<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002453</td>
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<tr>
<td>Centre county:</td>
<td>Monaghan</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:nuala.cusack@hse.ie">nuala.cusack@hse.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Kevin Carragher</td>
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<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
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<tr>
<td>Support inspector(s):</td>
<td>Jillian Connolly</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>12</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: 25 June 2014 09:30
To: 25 June 2014 17:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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</thead>
<tbody>
<tr>
<td>Outcome 02: Communication</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
</tr>
<tr>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 11. Healthcare Needs</td>
</tr>
<tr>
<td>Outcome 12. Medication Management</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
The designated centre consists of two community houses which are run by the Health Service Executive. There were as a total of twelve male and female residents living in the designated centre, five in one house and seven in the other.

The designated centre provides services for individuals over the age of 18 and all residents have a diagnosis of an intellectual disability. Residents also had a wide range of additional complex needs including healthcare complexities such as renal disease and arthritis. Inspectors met with the person in charge at the commencement of the inspection and the person in charge facilitated the inspection throughout the day of inspection of both houses. The person in charge and provider nominee was present at the feedback meeting.

On the day of inspection, inspectors met with residents and staff, reviewed documentation and observed practice. Staff confirmed that the service users were informed of the inspection. The inspectors visited and viewed their home and reviewed personal plan and care documentation with their consent. Inspectors observed that residents were content and that staff engaged with residents in a respectful and dignified manner.

On the day of inspection inspectors found that medication management practices posed a major risk to residents' welfare. This finding was communicated to the
management team including the provider and person in charge at the feedback meeting at the end of the inspection and was followed by an immediate action plan with specified timescales for action plan completion. The provider acted with immediate effect to mitigate the risk posed which was described in the provider response to the immediate action plan received on the 30 June 2014. Specific findings and actions taken are discussed in Outcome 12 of this report. These findings have been repeated in the action plan at the end of this report to obtain an update on progress with resolving non-compliances found.

The inspector found that policy and procedure documentation informing risk management, communication and medication management were not adequate.

Fire safety management was not of an adequate standard to assure the safe evacuation of residents in the event of a fire in the centre, particularly in the areas of ensuring safe evacuation of residents and fire drill procedures.

The action plan at the end of the report identifies actions which the provider and person in charge will need to take to come into compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Quality Standards for Residential Services for Children and Adults with Disabilities.
**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.**

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

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

**Theme:**
Individualised Supports and Care

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

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

**Findings:**

Residents' meeting were used as a forum to empower residents to be involved in the running of the house. These meetings were driven by residents. Residents had freedom to personalise their bedrooms to reflect their personalities and preferences. Many residents enjoyed shopping for the house and availed of the opportunity to influence the groceries purchased.

There was a policy in place for the management of complaints dated 13 November 2013. A list to confirm staff had read the policy was completed by three staff. Reference to timescales for completion of written complaints or arrangements for keeping the complainant informed was not included in the policy. However, the residents’ guide states timescales and is therefore not informed by the policy in place. Three verbal complaints were recorded in 2014 to date however, there was little evidence referencing positive outcomes for residents. The complaints procedure was not in accessible format.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Communication**

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

**Theme:**
Individualised Supports and Care
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors reviewed the communication policy in place dated 13 November 2013, to inform communication procedures in the centre. However, the contents did not adequately inform the range of communication needs of residents in the centre. Inspectors found that in practice staff had empowered residents to communicate their wishes and needs. From a review of residents’ documentation inspectors observed that residents were encouraged and supported to communicate. For example, inspectors observed that vividly coloured murals were painted on walls beside where one partially sighted resident liked to sit. Another resident has started speaking with the support and encouragement of staff.

There was a residents’ guide available in each of the houses in the designated however it was not in accessible format. A notice board in the dining room in one house displayed activities available in pictorial format. Staff were in the process of making a notice board displaying names of the staff on-duty, day of the week and other general information more accessible with use of pictures. One resident liked to populate a weather chart with velcro backed picture representations of the sun, rain and others.

