in April 2014. Records were not available showing preventive maintenance for other equipment such as assisted baths, beds, speciality mattresses and chair scales.

There were hand-washing facilities in each of the bedrooms with advisory signage, liquid soap and paper towel dispensers. Each unit had a kitchen for preparing snacks and for storing food, however main meals were always prepared in the central kitchen.

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:

This was the centre's first inspection by the Authority.

Findings:

Personal protective equipment was located throughout the centre and inspectors observed appropriate use by staff.

There was a safety statement dated May 2013. There was no documented emergency plan available in the centre on the days of the inspection. There was a risk and incident management policy dated September 2013 that predominantly addressed the management of incidents in the centre. The policy did not address the measures in place to control the risk of the unexpected absence of a resident, accidental injury, aggression and violence, or self-harm. While the policy specified the process for responding to incidents, based on records viewed by inspectors, this was not implemented in practice. For example, incidents were recorded on a clinical incident/close call event form and the section for remedial action was completed for a number of incidents. However, on some forms the remedial action was to prevent recurrence, but it was not specified how this would be achieved. While there were audits carried out on each unit of incidents, most of which were falls, the audit consisted of times, locations, number of residents with more than one fall and there was no evidence of further analysis or of an action plan to minimise recurrence.

A small number of residents smoked and records were available showing that some, but not all, were risk assessed in relation to the risk of smoking. Care plans were not in place identifying the safe level of access to cigarettes and lighter/matches, or the supervision level required when residents smoked.

Based on training records available it was not possible to easily determine what staff were due to attend training on manual and patient handling.

Inspectors viewed fire safety records, which were held in a number of folders containing historical records covering a number of years and it was not easy to access and retrieve current fire safety records. Based on records viewed by the inspectors, the fire alarm and emergency lighting were serviced quarterly, most recently in April 2014. Certificate of servicing of fire safety equipment such as fire extinguishers, fire hoses and fire blankets were not available, however stickers on individual items of equipment indicated that annual maintenance had most recently taken place in November 2013. Records indicated that fire safety training and fire drills had taken place during 2013, however, due to poor records management, it was not possible to determine what staff were overdue training. Fire safety checks were carried out on each unit, including the inspection of means of escape to ensure they were free from obstruction. All exits were seen to be free of obstruction on the days of inspection. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire.

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 - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was a policy on, and procedures in place, for the prevention, detection and response to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. Inspectors observed staff members interacting with residents in a respectful manner. Based on records viewed by inspectors, a significant number of staff had not received up-to-date training on the prevention and detection of abuse.

Based on a review of records and discussions with staff there have been no incidents, allegations or suspicions of abuse in the designated centre. There were adequate measures in place for the management of residents' finances centrally, however, some improvements were required at unit level. For example, small amounts of money were held for safekeeping in each unit and a new system for recording transactions had been introduced in November 2013. However, residents had contributed to a kitty for sundry items such as sweets and biscuits but there were inadequate records available demonstrating that each resident had agreed to contribute or that they benefited from the items purchased. Based on observations of inspectors, records viewed and on discussions with staff, a number of residents demonstrated challenging behaviour intermittently. Only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of challenging behaviour. Even though staff members spoken with by inspectors were familiar with residents, triggers for behaviour changes and alleviating factors were not appropriately documented in personal plans.

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

Based on a review of records of accidents and incidents the Authority was notified as appropriate of relevant accidents and incidents.

Outcome 10. General Welfare and Development*Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.***Theme:**

Health and Development

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

A small number residents attended activation centres each day from Monday to Friday and returned to the centre each evening. Based on a review of personal plans it was not possible to determine if the individual preferences of residents in relation to activities were facilitated in the activation centres. There was limited evidence of engagement in social activities either internal or external to the centre.

Outcome 11. Healthcare Needs*Residents are supported on an individual basis to achieve and enjoy the best possible health.***Theme:**

Health and Development

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

Residents had access to general practitioner (GP) services, including out-of-hours, and there was evidence of regular review.

Residents had ready access to some multidisciplinary services but limited or no access to others. For example, an occupational therapist was available in the centre for four days each week, a psychiatrist was available two days each week, a psychologist was available for one session each week and there was good access to dental services. However, there was limited access to services such as dietetics, physiotherapy and speech and language therapy.

Staff spoken with by inspectors were knowledgeable about residents' health and social care needs. Personal support plans were developed for each resident, and some were comprehensive in relation to addressing healthcare needs, however, others did not adequately capture or describe the healthcare needs of residents. For example, one resident was diagnosed with Type 2 diabetes, however this was not adequately addressed in his personal plan. There were not always adequate records maintained of care provided to residents. For example, a daily record of care was maintained that involved attaching a check mark adjacent to issues such as circulation and breathing, nutrition, challenging behaviour, and personal hygiene and dressing, however, it was not possible to interpret what information the check mark intended to relay about the condition of the resident or the care provided.

