

**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 CoAction West Cork
Centre ID:	OSV-0002105
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	CoAction West Cork
Provider Nominee:	Maurice Walsh
Lead inspector:	Mary O'Mahony
Support inspector(s):	Vincent Kearns
Type of inspection	Announced
Number of residents on the date of inspection:	15
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
18 November 2014 09:30	18 November 2014 18:30
19 November 2014 08:30	19 November 2014 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

The monitoring inspection of this centre by the Health Information and Quality Authority (HIQA or the Authority), was announced but had been triggered by the fact that notifications of certain events, required under legislation, had not been received by the Authority. As part of the inspection inspectors met with residents, the person in charge, her deputy, management personnel, social care leaders and social care workers. Inspectors reviewed the policies and procedures in the centre and examined documentation which covered issues such as staff training, complaints and advocacy, personal plans, and health and safety risk management. The person in charge informed inspectors that she had been in the position of person in charge for one year but had many years experience of working in the sector. During the inspection there were fifteen residents in the centre which was comprised of four houses within a two mile radius of each other.

The facilities and services in each of the four houses varied:

House 1: provided a seven day residential service: three full time residents lived in this house and there was one respite bed available

House 2: provided a four day respite service: there were three regular residents in this house and one night was shared between three respite residents.

House 3: provided a seven day residential service: three full time residents lived there, one resident stayed from Monday to Friday and two respite residents shared the week between them.

House 4: provided a respite service from Monday to Friday for three regular residents: sometimes a planned respite resident would replace a regular resident.

Inspectors met with a number of residents over the two day inspection period. The houses were located a short distance from the local town. They were spacious and generally well maintained. The furniture and the fittings were found to be of good quality and the premises was suitable for the needs of the residents. The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013. Some improvements were required in the area of staff training, fire safety, medication management and health and safety risk assessments. In view of the serious failings in fire safety management inspectors issued an immediate action plan to the provider. The centre was also required to respond to the Authority within a specified time frame in relation to identified failings in the management of medication including the provision of training to staff. Satisfactory responses were not received within the required time frame in the area of fire safety. These issues will be discussed in the body of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors noted that the rights of residents were supported by staff. Residents were treated with dignity and there was a regular consultation process in place. Residents spoken with by inspectors were aware of how to contact their advocate if required. The deputy person in charge was also an advocate and inspectors saw her picture and information about advocacy in the residents' bedrooms. Residents and staff confirmed that residents' views were sought in a number of ways and were used to inform the planning and running of the centre. One resident informed inspectors that she was a member of the advocacy group for the organisation and she was also facilitated to attend national fora on issues which impact on the sector. A house meeting was held weekly and inspectors saw minutes of these meetings. Inspectors observed staff interacting with residents in a respectful and warm manner. They were seen consulting with residents on various issues and their feedback was taken into account when planning menus and weekend events. A folder containing accessible documents was displayed in the houses. This included information on how to make a complaint, residents' rights, advocacy, communication and the Resident's Guide. There was pictorial input in most of the documents.

Residents were involved in developing their personal plans. Residents could make choices about their daily lives such as evening routine, the food shopping list and what interests they wanted to pursue. Staffing was arranged in a manner to support residents with their individual interests and preferences and there was continuity of staff members. Inspectors noted that residents were familiar with the staff on duty and had formed good relationships with them. Staff with whom inspectors spoke were knowledgeable about the residents' life stories and their medical needs. The provider

had developed a number of policies to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. Individual records were kept of the weekly spending money for each resident. Inspectors reviewed a number of these and noted transactions were being signed by two staff members and the resident where possible. The amounts checked correlated with the balance in the written record. Residents maintained control over their personal possessions. Residents were also enabled to do their own laundry if they wished.

Residents were supported to ensure their involvement with the local community. This included the use of local amenities such as the cinema, library, dancing, shopping centres, restaurants and hairdressing facilities. Some residents engaged in work experience and the person in charge said that the community provided excellent support to residents by providing work experience in a number of local business establishments. Residents were facilitated to go for walks and to take part in educational courses suitable to their abilities. The person in charge informed inspectors that residents were assessed individually to attend the day care centre or the 'outline' men's-club group and the recreational therapy (RT) group. Residents also went on day trips and overnight outings, which were in line with their individual preferences and goals and they attended events such as concerts and seasonal pantomimes. At the time of inspection a trip to the local garden centre and a fund raising event were planned and inspectors saw that some residents had been on a Christmas shopping trip.