A hands-free telephone was available to assist residents to make and receive phone calls in private.

Residents had access to advocacy services.

Judgment:
Non Compliant - Minor

Outcome 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Residents in the designated centre had diverse needs. Inspectors reviewed a sample of residents' personal support plans in both houses and were satisfied that each resident had a personal plan in place which was completed in consultation with them and/or their significant others. Personal centred support plans reviewed referenced clear and realistic short-term and aspirational goal setting. Daily progress notes detailed each resident's day including reference to their goals. Monthly evaluations ensured progress was regularly monitored and augmented as appropriate in response to changing needs. This information was used to inform annual reviews of personal support plans. There was evidence of progress by residents with achieving their goals and in making decisions about new achievements to work towards. Assessment of need was based on a framework of risk identification. Concomitant management plans were developed to support residents in areas that posed risk to them. Inspectors observed gaps in this documentation in relation to healthcare. This finding is discussed further in Outcome 11 of this report. Inspectors were told by the person in charge that all twelve residents from the two houses in the designated centre attended day activation, occupational and educational programmes and were supported by staff to engage in these activities that reflected their capabilities and interests. For example, one resident was supported to attend literacy classes and another was supported to attend computer classes and participate in a work experience programme as observed by inspectors in residents documentation.

In both houses, the resident population was stable. The most recent admission to the centre was approximately one year ago. This resident was supported with the transition phase and inspectors were told that she has now settled into life in the centre. There were no recent discharges from the centre. Inspectors discussed with the person in charge and the provider at the feedback meeting the value of ensuring that a proactive approach is taken as there was evidence that the needs of residents who were getting older were changing resulting in increased healthcare support needs becoming apparent and requiring intervention. The person in charge and provider verbally assured inspectors that this was being considered.

Inspectors observed that family contact and spending time with family in their homes was of great importance to most residents. Many residents went home to the care of their family at weekends. There was evidence of service support to establish and maintain this contact and inspectors saw the process where family illness prevented one resident going home as usual being supported to maintain contact by telephone.

Judgment:
Non Compliant - Minor

**Outcome 06: Safe and suitable premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

**Theme:**
Effective Services
Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
The designated centre consists of two community houses both were of a satisfactory standard and were suitable for their stated purpose in terms of design and layout of each premises. Both community houses were single storey and were accessible throughout. The communal areas were well decorated in a domestic style and were in good repair. Residents’ bedrooms were personalised and some residents were facilitated to decorate their bedrooms to suit their own preferences. Some residents used their own money to decorate bedrooms and en-suites to their own tastes including wallpaper and wall tiles. Most residents purchased their own furniture and choose to sleep on a double or single bed. Each resident had their own bedroom in both houses. While all bedrooms in one house had an en-suite, not all bedrooms in the second community house in the designated centre had individual en-suites. Two residents share an en-suite in one case, inspectors observed that there was a risk of either resident’s privacy been compromised while using the shared en-suite as there were no procedures in place to ensure doors to this area were closed. Inspectors also observed that the window of one resident’s bedroom was in view of two communal sitting rooms. The person in charge told inspectors that this potential privacy issue had been identified and the resident concerned was taught to draw curtains closed before undertaking personal care. An en-suite off one resident’s room had a jacuzzi bath fitted which the resident did not like. There was no evidence of review of this facility with the view of replacing the bath with a shower/conventional bath. Residents had access to safe enclosed garden areas.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
This outcome was partially reviewed on this inspection. Inspectors found that the health and safety of residents, staff and visitors was generally promoted and protected in the designated centre. Health and safety was informed in the designated centre was informed by an organisational policy which was dated 2009 and overdue for review. There was a safety statement which was reviewed annually and a risk register in place.
A regional risk management policy was available and was dated February 2014. The policy referenced the procedures to follow for risk identification, assessment, management and reporting. The risk management policy also referenced procedures for the prevention and management of severe challenging behaviour and aggression with the service. A stand alone policy document was available to inform management of a missing service user. There was no policy available to inform the prevention and management of resident self-harm.