Meals were prepared in the central kitchen that also prepared food for other designated centres and were then collected from the kitchen in a heated delivery trolley. On one of the days of the inspection the heated food trolley was collected by a staff member for one of the units without verifying that appropriate food hygiene records had been completed in the kitchen. Inspectors observed mealtimes and noted that residents requiring assistance were assisted by staff in an appropriate manner, sitting bedside residents and chatting with them. There was no evidence that residents were offered choice at mealtimes, even though choice was available from the kitchen. On the first day of the inspection the meat offering for the main course was bacon slices, minced bacon or liquidised bacon, with vegetables and mashed potatoes. Lunch was served at approximately 11.50 in one unit on one of the days on the inspection and there was no evidence that residents were consulted in relation to the times that meals were served.

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:

This was the centre's first inspection by the Authority.

Findings:

There was a medication management policy that addressed the prescribing, administration, recording and disposal of medicines. Some improvements were required in the policy as the procedure outlined for disposing of medication was unclear and also the policy specified the recording of the fridge temperature weekly rather than daily. Each resident had two prescription sheets one for "psychiatry" medications and the other for "medical". Based on a sample of prescriptions reviewed, not all contained a photograph of the resident, date of birth, the GPs name and not all contained the maximum dosage for PRN (as required) medications.

Based on inspectors' observations, medication administration practices were in compliance with relevant professional guidance.

There were adequate procedures in place for the management of drugs requiring special control measures. There was a procedure in place for the return of unused/out-of-date drugs, however, adequate records were not maintained in the centre, including verification from the pharmacist of receipt of the drugs.

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 - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was a written statement of purpose, however, it was out-of-date as it did not accurately reflect facilities and services currently provided in the centre.

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:

This was the centre's first inspection by the Authority.

Findings:

At the beginning of the inspection process, inspectors were informed by the nominated provider that it was anticipated there would be some changes in senior personnel and the process of appointing replacement staff in charge was at an advanced stage. The need to appoint new senior staff had also had implications for the management of other centres and the future management arrangements for all of the centres concerned was not confirmed. At the end of the inspection process, inspectors were not satisfied that there was a clearly defined management structure that identified lines of authority and accountability for the designated centre.

A number of audits were carried out in each unit on issues such as safe moving and handling, end of life, care planning, smoking, challenging behaviour and abuse. However, the audits focused on the availability of documentation rather than practice and were not always completed appropriately. For example, a number of audits viewed by inspectors indicated that all staff members had signed a form to indicate that they had read and understood policies, however many of the signature sheets seen by inspectors were blank. Where audits had identified shortcomings, there was no process in place to address them. Inspectors were not satisfied that there were adequate systems in place for a review of the quality and safety of care in the designated centre.

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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

As stated under Outcome 14, there was a lack of clarity around senior roles and the

nominated provider was informed by inspectors of the requirement to notify the Authority of any potential absence for 28 days or more of, a person in charge of a centre and of any interim management arrangements in place should such an absence occur.

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

There was adequate assistive equipment such as hoists, speciality mattresses and beds, and chair scales. As stated under Outcome 6, the design and layout of the centre was institutional in nature and therefore did not adequately meet the needs of residents. Large multi-occupancy bedrooms and inadequate communal space did not support the promotion of privacy and dignity, in addition to limited access to bedside lockers and the location of wardrobes for storing personal items of clothing away from residents' beds.

Cars were available to transport residents to external activities, however staff members spoken with by inspectors stated that some issues had arisen around the use of these vehicles for a number of weeks prior to the inspection and access was reduced. Irrespective of these issues, which inspectors were informed were now resolved, when transport vehicle were available, there were not always sufficient staff to accompany residents on outings or to external activities and inspectors formed the view that the centre's routines and activities were resource led rather than person centred. Resources allocated to education and training of staff required review to ensure the needs of the residents were met.

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 - Major

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

The centre falls under the remit of the HSE policy and procedure for the recruitment and selection of staff. Inspectors reviewed a sample of personnel records and noted that the records did not contain many of the requirements outlined in Schedule 2 of the Regulations. Many records did not contain evidence of:

- the person's identity, including a recent photograph
- the dates of commencement and cessation of employment
- Garda vetting disclosure
- a full employment history together with satisfactory history of gaps in employment
- two written references
- the position the person holds at the designated centre
- evidence of relevant qualifications

Inspectors reviewed a sample of staff rosters and noted that on the days of inspection the roster reflected the number of staff on duty. While the numbers of staff on duty were sufficient to meet the direct care needs of residents, such as in relation to the provision of healthcare and personal hygiene, inspectors were not satisfied that there were sufficient staff on duty to cater for the social care needs of residents. For example, there was minimal evidence of a programme of activities designed to meet the needs of residents and residents had few opportunities to participate in activities external to the centre.