There was a complaints policy in place. The policy seen by inspectors was dated 2009. However, the person in charge showed inspectors the new draft policy. An easy-to-read version of the protocol to be followed for residents was prominently displayed in the hallways. The Health Service Executive (HSE) leaflet on complaints 'Your Service, Your Say' was on display on the notice boards. The centre had a dedicated complaints officer. Staff and residents were aware of the name of this person and how to initiate a complaint. Inspectors viewed the complaints log and observed that complaints were recorded. However, records were not maintained in a detailed manner. Inspectors noted that the satisfaction of the complainant and any improvement or learning which had occurred was not recorded as required.

Staff confirmed that residents were supported to exercise their political, civil and religious rights in line with their individual wishes and abilities. Examples of this were that residents were supported to attend religious ceremonies of their choice and other residents spoken with by inspectors were aware of their voting rights.

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:

Each resident's wellbeing and welfare was seen to be maintained within the centre. Each resident was facilitated to participate in activities appropriate to their preferences and their abilities. Inspectors were informed by staff that residents were involved in some daily chores and were involved in planning the shopping lists. Their likes and preferences were ascertained from their representatives, where necessary. Inspectors observed residents going out to the day centre in their bus in the morning and also spent time with residents when they returned at tea time and saw that they were involved in kitchen tasks and preparing their meals. Inspectors heard staff talking to the residents about activities they had engaged in during the day. Staff outlined the residents' routine for relaxation in the house such as beauty therapy, listening to music, art and crafts as well as favourite TV programmes and films. Inspectors were shown DVDS and music collections and noted that the equipment for these was kept in good repair. All residents attended day care facilities on weekdays. The centre had its own minibus in which residents travelled to the day care facilities. There was good communication between the centres. A staff member from the centre accompanied the residents in the morning to provide a care update to the day centre staff, depending on the abilities of those travelling.

Inspectors saw that the bedrooms were furnished with duvet covers, pictures, trophies and other personal items. However, in one house (house 4) the rooms were not personalised as the staff were constrained by the fact that the house is not owned by the centre. This limited their freedom to improve décor in that house. Residents had not made use of the lockers and wardrobes and there were limited pictures on the walls. There were fire safety issues in that house also which will be addressed under outcome 7: Health and Safety and Risk Management. There were television sets and bedside lamps in some bedrooms depending on the individual resident's needs. Inspectors saw that some residents seemed very relaxed when returning to their houses in the centre and saw that the staff were available to provide physical and psychological support where required. Inspectors were informed by staff of goals which had been reached by the residents with staff support and they expressed pride at the progress made by residents.

The arrangements to meet each resident's assessed needs were outlined in a personal care plan (PCP). The person in charge showed inspectors these plans and it was evident that they had been drawn up in line with the specific assessed needs of residents. The plans had been personalised with residents' photographs and the person in charge informed inspectors that this ensured that residents were able to identify their file. Inspectors noted that all residents had been given an opportunity to sign their personal

plans. New 'communication passports' were seen which were detailed and informative. These were to be provided for all residents. The person in charge also said that 'medical passports' were to be created for use in the event that a resident had to go to hospital. However, not all PCPs seen by inspectors contained the name of the key worker and the objectives and timescales for goal achievement. The person in charge informed inspectors that these would be updated in line with Regulations. Inspectors viewed evidence that residents had access to the multidisciplinary team such as the dietician, the GP, physiotherapist, occupational therapist, dentist, social worker and the psychological services. There was evidence of consultation with family members or representatives. Inspectors saw evidence that where goals were set the needs residents in this centre required flexibility and that time-scales could change depending on their needs at a particular time. There were large photographs of staff members on the notice board to inform residents of the staff on duty. Personal plans were being reviewed as required by the Regulations.