Policies and procedures were in place to inform fire safety in the centre including prevention strategies and the procedure to be followed in the event of a fire. Individuals had personal emergency evacuation plans in place which assessed their needs in terms of equipment, staff resources and any issues that may delay evacuation e.g. reluctance to leave. The inspectors observed that there were risks posed to residents due to the arrangement of locking doors with a key which was then removed and held on the person of one staff member especially at night. Break glass units containing a key adjacent to doors were not in place and residents were dependant on staff unlocking the doors. This arrangement potentially obstructed residents’ safe and timely exit in the event of an emergency.

Fire drills occurred regularly in the designated centre, however inspectors were not satisfied that they were reflective of the actual conditions that could occur in the designated centre. For example, records of fire drills were reflective of the full training inclusive of staff training of the use of fire extinguishers therefore it did not explicitly evaluate the effectiveness of the drill or the length full evacuation took as it was combined with fire safety training procedures. Inspectors were not clear from discussions with staff whether full evacuation or evacuation from one zone to another was required in the event of a fire in either house. Curtains were fitted over exits designated as fire exits by signage. This finding may impede safe evacuation.

**Judgment:**
Non Compliant - Moderate

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**Outcome 11. Healthcare Needs**

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
Inspectors found that the documentation did not adequately support conclusion that all residents’ healthcare needs were met. However, in practice residents’ healthcare was adequately monitored and maintained. As referenced in Outcome 5, a risk based
assessment framework was in use to identify residents needs which required support intervention by staff to mitigate risk of potentially negative outcomes for residents from non addressed, Inspectors noted gaps in this documentation in relation to identification of some significant needs and concomitant interventions in management plans. Residents with swallowing issues were not reviewed by a speech and language therapist. For example, some residents had a tendency to choke on their food which was not identified as a hazard in their risk assessments and although managed by close monitoring and food consistency modification, these controls were not documented in a management plan. A resident with advanced renal disease did not have controls regarding fluid management stated in care documentation while prescribed for medication to promote fluid output. However, monitoring of weight and electrolytes, a renal diet and review by the community renal nurse specialist was included as part of this resident's renal disease management plan. There was evidence of comprehensive management of epilepsy and mobility issues. For example a resident had difficulty accessing the centre's transport and the documentation referenced review by an occupational therapist to ascertain techniques that could be used for a positive outcome for this resident.

There was evidence that residents were referred and were reviewed by allied health professionals including physiotherapy, occupational therapy and medical care including GP services. Some residents accessed dietetic support with specialist diets at the local health clinic. However, the inspectors noted that a number of residents were in receipt of specialist diets and while staff in both community houses had attended food hygiene training, there was an absence of evidence that their meal preparation decisions were supported by the advice of a dietician. The inspectors observed a concentration of processed foods in use on residents' menu plans. The inspector was told by the person in charge that some residents had problems with continence and wore incontinence wear at all times. There was no documentary evidence of any referral or assessment by a continence specialist.

There was no accredited dependency measurement tool in place to ensure residents with increased needs were supported with adequate resources.

Judgment:
Non Compliant - Moderate

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.
Findings:
On the day of inspection inspectors found that residents were not adequately protected by safe medication policies and practices. There was no approved medication management policy to inform staff practices in medication ordering, receipt, prescribing, storage, disposal and administration of medicines in the designated centre.
Inspectors found the following-
- Maximum recommended ‘as required’ (PRN) medication dosage over a 24hour period was not stated in medication prescriptions.
- Residents’ drug allergy status was not stated on medication prescriptions.
- Each prescribed medication was not signed by a General Practitioner on transcribed medication prescriptions.
- Not all medications administered to residents were prescribed.
- Transcribed medication prescriptions were not subject to audit in line with recommended best practice.
- Medications were being administered by reference to pharmacy generated lists of medications; a pictorial reference did not reflect contents of blister packs.
- Medications were administered from a pharmacy generated list of medications, prescription of these were referenced by a General Practitioner’s signature.
- Medication stock was not audited and there was no system in place to ensure unused medications were returned to the pharmacy.