Staff members spoken with by inspectors were knowledgeable of resident's individual needs and preferences. There were records available of attendance by staff members at various education/training sessions, such as protection from abuse, fire safety, manual handling, however, attendance at many of the sessions was poor. There was no systematic process in place to monitor attendance by staff and to ensure they had received up-to-date training on mandatory training such as protection from abuse, manual handling and fire safety.

There was no evidence of a coordinated strategy for staff development to ensure staff had the required training to support residents maximise their independence. For example, a new assessment process was launched in 2012 that would support the delivery of person-centred care and training was available, however, based on discussions with staff members a training programme was not facilitated for staff by management.

There was minimal evidence of attendance at additional training for issues relevant to residents in the centre such as modified diets and dysphagia, and dealing with challenging behaviour.

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

This was the centre's first inspection by the Authority.

Findings:

Inspectors reviewed the centre's policy and procedures, however not all the policies listed in Schedule 5 of the Regulations were present and some policies required review, including:

- medication management
- communicating with residents
- staff training and development
- provision of information to residents
- records management
- the emergency plan
- complaints policy

Records, including the fire safety register and maintenance records were not available in a manner that was readily accessible and easily retrievable.

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by St Raphael's Centre
Centre ID:	ORG-0008616
Date of Inspection:	29 April 2014
Date of response:	17 June 2014

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: DCAD10 Individualised Supports and Care

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

There was no systematic process for consulting with residents in relation to routines and practices in the centre. There were no residents' meetings or no surveys of residents or their relatives in relation to the quality and safety of the service provided.

Action Required:

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

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

1. Additional Training for staff on person centred care planning, has commenced and is ongoing. Following this upskilling, staff will on an individual basis and as part of the

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

care planning process, address the current deficits in relation to engagement with families and residents and documentation of same as part of PCP process.

2. Meeting held with CAS to develop existing speaking out group into Service user forum - open to all residents within SRC talks ongoing at present proposed to have same implemented by 31st December 2014

3. Families will be contacted in writing to ascertain their interest in forming a family forum. Based on this feedback, a decision will be made as to whether a family forum would be feasible, or whether communication is focussed on an individual basis at this time.

Proposed Timescale: 31/12/2014

Theme: DCAD10 Individualised Supports and Care

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

The centre has a named independent advocate but the advocacy service is not adequately promoted to ensure that all residents and/or their relatives are aware that it is available.

Action Required:

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

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

1. The service will promote the National Advocacy Service further within the centre by
 - a. Displaying information
 - b. Advising each residents and noting the interaction in their care plans
 - c. Writing out to families to advise them of the service.
2. From meetings it is envisaged that the structure for advocacy service within SRC is as follows
 - for advocacy format within a group structure we use CAS Cork Advocacy Service-current "Speaking Out " Group
 - For advocacy in individual cases we use NAS National Advocacy Service.
3. The National Advocacy Service will also be contacted with regard to what other steps could be taken to promote their service and advocacy in general.

Proposed Timescale: 01/09/2014

Theme: DCAD10 Individualised Supports and Care

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

Routines and practices did not support residents to maximise their independence or enhance the quality of their lives.

Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

1. Staff will on an individual basis and as part of the care planning process, review and identify how residents are supported to maximise their choice and independence in daily life. This will be supported by the current process of training staff in PCP.
2. Any deficits identified in the operation of the service arising from this process will be documented and a work plan developed to maximise independence and enhance residents' quality of life, within the parameters of operating a congregated setting.
3. The service will identify key areas for development in terms of routine /practise and resident preferences:
 - Mealtimes
 - Meal choices
 - Bathing/Showering preferences
 - Morning Rising and Bed times

Proposed Timescale: 31/10/2014

Theme: DCAD10 Individualised Supports and Care

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

There were limited opportunities for residents to engage in activities and it was not possible to determine, based on available records, if the activities available suited the residents' need, interests and capacities.

Action Required:

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

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

1. A review of all current programmes will be undertaken through the development and completion of a current activation service audit.
2. The interests, capacities and developmental needs for each resident will be robustly reviewed and documented as part of the care planning that is currently being rolled out.
3. Deficits in the service and/or access to existing services arising from this process will be documented and a business plan developed regarding improved activities.
4. Subject to service resources and feasibility based on the plans for service reconfiguration and de-congregation, activities will be developed/ accessed based on this unmet needs identified.