Judgment:

Non Compliant - Minor

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:

The centre had a health and safety statement and it was dated 2010. An updated statement was seen by inspectors to be currently in draft form, awaiting approval. It identified, assessed and outlined the controls required for certain risks in the centre. Procedures were in place for the prevention and control of infection. Alcohol hand gels, plastic aprons and disposable gloves were available. Staff had training in the correct hand washing technique and there were Health Service Executive (HSE) leaflets on display. Housekeeping duties were carried out by the staff. There were coloured coded systems in use for cleaning and food preparation.

There was a washing machine and tumble dryer in each house and the equipment was in working order and in good repair. All of the residents had individual laundry baskets. There was a hot press in the centre and inspectors noted that there was a sufficient supply of clean towels and bed linen stored there. There was a colour coded system in place for the towels which were used by residents who availed of the respite service. The centre had a risk management policy and a risk register capturing potential risks (environmental, operational and clinical) associated with the centre. However, the risk management policy did not outline the controls in place for the risks specified under Regulation 26 (c). There was no policy on the prevention of self harm and this was

particularly relevant as a resident had been identified as exhibiting self-harm behaviour.

A fire evacuation plan was in place and in the event of an evacuation of the centre being necessary, alternative accommodation had been identified. Regular fire drill training was documented. However, there were no personal evacuation plans (PEEPS) for residents and this was significant as some residents were immobile and required transportation by wheelchair or alternative means. Records reviewed by inspectors indicated that the fire alarm was serviced on a quarterly basis, fire safety equipment was serviced on an annual basis, and fire drills took place on a regular basis. However, not all fire assembly points were identified. There was emergency lighting in place. There was evidence that arrangements were in place for reviewing fire precautions which included the alarm panel, fire exits and the testing of fire equipment. Inspectors were very seriously concerned about the lack of fire safety measures in the houses. For example; the fire testing certificate was displayed on the wall however, when inspectors reviewed the service date written on the fire extinguishers they noted that these were not up to date. There was a lack of smoke detectors in house 4. In addition, there were open fires and a stove in use in the centre and this increased the risk of a fire or burns to residents. These hazards had not been risk assessed and carbon monoxide detectors had not been installed. Furthermore, not all staff with whom inspectors spoke were aware of the procedures to be followed in the event of a fire and not all staff had been afforded the mandatory fire training. Other fire safety issues included: the procedure to be followed in the event of a fire was displayed behind the kitchen door and not displayed prominently as required by the regulations: the fire blanket in one kitchen was not attached to the wall and the fire extinguishers were not affixed in one house but were stored free-standing in various areas: the bracket holding one extinguisher had become loose and the bracket and screws were lying on an adjoining shelf, any additional risks associated with this arrangement had not been assessed. The centre was a smoke free zone. Fire drills were carried out regularly by staff and residents and inspectors saw evidence of the fire drill undertaken on 18 September 2014. However, staff from house 2 with whom inspectors spoke said that the fire panel was located in an adjoining house which was temporarily not in use. These houses had previously been joined by a connecting upstairs hallway however, the current location of the fire panel did not meet the needs of staff in locating a fire outbreak in house 2. This had not been risk assessed. An immediate action plan was given to the person in charge as regards the lack of a robust fire safety arrangements in the centre. The provider had not provided a satisfactory response to the Authority as regards the provision of a fire safety culture and environment in the centre within the required timeframe as set by the Chief Inspector.

Inspectors noted other risks in the centre had not been assessed such as unsafe objects, equipment and liquids stored in unsecured cupboards, shared ointments, no bathroom or bedroom door keys, an unsuitable access ramp, unsafe outdoor/sports equipment on the site, unsecured lighters and matches in the sitting room. In addition, the upstairs window openings in all houses had not been risk assessed and the hoists had not had an up to date service. Servicing of the hoists was arranged while inspectors were on the premises.

Staff had up to date moving and handling training, infection control and hand hygiene training. However, other aforementioned mandatory training, for example, positive

behaviour support training and fire training was not up to date and some staff did not have this provided. This will be addressed under outcome 17: Workforce. The person in charge informed inspectors that fire training was planned and a meeting was organised to discuss the provision of training in 'behaviours which challenge'. Documentation confirming these events was seen by inspectors.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

The person in charge informed inspectors that she was involved in the management of the centre on a consistent basis and would attend and supervise, together with her deputy, on a regular basis. She said she ensured the safety of residents in the centre by talking to them and speaking to their relatives and representatives. She informed inspectors that she met with the staff regularly and that she was aware of her obligation to report any allegation of abuse to the Authority. During the inspection staff were seen to be respectful of residents and included them in conversation. Residents had been informed about the inspection and some residents had expressed a wish to speak with inspectors. They informed inspectors that they felt safe in the centre and that their independence was encouraged. One resident told inspectors that she was an advocate for others who were non-verbal and she was aware of how to report her concerns or complaints.