A record of medications administered by staff to residents was not maintained or available. Medication was being administered to residents in the designated centre by staff who did not have the knowledge or skills to safely monitor effect or recognise adverse reaction. Unprescribed paracetamol was being administered to a resident by staff who did not have the knowledge or skills to monitor effect or adverse reaction. Residents not taking responsibility for their own medications did not have risk assessments and assessment of capacity to manage their own medications. Residents engaged in self medicating did not have adequate assessment of capacity or risk completed.

The provider and person in charge were informed of these findings of major risk to the welfare of residents at the feedback meeting on the day of inspection. An immediate action plan with specified timescales for completion of action to mitigate risks found was issued to the provider and person in charge on the 25 June 2014 and was returned to the Authority on the 30 June 2014. Some additional information was required which was submitted on the 08 July 2014.

During inspection on the 26 June 2014 of another designated centre run by the same provider, inspectors observed that the provider had initiated immediate action on the evening of inspection which was applied in practice to this centre in respect of medication management. Changes included arrangements where responsibility was assigned to the responsibility of staff adequately trained in medication management best practice procedures. The medication management policy which was in draft format was approved and implemented. Record keeping of medication administered to residents was initiated and an audit of practice to ensure compliance was commenced on the 27 June 2014. The provider informed the Authority in his response to the immediate action...
plan of 26 June 2014 that a training programme in medication management was arranged for all staff nurse attendance. Initial training dates had been agreed for July 22nd & 29th, with additional dates for August and September to be agreed with a timeframe for completion stated as 30 September 2014.

The inspector formed the view that these actions would substantially mitigate risk to residents. However, these actions have not yet been verified by the Authority.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre’s first inspection by the Authority.

Findings:
Inspectors found that staffing skills and supervision in one community house in the designated centre on the day of inspection was not adequate in relation to inadequate medication management practices that posed a major risk to residents. The areas of non-compliance found are discussed in Outcome 12 of this report. The provider reviewed and satisfactorily resolved this issue with immediate effect. Inspectors reviewed a copy of the staffing rota for each house and were satisfied that a staffing level and skill mix had been determined and maintained to meet the assessed needs of residents; however, most residents were on day programmes on the day of inspection. Therefore, review of adequacy of staffing levels was not possible when all residents were not at home in addition to the absence of use of a tool to determine resident dependency levels and staff requirements.

While staff has access to education and training in line with their professional development requirements, there was evidence that education and training on medication management and menu planning for specific dietary needs was required to ensure residents' needs were met in these areas. Inspectors found that staff received required mandatory training at appropriate intervals such as fire management and prevention, protection and response to abuse. Three staff had not attended refresher training in safe moving and handling of residents since 2011.

Inspectors reviewed a sample of staff files and found that all required documents were
not on file. Missing documents included verified identification, contracts of employment and job descriptions to include details of position, hours of employment, role and reporting relationships. There was evidence of induction program for new staff and inspectors found that the person in charge was aware of the needs of staff and ensured appropriate input was provided if extra support was required by review of the induction documentation.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

Centre name: A designated centre for people with disabilities operated by Health Service Executive
Centre ID: OSV-0002453
Date of Inspection: 25 June 2014
Date of response: 31 July 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.

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure or residents' guide was not in accessible format to ensure residents were aware of its content.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Complaints Policy will be reviewed through the Policy Development Group to ensure that the policy outlines recommended time-scales for the receipt and action required to ensure the complaint is satisfactorily dealt with. The review of this policy will also incorporate and include an appeals procedure which a resident/advocate/representative may access if they are not satisfied with the initial outcome of complaint. The policy will also outline the protocol around how complaints are communicated to residents/advocate/representative. This process will commence on Tuesday 5th August 2014.

Each resident’s communication strengths/supports are identified in their Person Centred Plan. Based on these individual identified strengths/supports, an individualised and user friendly Resident’s Complaints Guidance will be developed. This development will coincide with supportive training in alternative communication methods, which has been agreed with the Speech and Language Department. Staff will commence communication assessment process Tuesday 5th August 2014. All residents will be referred for formal Speech and Language Assessments.