Proposed Timescale: 31/12/2014

Theme: DCAD10 Individualised Supports and Care

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

There was a notice on display identifying the complaints officer and there were separate notices on display outlining the complaints process, but not prominently, in adequate detail or in an accessible format.

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

1. A comprehensive memo has been drafted and sent to all staff identifying the current suite of policies relevant to the service with regard to complaints and identifying the Complaints Officer.
2. A letter has been drafted and sent to all families identifying the current suite of policies relevant to the service with regard to complaints and identifying the Complaints Officer. A copy of the new local Complaints policy and procedure and easy read version have been attached.
3. The local complaints procedure for residents and families has been developed in an easy read version.
4. All the residents will be assisted by their key worker or the day therapy staff, to go through the complaints procedure, so that they are aware of this and how to make a complaint. A copy of the easy read version will be placed on the person's care plan file once this is completed and the engagement will be noted on their file. The staff members will notify the CNM2, as each resident is advised on the procedure and the CNM2 will keep and monitor a central log to ensure this is completed for each resident.
5. A copy of the easy read complaints procedure has been sent to the National Advocacy Service, with a covering note, to make them aware of the new complaints policy and procedure.
8. Additional Your Service Your Say signage will be sourced and displayed to identify the complaints procedure.

Proposed Timescale: 30/08/2014

Theme: DCAD10 Individualised Supports and Care

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

Based on records available complaints were not always adequately investigated.

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:

1. A complaints log and complaints log summary sheet is in place. A Standard Operating Procedure will be developed to further strengthen and support the

implementation of the Complaints Log process, that will identify:

- a. Mechanism for complaints review by service management – person responsible, timeframe, documentation, actions etc
- b. Mechanism and process of engagement with relevant stakeholders including complainant.

2. The management and review of complaints will be a standing item on the agenda for the management team and the QPS committee (once formed- see Outcome 14 Actions to be taken)

Proposed Timescale: 30/07/2014

Theme: DCAD10 Individualised Supports and Care

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

It was not always possible to determine if the complainant was satisfied with the outcome of the complaint

Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

1. A complaints log and complaints log summary sheet is in place. A Standard Operating Procedure will be developed to further strengthen and support the implementation of the Complaints Log process, that will identify:
 - a. Mechanism for complaints review by service management – person responsible, timeframe, documentation, actions etc
 - b. Mechanism and process of engagement with relevant stakeholders including complainant.
2. The management and review of complaints will be a standing item on the agenda for the management team and the QPS committee (once formed- see Outcome 14 Actions to be taken)

Proposed Timescale: 30/07/2014

Outcome 02: Communication

Theme: DCAD10 Individualised Supports and Care

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

While staff members appeared to be aware of non-verbal cues from residents, from a sample of care plans viewed by inspectors, communication needs were not highlighted or addressed in care plans.

Action Required:

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

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

A senior staff member is scheduled to receive "Train the Trainer" training in Communication, in October 2014. Once completed this person will roll out a training programme around Communication to staff across the service. As there are significant staff numbers in the service and multiple training needs, it will take up to 12 months to complete this process.

Staff training on PCP's is ongoing, which will support staff to complete PCP documentation more comprehensively and accurately.

Proposed Timescale: 30/06/2015

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

Theme: DCAD10 Individualised Supports and Care

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

There were not suitable facilities within the centre for residents to meet with visitors in private.

Action Required:

Under Regulation 11 (3) (b) you are required to: Provide a suitable private area, which is not the resident's room, to a resident in which to receive visitors, if required.

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

Families and residents can be facilitated to meet in private, in the ground floor meeting room, but this is not very homely and not easily accessible for some residents, who are frail.

The provision of alternative visitor rooms on the ground floor will be examined in the context of the overall plan for the site. Where feasible a suitable room will be provided and appropriately equipped.

Proposed Timescale: 31/12/2014

Theme: DCAD10 Individualised Supports and Care

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

There was insufficient evidence that residents were supported to integrate, socialise or to maintain links with the wider community.

Action Required:

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

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

Accesses to supports that can facilitate significant community integration are limited.

- A legal issue over the provision of vehicles has been addressed and all areas now have access to vehicles to facilitate residents going out of the unit.
- A business case has been developed and submitted for additional staff resources that would alleviate the pressure of staff ratios on the units.
- The training of staff in PCP development is ongoing. This will support staff to develop a more holistic appreciation of each individual resident's wishes and needs including socialisation and engagement outside of the service.
- A mentoring system to support staff in rolling out PCP's will be developed to enhance and promote this.
- The management team will examine and explore the opportunity for a social integration subgroup being formed that can link with the service user forum.