Inspectors observed care plans for managing any behaviour escalations and saw that interventions were being implemented where required. There was a policy on 'behaviours which challenge'. However, this was not updated since 2011. The centre availed of the services of behaviour experts such as psychologists and occupational therapists in the day care centre to support them in drawing up these plans. The plans were seen to be person-centred and supportive for both residents and staff. Associated risk assessments were seen. Residents' representatives were involved in discussions where appropriate. However, the majority of staff with whom inspectors spoke had not received updated training in positive behaviour support and de-escalation techniques.

This will be addressed under outcome 17: Workforce.

There was a policy on the management of allegations of abuse which was updated in April 2013. There was a named person identified as the person responsible for investigating allegations and the responsibility to report any allegation to the Authority was documented. Inspectors spoke with staff who were knowledgeable of what constituted abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. There was a nominated person to manage any incidents, allegations or suspicions of abuse and staff were able to identify the nominated person. Training records indicated that some staff had received training in the prevention of abuse however not all the staff had received updated training. This non compliance with the regulatory requirements for mandatory training will be addressed under Outcome 17: Workforce. In addition residents did not have individual intimate care plans in place. Inspectors spoke with the deputy person in charge who also worked as an advocate and she explained how the advocacy group was set up to include residents and all grades of staff. There was a policy in the centre to support respite residents. However, inspectors noted that this policy did not contain guidance for staff in protecting these residents from peer abuse.

There was a policy on the use of restrictive interventions which outlined measures to promote a restraint free environment. This was last updated in October 2013. This policy stated that there was a 'physical interventions' committee in the centre. However, the person in charge informed inspectors that this committee was no longer in use. Furthermore, not all residents or their representatives had signed consent for the use of restrictive procedures. There was a policy and measures in place in the centre for the management of residents' finances. Records were maintained of financial transactions made by and on behalf of residents. Records reviewed by inspectors were seen to be in order.

An email was received by the Authority following the inspection to confirm that the 'physical interventions' committee was still in operation.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

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

Findings:

A record of all incidents occurring in the designated centre was being maintained however, these were not notified to the Chief Inspector where and when required. Quarterly reports or six monthly nil returns were not provided to the Authority.

Judgment:

Non Compliant - Major

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

Residents had access to the general practitioner (GP) services and appropriate therapies, such as, the dentist, the psychologist, the dietician, the occupational therapist, pharmacist and the speech and language therapist. There was evidence that residents had availed of allied health care services and specialist consultants. Residents had been assessed by the speech and language therapist and the dietician. Documentation seen by inspectors with regard to information from these reviews was detailed.

Regular multidisciplinary input was evident in the personal plans. Residents were included in these reviews and inspectors viewed the records of recent reviews which had taken place. Residents were seen to be central to these review meetings and took an active part in planning the date and venue of the meeting. Some of the residents had documented their advanced care plans and these were recorded in the day centre. Inspectors noted that residents had access to refreshments and snacks with a selection of drinks and fresh fruit. Inspectors observed that there were adequate stores of both fresh and frozen food in the houses. Residents, spoken with by inspectors, indicated that there was a choice available to them and that their individual likes and dislikes were taken into account. Staff told inspectors that residents accompanied them on shopping trips and were involved in writing up the shopping list when possible. There was an emphasis on a healthy lifestyle and residents were encouraged to walk to the town and to go for walks with staff after work. There was a 'food pyramid' poster on display in each kitchen. The person in charge informed inspectors that a policy was being developed entitled 'enabling best health policy' which was to be implemented for residents. Inspectors saw a folder entitled 'choose your food' which had pictorial input to aid residents, who were non-verbal, to choose a favourite meal. This folder was seen in use by staff members when supporting residents.