Policy will be reviewed and amended by September 30th 2014. Individualised resident’s guidance relating to complaints procedure to be completed December 31st 2014.

Proposed Timescale: 31/12/2014
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A list to confirm staff had read the complaints policy was completed by three staff. Reference to timescales for completion of written complaints or arrangements for keeping the complainant informed was not included in the policy.

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:
Since inspection remaining members of staff have signed confirmation sheet that they have read the complaints policy.

Complaints Policy will be reviewed through the Policy Development Group to ensure that the policy outlines recommended time-scales for the receipt and action required to ensure the complaint is satisfactorily dealt with. The review of this policy will also incorporate and include an appeals procedure which a resident/advocate/representative may access if they are not satisfied with the initial outcome of complaint. The policy will also outline the protocol around how complaints are communicated to...
residents/advocate/representative. This process will commence on Tuesday 5th August 2014.

Each resident’s communication strengths/supports are identified in their Person Centred Plan. Based on these individual identified strengths/supports, an individualised and user friendly Resident’s Complaints Guidance will be developed. This development will coincide with supportive training in alternative communication methods, which has been agreed with the Speech and Language Department. Staff will commence communication assessment process Tuesday 5th August 2014. All residents will be referred for formal Speech and Language Assessments.

Policy will be reviewed and amended by September 30th 2014. Individualised resident’s guidance relating to complaints procedure to be completed December 31st 2014.

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

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**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The communication policy did not adequately inform the range of communication needs of residents in the centre.

**Action Required:**
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents’ needs and wishes.

**Please state the actions you have taken or are planning to take:**
Communication Policy will be reviewed and amended through the Policy Development Group. This revision shall ensure that the policy incorporates individual residents who have additional sensory needs – visual/aural. The policy will also outline possible alternative communication methods – non-verbal behaviour.

Each resident’s communication strengths/supports are identified in their Person Centred Plan. Based on these individual identified strengths/supports, an individualised and user friendly Resident’s Complaints Guidance will be developed. This development will coincide with supportive training in alternative communication methods, which has been agreed with the Speech and Language Department. Staff will commence communication assessment process Tuesday 5th August 2014. All residents will be referred for formal Speech and Language Assessments.

Policy will be reviewed and amended by September 30th 2014. Individualised resident’s guidance relating to complaints procedure to be completed December 31st 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:**

Inspectors observed gaps in assessment documentation in relation to identification of healthcare needs.

**Action Required:**

Under Regulation 05 (1) (b) you are required to:

Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

All health related risk assessments and management plans will be reviewed to identify specific medical interventions/monitoring. Where it is identified that onward referral to specialised medical input will contribute positively to health gains, this referral will be forwarded to appropriate allied health care professional. Where medical interventions have been identified, they will be developed in the form of specific care pathways. The risk management plan will therefore direct the reader to specific care pathways in the resident’s Person Centred Plan. These care pathways will be reviewed as part of an annual review. This process will begin Tuesday 5th August 2014. This process to be completed by December 31st 2014.

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

### Outcome 06: Safe and suitable premises

**Theme:** Effective Services

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

Two residents share an en-suite in one case, inspectors observed that there was a risk of either resident's privacy been compromised while using the shared en-suite as there were no procedures in place to ensure doors to this area were closed. Inspectors also observed that the window of one resident's bedroom was in view of two communal sitting rooms. An en suite off one resident's room had a jacuzzi bath fitted which the resident did not like. There was no evidence of review of this facility with the view of replacing the bath with a shower/conventional bath.

**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.

**Proposed Timescale:** 31/12/2014
Please state the actions you have taken or are planning to take:
Since Inspection, the en-suite identified has been allocated to one resident. The door from the other resident's room has been secured and is no longer accessible by that resident. This resident will continue to be supported by one staff member to access the main bathroom in the house.