Proposed Timescale: 30/11/2014

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:

Residents did not have a contract of care.

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:

The Contract of Care Document has been developed and will be implemented for all residents by July 31st 2014.

Proposed Timescale: 31/07/2014

Theme: Effective Services

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

Inspectors found and the provider acknowledged that the physical design and layout of the centre and access to multidisciplinary services are not suitable for the needs of the residents.

Action Required:

Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

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

A business case has been submitted and approved for additional MDT resources at area management level. The service will complete the application and approval process for each individual MDT post to the required level.

Within the physical constraints of the service, the service prioritises the deliver of individual care, dignity and privacy for the residents. A long term strategic plan for the development / de congregation of the centre will be developed in consultation with Senior HSE managers and stakeholders, including the residents and families.

Proposed Timescale: 31/12/2014

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:

Care plans primarily focused on healthcare needs, were written from a staff perspective and there was variation in the quality of the care plans. Social care needs were not addressed in the plans and there was no evidence that residents or their relatives, where possible, were consulted in relation to developing the plans or if residents had declined to engage in the process.

Action Required:

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, 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:

- PCP training has been delivered to a cohort of staff
- A full training gap analysis and training development plan will be undertaken to identify the need for additional PCP training
- The development of a PCP mentoring programme will be examined and developed to support staff to develop care plans effectively and inclusively.

Proposed Timescale: 30/09/2014

Theme: Effective Services

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

A copy of the plans were not available to residents and they were not in an accessible format.

Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The development of an accessible format PCP will be examined and developed. In the interim all residents and family members /representatives will be advised of the current PCP format and supported to access this by the key worker.

Proposed Timescale: 01/03/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The design and layout of the premises did not meet the aims and objectives of the service, for example:

- the premises was institutional in nature, with large multi-occupancy dormitory style bedroom accommodation for the majority of residents
- there were insufficient communal and dining area for the residents
- there was inadequate storage space for equipment
- some of the beds were very close together and there were no screens between some beds,
- the cubicle style toilets did not support residents' privacy and dignity.

Action Required:

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

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

- A long term strategic plan for the development / decongregation of the centre will be developed in consultation with Senior HSE managers including the Estates Department. Target Date 31st December 2014.
- Consultation will also take place with the residents and families on this, in relation to how it will affect each individual. Target Date : 1st June 2015
- The centre is currently closed to long term admissions. As resident numbers reduce opportunities for reconfiguration of the internal space will be examined. This may allow for improved personal and individualised space in bedrooms, additional and alternate communal rooms and dining facilities etc.

Proposed Timescale: 01/06/2015

Theme: Effective Services

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

Records were not available showing preventive maintenance for all equipment such as assisted baths, beds, speciality mattresses and chair scales.

Action Required:

Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly as possible so as to minimise disruption and inconvenience to residents.

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

A full review of all documentation records will be undertaken. Any equipment without adequate service/maintenance records will be risk assessed and de-commissioned where appropriate to reduce risk of injury, pending appropriate maintenance.

Proposed Timescale: 30/08/2014

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:

Improvements were required in the management of risk:

- not all residents that smoked were risk assessed in relation to risk of smoking
- the sluice room was unlocked and there were cleaning chemicals stored, unsecured, on shelving in the room.

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:

- Risk assessments will be completed on all residents that are smokers
- Risk assessments will be completed on the need to secure the sluice room and the location of hazardous chemicals

Proposed Timescale: 30/08/2014

Theme: Effective Services

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

The risk management policy did not address the measures and actions in place to control the risk of the unexpected absence of a resident, accidental injury, aggression and violence, or self-harm.

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:

All of the policies named below were in situ at time of inspection:

1. SOP in place re missing service user
2. Challenging Behaviour policy in place
3. Reporting Incidents involving Clients in place
4. Self Injury policy in place

These policies will be reviewed to ensure they are comprehensive and up to date. The service will put these into one file when distributing schedule 5 policies.

Training of all staff in PMAV to be rolled out across the service

This will take approx 18 months to facilitate, (subject to a business plan to facilitate releasing/replacing of staff on mandatory training days). Staff will be nominated for training on a priority basis

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

The sluice room was used to store cleaning equipment such as mops and buckets, and the mop heads were stored in buckets containing unclean water. Inspectors were satisfied that the storage of cleaning equipment in the sluice room and the manner in which it was stored, was poor infection prevention and control practice and had the potential to cause cross contamination.

Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

Practise and storage facilities will be reviewed by the Infection Control Nurse and unit managers immediately to ensure all cleaning equipment is appropriately stored in line with HCAI guidelines.