Inspectors observed that staff in the centre encouraged residents to make healthy

choices in relation to exercise, weight control and dietary considerations. Staff informed inspectors that the level of support which individual residents required would vary. This was supported by information in the personal plans reviewed on inspection. Staff were knowledgeable about residents' health and social care needs and were observed to provide care as outlined in the personal plans. They gave detailed information to inspectors about each resident and how these needs were met. It was evident to inspectors from talking with staff and residents that each person had an opportunity to participate in a variety of healthy living activities which were meaningful and purposeful to them. These activities and pursuits were detailed under outcome 5: Social Care Needs.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Inspectors noted that there was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications for the centre. However, inspectors spoke with staff and found that they were not familiar with the guidance and protocols as outlined in the policy. For example staff in the centre transcribed medication and were not following the guidelines on transcribing medication as set out by An Bord Altranais agus Cnaimhseachais na HEireann which was referenced in the centre's policy. In addition, the centre did not have a policy document on transcribing medications to guide this practice. Furthermore, PRN (given as required) medication which had been administered by a care staff member had not been administered in accordance with the dose specified in the prescription. The medication was not administered from the prescription as required by the policy. The centre's policy contained a protocol for the administration of PRN medication, however, inspectors found that staff were not familiar with this and consequently did not follow the protocol as set out.

Staff who administered medication had not signed the medication administration chart in a manner that was in line with best practice guidelines and again inspectors noted that the practice was not in line with the instructions for staff in the centre's policy. Staff did not have up to date training in medication management and the training they had been given did not follow the training outcomes outlined in the medication policy for the centre. Medication errors were recorded on the computerised system however, as the

aforementioned medication errors had not been identified as errors, they had not been recorded. The person in charge indicated that she would ensure that these were recorded as errors and that she would develop a regular medication administration audit system. The medication error form attached to the policy had not been used to record errors and errors had not been notified to the pharmacist.

All medications were individually prescribed. Inspectors noted that the maximum dosage of PRN medications was prescribed and medications were regularly reviewed by the GP. There were no controlled medications in use at the time of inspection. There were other issues of unsafe practice noted by inspectors for example: the drug keys were not kept by designated staff member but were stored in a drawer: medications were stored on open shelves in one house and there was no locking mechanism for these medications: there was no staff signature sheet available: not all medications contained the GP's signature: the time of medication administration was not recorded; one medication sheet was pre-ticked in advance of medication been given: some medications had not been signed as given or withheld: there was no space to record why a medication was withheld; there was no evidence that staff competence was evaluated following training. Residents had not been assessed as to their competence to self-administer medication as required by the Regulations.

Residents did not require their medications to be crushed at present. A medication fridge was in place. This was locked and the temperature of the fridge was seen to be recorded daily. Unused and out of date medications were segregated from other medicinal products, as required by the Regulations and a record of returns to pharmacy was maintained. There were a number of residents in the centre with epilepsy and some respite residents were prescribed emergency epilepsy medication. However, staff with whom inspectors spoke were not aware of how to administer this medication and had not been trained in its use. Some staff with whom inspectors spoke were not knowledgeable about the reason for using certain essential medication or of the correct route of administration. There was no medication reference book available for staff to consult and staff members informed inspectors that they used the internet to check the drug usage and side effects, if required. Inspectors formed a view that this training was inadequate and this was addressed under outcome 17: Workforce. Oversight of medication management, including PRN and psychotropic medications was done by the local pharmacists, whom the person in charge said were very attentive to the centre. Inspectors asked the person in charge to provide the Authority with a plan for medication management within two days of the inspection and a prompt response was received to this issue with support from the local pharmacists.

Judgment:

Non Compliant - Major

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a

suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

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

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

Findings:

There was a governance and management structure in place which was in accordance with the structure outlined in the Statement of Purpose. The person in charge told inspectors that her post was full time and she was engaged in the governance, operational management and administration of the centre on a regular basis. Regular management meetings were held between the person in charge and her deputy. Staff were facilitated to discuss issues of safety and quality of care at team meetings which the person in charge or her deputy attended. Audit of areas such as infection control and health and safety had taken place in 2014. However, inspectors noted that audit action plans had not been developed and many of the findings of these audits had not been addressed at the time of inspection. In addition, medication management audits had not commenced, however, the person in charge informed the inspector that this would be set up in response to the findings in this report.