Since Inspection, the en-suite with jacuzzi bath has been reviewed. The resident’s dislike of the jacuzzi facility within the bath is clearly reflected within his Person Centred Plan. All staff have been alerted to this. Contact has been made with Maintenance Department to permanently disconnect the jacuzzi facility and therefore reverting it's use to that of a normal bath. To be completed by 30th September 2014.

Proposed Timescale: 30/09/2014

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:
Health and safety was informed in the designated centre by an organisational policy which was dated 2009 and overdue for review.

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

Please state the actions you have taken or are planning to take:
Since Inspection, Health and Safety Department has replaced Corporate Health and Safety Policy 2009 with Corporate Health and Safety Policy 2014.

Proposed Timescale: 31/07/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no policy available to inform the prevention and management of resident self-harm.

Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
The policy on Risk Management and Escalation is regularly reviewed through the Policy Development Group and includes specific measures and actions that the service have put in place to manage self harm/self-injurious behaviour. Clear guidance is also provided for staff should specialist assessment and/or intervention be required. The policy also includes a comprehensive explanation as to how the process relating to the Prevention and Management of Severe Challenging Behaviour and Physical Aggression within the Service is managed.

**Proposed Timescale:** 31/07/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspectors observed that there were risks posed to residents due to the arrangement of locking doors with a key which was then removed and held on the person of one staff member especially at night. Break glass units containing a key adjacent to doors were not in place and residents were dependant on staff unlocking the doors. This arrangement potentially obstructed residents' safe and timely exit in the event of an emergency.

**Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
Since Inspection, contact has been made with Fire Officer to provide break glass units at all emergency exits. In the interim all staff have been made aware that the key should not be removed from door and remain accessible to all people in the house. All emergency lighting is in place. To be completed by September 30th 2014

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not clear from discussions with staff whether full evacuation or evacuation from one zone to another was required in the event of a fire in either house.

Curtains were fitted over exits designated as fire exits by signage. This finding may impede safe evacuation.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.
Please state the actions you have taken or are planning to take:
Since Inspection, contact has been made with Designated Fire Officer. Guidance in relation to full evacuation and zone to zone evacuation will be issued to each unit of service.

Evacuations are completed on a monthly basis within each house, alternating between day/night evacuations.

Since Inspection, curtains have been removed from over fire exits.

Proposed Timescale: 30/09/2014

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors noted gaps in supporting documentation in relation to identification of some significant healthcare needs and concomitant interventions in management plans.

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

**Please state the actions you have taken or are planning to take:**
All health related risk assessments and management plans will be reviewed to identify specific health care interventions/monitoring. Where it is identified that onward referral to specialised health care input will contribute positively to health gains, this referral will be forwarded to appropriate allied health care professional. Where health care interventions have been identified, they will be developed in the form of specific care pathways. The risk management plan will therefore direct the reader to specific care pathways in the resident’s Person Centred Plan. These care pathways will be reviewed as part of an annual review. This process will begin Tuesday 5th August 2014. This process to be completed by December 31st 2014

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:**
Residents with swallowing issues were not reviewed by a speech and language therapist.

The inspector was told that some resident had problems with continence and wore
incontinence wear at all times. There was no evidence of any referral or assessment by a continence specialist.

**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:**
Since Inspection, referrals have been made to the Speech and Language Department for urgent and immediate assessments to be conducted.

Since Inspection, referrals have been made to a Continence Specialist to have appropriate individual assessments to be conducted.

**Proposed Timescale:** 31/07/2014

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no accredited dependency measurement tool in place to ensure residents with increased needs were supported with adequate resources.

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

**Please state the actions you have taken or are planning to take:**
Since Inspection, contact has been made with the Regional Centre for Nursing and Midwifery Performance and Development Unit with a view to identify a suitable measuring tool which can be used to assess resident dependency needs. To be completed by September 30th 2014.

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

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of residents were in receipt of specialist diets and while staff in both community houses had attended food hygiene training, there was an absence of evidence that their meal preparation decisions was supported by the advice of a dietician. There was evidence of overuse of processed foods.