Proposed Timescale: 08/08/2014

Theme: Effective Services

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

Records indicated that fire safety training and fire drills had taken place during 2013, however, due to poor records management, it was not possible to determine what staff were overdue training.

Action Required:

Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

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

- A review of all training records is being undertaken. All information is being collated to create accurate and effective training records system for all staff.
- Service has engaged with relevant internal and external trainers with regard to training on use of fire equipment, fire safety training and fire evacuations. Training schedule is being developed to deliver a rolling programme of training.
- Staff will be nominated for training on a priority basis to address those that require refreshers etc. at the earliest opportunity.

Proposed Timescale: 30/11/2014

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:

Even though staff members spoken with by inspectors were familiar with residents, triggers for behaviour changes and alleviating factors, this was not appropriately documented in personal plans.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

- Training on PCP development and identifying the causes of Challenging Behaviour has been delivered to a cohort of staff.
- More training for a further group of staff, those who works in areas where challenging behaviour is prevalent, is being arranged with external consultants
- A Mentoring system to support staff in developing PCPs is being developed internally.

- Two senior staff members are completing advanced training in the management of behaviours that challenge. On completion of their training, these staff will be utilised as a resource to support others in the centre.

Proposed Timescale: 31/12/2014

Theme: Safe Services

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

Only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of challenging 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:

- Training on PCP development and identifying the causes of Challenging Behaviour has been delivered to a cohort of staff.
- More training for a further group of staff, those who works in areas where challenging behaviour is prevalent, is being arranged with external consultants
- A Mentoring system to support staff in developing PCPs is being developed internally.
- Two senior staff members are completing advanced training in the management of behaviours that challenge. On completion of their training, these staff will be utilised as a resource to support others in the centre.

Proposed Timescale: 31/12/2014

Theme: Safe Services

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

Based on records viewed by inspectors, a significant number of staff had not received up-to-date training on the prevention and detection of abuse.

Action Required:

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

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

- Review of all training records is being undertaken. All information is being collated to create accurate and effective training records system for all staff.
- All staff have been circulated with information regarding the current policies, procedures and mechanisms under which complaints, suspicions or allegations of abuse

should be managed.

- Training material on the management of elder abuse has been sourced and an internal programme on the prevention and detection of abuse will be developed.
- A schedule of training will be developed and implemented, commencing in 2014.

Proposed Timescale: 31/10/2014

Theme: Safe Services

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

Improvements were required at unit level in relation to the management of residents' finances.

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 practise of pooling resources and operating a kitty system for goods at a unit level is not service policy.
- An instruction to cease this practise will issue and periodic unit audits will be carried out to ensure the practise has discontinued.

Proposed Timescale: 31/07/2014

Outcome 10. General Welfare and Development

Theme: Health and Development

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

Based on a review of personal plans it was not possible to determine if the individual preferences of residents in relation to activities were facilitated in the activation centres.

Action Required:

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

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

To improve PCP documentation:

- Training on PCP development and has been delivered to a cohort of staff.
- More training for a further group of staff, is being arranged with external consultants
- A Mentoring system to support staff in developing PCPs is being developed internally.

As noted in the response to Outcome 03 on Individualised Support and Care :

- A review of all current programmes will be undertaken through the development and completion of a current activation service audit.
- The interests, capacities and developmental needs for each resident will be robustly reviewed and documented as part of the care planning that is currently being rolled out.
- Deficits in the service and/or access to existing services arising from this process will be documented and a business plan developed regarding improved activities.
- Subject to service resources and feasibility based on the plans for service reconfiguration and de-congregation, activities will be developed/ accessed based on this unmet needs identified.

Proposed Timescale: 31/12/2014

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Residents had ready access to some multidisciplinary services but limited or no access to others.

Action Required:

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

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

- A business case has been submitted for additional and replacement MDT staff resources to the Area Manager.
- The service continues to target the limited resources towards meeting the priority needs of the individual residents.
- A range of complementary therapies are also used to support the residents where these are available. The service has two aroma therapists, art therapy, podiatry and masseurs.
- The service supports some individuals to access physiotherapy and SLT within the community /privately (paid by the service) to address their individual priority needs when the service is not available within the centre itself.
- Psychology is provided on a sessional basis.

Proposed Timescale: 31/12/2014

Theme: Health and Development

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

There was no evidence that residents were offered choice at mealtimes, even though choice was available from the kitchen.

Action Required:

Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

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

The kitchen will implement daily meal choice selection sheets for residents.

Proposed Timescale: 15/09/2014

Theme: Health and Development

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

On one of the days of the inspection the heated food trolley was collected by a staff member for one of the units without verifying that appropriate food hygiene records had been completed in the kitchen.