A yearly report on the centre was commissioned and this was available to all residents and their representatives. Staff and resident surveys were carried out previously but these had not occurred on a regular basis and the survey forms seen by inspectors were not dated. The bi-annual unannounced inspections of the centre, by the person in charge, required by the regulations, had yet to commence in a formal manner. The person in charge informed inspectors that she had hoped to commence these just prior to the announcement of the inspection.

The person in charge was qualified, experienced and demonstrated leadership skills. Staff and residents were able to identify the person in charge as being the manager and staff told inspectors that she was supportive and approachable. The person in charge outlined to inspectors her plans to continue to improve the service for residents. She demonstrated some knowledge of the legislation however, she had not understood the statutory duty to notify the Authority of events outlined and addressed under outcome 9. The provider was not present during the inspection. The person in charge had a commitment to ongoing professional development and she was on a study day on the day prior to inspection.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the

designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

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

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

Findings:

There had been a situation where the person in charge was absent for 28 days or more. Suitable deputising arrangements were in place for the management of the designated centre in the absence of the person in charge. However, the provider had not fulfilled the statutory duty to report any such absence and to inform the Authority of the arrangements in place to manage the centre during this absence .

Judgment:

Non Compliant - Major

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:

A sample of staff files reviewed by inspectors generally complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. However, in the sample of staff files viewed photographic identification was missing in one file and a curriculum vitae (CV) gap analysis had not been undertaken for another staff member for a gap in employment details of 16 years. Inspectors viewed the policy on staff recruitment and saw that staff had fulfilled the required vetting procedures. There was an induction policy and procedure in place.

Training records reviewed by inspectors indicated that staff had attended a range of training. However, not all staff had received mandatory and updated appropriate training required by the Regulations such as medication management to include

specialist epilepsy training, managing challenging behaviour and abuse prevention training. Staff members had not received mandatory fire training. Inspectors saw a schedule which indicated that all staff were to undertake fire training at the end of November. Staff supervision records were seen and inspectors saw that staff appraisals had commenced. While inspectors were present residents received attention and care in a respectful manner. However, rosters were not available for viewing by inspectors. These were arranged informally and the person in charge explained that as staff worked regular days they were aware of their roster. Nevertheless, a copy of the required planned and worked roster was sent to the Authority following the inspection. The fact that this record was not available on inspection will be addressed under outcome 18: Records and Documentation. Inspectors found that staff had a good understanding of the responsibilities of their role and of the needs of the residents. Staff with whom inspectors spoke were interested in residents and in their welfare and achievements and were found to be committed to the ethos of the centre. Residents were seen to be familiar and relaxed with the staff on duty during the inspection. Staff had access to the Health Act 2007, a copy of the relevant Regulations, and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Inspectors noted that records and documentation in the centre were generally maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. A directory of residents was maintained in the centre and this contained all of the items required by the Regulations. A record of residents' assessments and copies of personal plan were available. Inspectors noted that a record of nursing and medical care provided to the resident including any treatment or intervention was maintained. Resident's files were found to be complete and were kept in an accurate manner and were up to date. For example, a record was maintained of all referrals and the outcome of these. Records

relating to communication needs, money or valuables, complaints, incidents, fire safety were stored securely and were easily retrievable. The policies required under Schedule 5 of the Regulations were in place such as: medication management, the prevention of abuse, approaches to challenging behaviour and the provision of information to residents, among others. However, not all policies were adopted and implemented in practice and had not been updated regularly as required. Examples of this were the medication policy and the risk management policy. Furthermore, not all records were maintained in the centre as required under Schedule 3 and 4 of the Regulations, such as, a record of medication errors, a copy of the duty roster and a record of notifications to the Authority.

Judgment:

Non Compliant - Major

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:

Mary O'Mahony
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 CoAction West Cork
Centre ID:	OSV-0002105
Date of Inspection:	18 November 2014
Date of response:	27 January 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The nominated person had not maintained complete 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 or complainant was satisfied.