**Action Required:**
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate
quantities of food and drink which are consistent with each resident’s individual dietary needs and preferences.

**Please state the actions you have taken or are planning to take:**
Since Inspection, Individual BMI assessments have been completed for each resident. Where identified, onward referral to dietician has been made to ensure individual dietary needs and nutritional plans are formulated and implemented.

Contact to be made by Senior Nursing Management with Dietician Service with a view to organising information sessions for all staff in relation to health eating, nutritional advice and development of meal plans.

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

**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:**
Inspectors found the following-
- The medication manage policy was in draft format and not available to inform practice.
- Maximum recommended ‘as required’ (PRN) medication dosage over a 24hour period was not stated in medication prescriptions.
- Residents’ drug allergy status was not stated on medication prescriptions.
- Each prescribed medication was not signed by a General Practitioner on transcribed medication prescriptions.
- Not all medications administered to residents were prescribed.
- Transcribed medication prescriptions were not subject to audit in line with recommended best practice.
- Medications were being administered by reference to pharmacy generated lists of medications; a pictorial reference did not reflect contents of blister packs.
- Medications were administered from a pharmacy generated list of medications, prescription of these were referenced by a General Practitioner’s signature.
- Medication stock was not audited and there was no system in place to ensure unused medications were returned to the pharmacy.
- A record of medications administered by staff to residents was not maintained or available.
- Medication was being administered to residents in the designated centre by staff who did not have the knowledge or skills to safely monitor effect or recognise adverse reaction.
- Unprescribed paracetamol was being administered to a resident by staff who did not have the knowledge or skills to monitor effect or adverse reaction.

**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:**
Immediate Action Plan developed, submitted and implemented on 30th June 2014.

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents not taking responsibility for their own medications did not have risk assessments and assessment of capacity to manage their own medications. Residents engaged in self medicating did not have adequate assessment of capacity or risk completed.

**Action Required:**  
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

**Please state the actions you have taken or are planning to take:**
Immediate Action Plan developed, submitted and implemented on 30th June 2014.

Capacity Assessments to be completed for each resident in relation to taking responsibility for their own medications. Capacity Assessments to be completed by August 27th 2014.

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**Proposed Timescale:** 27/08/2014

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**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors reviewed a sample of staff files and found that all required documents were not on file. Missing documents included verified identification, contracts of employment and job descriptions to include details of position, hours of employment, role and reporting relationships.

**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:
Contact made with Human Resource Department to include verified identification, contracts of employment and job descriptions in individual staff files. To be completed by September 30th 2014.

**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:**
Staffing skills and supervision in one community house in the designated centre on the day of inspection was not adequate in relation to inadequate medication management practices that posed a major risk to residents.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Since Inspection, Medication Management Training for all staff in the house referred to as been delivered on July 10th 2014.

A Competency Assessment Framework to provide governance to this practice has also been developed. Competency Assessments and supervision provided on an ongoing basis.

All staff have undergone three competency assessments specific to the administration of medication. Competency Assessments involves the supervision of staff in the preparation of environment, checking and administration of medication, documentation and recording of medication administration and assessing staff knowledge on medication used on unit. Competency Assessments will be conducted on an annual basis and staff will also be subject to unannounced intermittent Competency Assessments throughout the year.

Monthly Medication Management audits are now being conducted since inspection.

**Proposed Timescale:** 10/07/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While staff have access to education and training in line with their professional development requirements, there was evidence that education and training on medication management and menu planning for specific dietary needs was required to
ensure residents’ needs were met in these areas. Three staff had not attended refresher training in safe moving and handling of residents since 2011.

**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:**
Since Inspection, Medication Management Training for all staff in the house referred to as been delivered on July 10th 2014.

Since Inspection, all staff who require Manual Handling training have either received this training or are scheduled for next available training. Moving and Handling Training to be completed by September 30th 2014.

Contact to be made by Senior Nursing Management with Dietician Service with a view to organising information sessions for all staff in relation to health eating, nutritional advice and development of meal plans. Training in relation to dietary needs and menu planning to be completed by December 31st 2014.

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