Action Required:

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

- The practise and documentation in terms of food safety has been reviewed.
- The deficit identified on the day of inspection has been addressed and communicated to staff. The need for greater vigilance and robust procedures has been communicated to the staff, to ensure verification is completed prior to removal of food trolleys from the kitchen area.

Proposed Timescale: 17/06/2014

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:

There was a procedure in place for the return of unused/out-of-date drugs, however, adequate records were not maintained in the centre, including verification from the pharmacist of receipt of the drugs.

Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national

legislation or guidance.

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

The service has engaged with the external pharmacy to ensure the documentation of returned drugs is copied to the service.

Proposed Timescale: 17/06/2014

Theme: Health and Development

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

Based on a sample of prescriptions reviewed, not all contained a photograph of the resident, date of birth, the GPs name and not all contained the maximum dosage for PRN (as required) medications.

Action Required:

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

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

The Medical Officer with the support of the Nurse managers will review all current prescriptions to ensure that all the relevant identification is included in each chart for each individual and in relation to prescribed medication.

Proposed Timescale: 01/08/2014

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:

There was a written statement of purpose, however it was out-of-date as it did not accurately reflect facilities and services currently provided in the centre.

Action Required:

Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

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

The statement of purpose will be reviewed and updated to accurately reflect the current facilities and service provision.

Proposed Timescale: 01/09/2014

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:

Inspectors were informed that the person in charge had retired, however a new person in charge had not been appointed.

Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

The Absence of the PIC NF20 notification documentation has been submitted, which identifies the alternate PIC on the basis that the named PIC would be absent for over 28 days.

The Change in PIC notification documentation is now being completed (due 24th June 2014).

Proposed Timescale: 30/07/2014

Theme: Leadership, Governance and Management

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

Previously, the person in charge of this designated centre was also the person in charge of a number of other designated centres and it was not confirmed that this would continue for all of the centres concerned.

Action Required:

Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

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

The change in PIC notification form is being completed and will be submitted by 24th June 2014. This person will be identified as the PIC for all designated services.

Proposed Timescale: 30/07/2014

Theme: Leadership, Governance and Management

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

Inspectors were not satisfied that there was a clearly defined management structure that identified lines of authority and accountability for the designated centre.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

In relation to the PIC:

The service has a clear structure and is undergoing a reconfiguration to move to a new management structure. These are clearly demonstrated on the current and proposed management /organisational charts.

Proposed Timescale: 31/08/2014

Theme: Leadership, Governance and Management

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

Inspectors were not satisfied that there were adequate systems in place for a review of the quality and safety of care in the designated centre.

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:

1. A Quality and Patient Safety Committee is being established as a subgroup of the Management Team. The service has liaised with the Regional Quality and Risk Manager and the Cork integrated service area (ISA) staff supporting Quality and Risk to obtain draft TOR and documentation for the roll out and development of the local committee. This committee, as defined in the TOR will have responsibility for systematically reviewing practise, incidents, accidents, events to improve quality and standards. Completion Date for establishment of committee: 30th September 2014

Proposed Timescale: 30/10/2014

Outcome 15: Absence of the person in charge

Theme: Leadership, Governance and Management

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

Clarity was required in relation to the current status of the person in charge.

Action Required:

Under Regulation 32 (1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

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

The Absence of the PIC notification documentation has been submitted.

Proposed Timescale: 30/07/2014

Theme: Leadership, Governance and Management

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

The nominated provider was also informed of the requirement to notify the Authority of a new person in charge.

Action Required:

Under Regulation 33 (2) (b) you are required to: Give notice in writing to the Chief Inspector of the arrangements that have been, or are proposed to be, made for appointing another person in charge to manage the designated centre during that absence, including the proposed date by which the appointment is to be made.

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

The Change in PIC notification documentation is now being completed.

Proposed Timescale: 30/06/2014

Outcome 16: Use of Resources

Theme: Use of Resources

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

Resources were required to meet the needs of residents in relation to:

- the design and layout of the premises
- numbers and skill mix of staff to support residents participate in activities external to the centre
- the education and training of staff

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the

statement of purpose.

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

- The service is engaging with Senior Managers within the HSE in order to discuss and agree a plan for the service with regard to the infrastructural needs of the service and the future of the building/campus.
- A Business case has been submitted for additional staff resources and this is being pursued through the relevant HSE channels.
- A comprehensive review of the training needs of the staff is being undertaken and proposals on how the service can address these deficits in light of the significant staff numbers, skill mix, priority training needs etc will be documented, to inform a business case to senior management.