Action Required:

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

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:

All complaints logged and managed centrally in accordance with the Complaints Policy. To supplement this, for the softer day to day issues: A house issue book is now in place 15th January 2015 for each house to record any issues of dissatisfaction within the house for residents and/or families, e.g. misplaced items of clothing, etc. This record will indicate the actions taken by whom and if the person and/or family member was satisfied. The form also contains a section for further intervention and invocation of complaints policy should the person not be satisfied with the outcome.

This log will be reviewed on monthly basis by the P.I.C

Proposed Timescale: Implemented –January 15th 2015 . Ongoing review.

Proposed Timescale: 15/01/2015

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:

Not all personal care plans seen by inspectors contained the name of the key worker and the objectives and timescales for goal achievement.

Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

a)

PCPs will be incorporated with the individuals personal support plan." How you can support me". Residential staff will work with day staff (who have historically completed PCPS with the individual) to ensure that all required information- Name of key worker, goals-long and short term are documented as well as timelines for each goal and name of person(s) responsible for supporting the individual to achieve their goals. Visual PCPs will also be made available to the individuals with outcomes and dates achieved. This will be available in both day and residential centres.

b) We are in the process of developing an holistic system of" person directed" planning system which will include two aspects

1. 'Things that are important for me'
2. 'Things that are important to me'

This will incorporate every aspect of the person being supported from daily living support needs to hope, dreams and aspirations.

Proposed Timescale:

A) Commenced January 2015. It is hoped that all persons will have updated and complete PCPs incorporated with personal support plans 'How you can support me' in 6 months .- 15-July-2015

B) It is projected that this new way of supporting and planning with the people we support and their families will be in place by 30-Sep-2015. A coordinator for this project was appointed in October 2014. He has begun this process already.

Proposed Timescale: 30/09/2015

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:

The controls required to manage the risks specified under Regulation 26 were not included in the risk management policy.

All risks in the centres were not identified as hazards and controls were not in place for the following identified risks:

- unsafe objects and liquids stored in unsecured cupboards
- shared ointments
- no bathroom or bedroom door keys
- an unsuitable access ramp
- unsafe outdoor/sports equipment on the site
- unsecured lighters and matches in the sitting room.
- the upstairs window opening in all houses
- self-harm

The centre did not have a policy on self harm identification and prevention.

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:

Risk management policy currently being reviewed by policy development board.

Health and Safety monitoring is in place, Risk register is currently being compiled.

Active monitoring visits will be annual –Completed for Centre 1(16/01/15): Centre 2 has commenced 14 /01/15.

Reports issued with detailed actions/timelines. It will be the responsibility of the PIC to ensure that actions are completed in a timely manner. SCL/SCW in each house to be

responsible to ensure audits take place.

With reference to identified risks outlined in the report above:

- All unsafe objects and liquids now stored in a locked cupboard – 15/05/15
- All ointments used by individuals are clearly labelled and used for the sole purpose of the individual with a note of " date of opening ". 15/05/15
- Bathroom and bedroom door keys will be risk assessed and installed as appropriate. risk assessments commenced – 12/01/15
- Unsuitable access ramp replaced 19/12/14
- Unsafe outdoor/sports equipment removed 15/01/15
- Unsecured lighters and matches in sitting room – risk assessments carried out , items locked away 6/01/15
- Upstairs windows –risk assessed and restrictors installed as appropriate. 12/01/15

- Positive behaviour support policy now has self-harm – definitions, identification and strategies for prevention included. 19/01/15

Proposed Timescale: Risk management policy update: 28-Feb-2015

Active monitoring actions: 31-Mar-2015

Proposed Timescale: 31/03/2015

Theme: Effective Services

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

An immediate action plan was given to the person in charge as regards the lack of a robust fire safety strategy in the centre.

- There were no personal evacuation plans (PEEPS) for residents
- The fire assembly points were not identified in all houses in the centre.
- The service date written on the fire extinguishers was out of date by two years in one case.
- There was a lack of smoke detectors in house 4.
- Open fires and a stove had not been risk assessed and carbon monoxide detectors had not been installed.
- Not all staff with whom inspectors spoke were aware of the procedure to be followed in the event of a fire and staff had not been afforded the mandatory fire training.
- The procedure to be followed in the event of a fire was displayed behind the kitchen door and not displayed prominently as required by the regulations.
- The fire blanket in one kitchen was not attached to the wall and the fire extinguishers were not affixed securely in one house. The bracket holding one extinguisher had become loose and the bracket and screws were lying on an adjoining shelf. Any risks associated with this had not been assessed.
- The fire panel for house 2 was located in an adjoining house which was temporarily closed.
- Matches and lighters were not stored securely.
- The response to the immediate action plan was not satisfactory.