Proposed Timescale: 30/09/2014

Outcome 17: Workforce

Theme: Responsive Workforce

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

Personnel records did not contain evidence of:

- the person's identity, including a recent photograph
- the dates of commencement and cessation of employment
- Garda vetting disclosure
- a full employment history together with satisfactory history of gaps in employment
- two written references
- the position the person holds at the designated centre
- evidence of relevant qualifications

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 personnel files will be reviewed and where deficits are identified the additional information will be sought and sourced.

Proposed Timescale: 31/12/2014

Theme: Responsive Workforce

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

Inspectors were not satisfied that there were sufficient staff on duty to cater for the social care needs of residents.

Action Required:

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

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

- A business case has been submitted for additional replacement staff resources to the Area Manager, that will ensure the maintenance / improve the staff ratios and facilitate greater activation and individualised supports .
- The service is progressing the implementation of a significant staff reconfiguration. This will ensure that the staff are allocated to deliver the optimal level of support for the residents from the overall available resources.
- Unit based time management is being examined to determine how existing staff resources could be configured to provide enhanced social support.

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:

There was no systematic process in place to monitor attendance by staff and to ensure they had received up-to-date training on mandatory training and other relevant training, including, but not limited to:

- protection from abuse
- manual handling
- fire safety
- communication
- dysphagia
- wound care
- challenging behaviour
- person-centred care planning

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:

- Review of all training records is being undertaken. All information is being collated to create accurate and effective training records system for all staff.
- A comprehensive review of the training needs of the staff is being undertaken and proposals on how the service can address these deficits in light of the significant staff numbers, skill mix, priority training needs etc will be documented, to inform a business case to senior management
- An overall schedule of training will be developed and implemented, in relation to training that can be provided internally or through external consultants already associated with the service, from within current resources, commencing in 2014

- Protection from Abuse:
 - o All staff have been circulated with information regarding the current policies, procedures and mechanisms under which complaints, suspicions or allegations of abuse should be managed.
 - o Training material on the management of elder abuse has been sourced and an internal programme on the prevention and detection of abuse will be developed.
- Communication:
 - o "Train the trainer" training has been organised for a lead staff member, who will roll out communication training following completion of the course expected start date Nov 2014
- Fire Safety and Manual Handling- this training is provided by specialists within the HSE and private contractors to the HSE. These individuals have been contacted and are agreeing schedules for training days that will be rolled out over the next 12 months to delivery training to all staff.
- PCP training:
 - o A small cohort of staff attended training in May and June 2014 . Additional training will be provided by an external consultant to further staff groups from the service. Dates yet to be confirmed.
 - o The service in consultation with the external consultant will develop a mentoring system to support staff to roll out the PCPs.
- Challenging Behaviour training:
 - o A small cohort of staff attended training in June 2014 . Additional training will be provided by an external consultant to further staff groups from the service. Dates yet to be confirmed.
 - o The service is supporting two senior staff to complete post graduate training in the management of challenging behaviour. Once completed these staff will have a role supporting, training and mentoring other staff in the centre.
- Dysphagia Training:
 - o The service will arrange for some targeted training of staff from external consultants as part of the overall training schedule
- Wound Care:
 - o The service will arrange for some targeted training of staff from external consultants as part of the overall training schedule

Proposed Timescale: 30/06/2014

Outcome 18: Records and documentation

Theme: Use of Information

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

The complaints policy did not specify who was responsible for dealing with complaints, the independent appeals process or the the person responsible for ensuring all complaints were managed appropriately.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

1. The current policy will be reviewed and the deficits identified regarding appeals process and management of complaints addressed.
2. The service has an identified Complaints Officer and this person will be identified in the policy.
3. The service has nominated a staff member to satisfy Regulation 34 (3) and this person will also be identified in the policy.

Proposed Timescale: 31/07/2014

Theme: Use of Information

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

Inspectors reviewed the centre's policy and procedures, however not all the policies listed in Schedule 5 of the Regulations were present and some policies required review, including:

- medication management
- communicating with residents
- staff training and development
- provision of information to residents
- records management
- the emergency plan

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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:

Deficits in policies and procedures required under Schedule 5 will be risk assessed and addressed in priority order. Policies relating to health and safety issues ie medication management, absconding will be prioritised.

Proposed Timescale: 31/12/2014

Theme: Use of Information

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

Records, including the fire safety register and maintenance records were not available

in a manner that was readily accessible and easily retrievable.

Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:

Review of files undertaken to implement a streamlined filing system to improve record accessibility.

Proposed Timescale: 17/06/2014

Theme: Use of Information

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

There was a policy on residents personal property and possessions and records were maintained of residents' personal finances, however, there were no records maintained of other personal property and possessions.

Action Required:

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

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

Records on personal property and possessions to be developed in keeping with policy on same.

Proposed Timescale: 30/08/2014