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:

- PEEPs have commenced November 24th 2014 and are ongoing. It is hoped to have these completed by end of March 2015
- Fire assembly points have now been clearly identified – Dec 14
- Service date on all firefighting equipment –Dec 14
- Smoke detectors and carbon monoxide detectors in house 4 – Dec 14
- Fire training for remainder of staff names submitted to inspector – 16/01/15
- FEP. Displayed in obvious site 18/11/14
- Fire blanket and all firefighting equipment secured 24/11/14
- Fire panel to be installed in house 2. 28-Feb-2015
- Documentation re immediate action plan was resubmitted with additional information. 06/01/15

Proposed Timescale: PEEPS 31-Mar-2015

Fire panel : 28- Feb- 2015

Proposed Timescale: 31/03/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff had not received training in the management and de-escalation of behaviour which challenges.

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:

In house training on positive behaviour supports, identification and proactive strategies to be provided by psychology team.

All staff to have completed training by end of June 2015

Proposed Timescale: 30/06/2015

Theme: Safe Services

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

The policy on restrictive procedures did not follow the guidelines in national policy, in best evidence practice and in the centre's own policy.

Action Required:

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

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

The centre's policy on restrictive practices will be amended in accordance with the national policy.

Proposed Timescale: 31/03/2015

Theme: Safe Services

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

Consent for therapeutic interventions had not been obtained for residents.

Action Required:

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

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

Consent for medical intervention when in residential is recorded now in the personal support plan "How You Can Support Me" document and each person's individual information sheet. Audit of all plans has commenced and will be complete by January 2015

Proposed Timescale: 30/01/2015

Theme: Safe Services

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

There was a lack of guidance available to staff to prevent an incident of peer abuse.

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 centres "Vulnerable Adult policy" will address this in line with national policy It will also be included in the anti-bullying policy, Training will be provided on this policy for staff and the people we support in the service.

Proposed Timescale: Staff: 30th May 2015. People who use the service 11/Dec/15

Proposed Timescale: 11/12/2015

Theme: Safe Services

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

There were no individual intimate care plans in place to guide staff in this aspect of care.

Action Required:

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

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

This is currently provided for in "How You Can Support Me", an Intimate Care Plan will be developed for those that need it and attached as an appendix to this document.

Proposed Timescale: 28/02/2015

Theme: Safe Services

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

Not all staff had received appropriate training in the safeguarding of residents and in the recognition, detection and response to 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:

Training in line with National policy & Procedures "Safeguarding Vulnerable persons at Risk of Abuse" (Hse Dec 14)

Proposed Timescale: 30th May 2015 (staff), 11-Dec- 2015 (People who use the service)

Proposed Timescale: 11/12/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

There had been a power loss in house 2 last Christmas which had not been reported to the Authority in line with the Regulations.

Action Required:

Under Regulation 31 (1) (c) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place.

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

There had been a misunderstanding of the commencement date of notifications. Provider understood that it would commence post registration. Commenced returns for new events, last quarter has been submitted. 15/01/15

Proposed Timescale: Commenced 15/01/15 Ongoing

Proposed Timescale: 15/01/2015

Theme: Safe Services

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

A resident had an injury which required hospitalisation and this had not been reported to the Authority.

Action Required:

Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

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

As part of our monitoring inspection the inspector requested that notifications were submitted retrospectively. These were submitted for July-September 2014 on the 15/01/15

Proposed Timescale: Commenced and ongoing

Proposed Timescale: 19/01/2015

Theme: Safe Services

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

The centre did not provide a quarterly written report to the Authority on all occasions when restrictive procedures were used.

Action Required:

Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

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

All restrictive practices, new and ongoing are now reported to the P.I.C. who will in turn notify the Chief Inspector in a timely manner.

Proposed Timescale: Commenced 15/01/15 and Ongoing

Proposed Timescale: 15/01/2015

Theme: Safe Services

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

The centre had not provided a quarterly written report to the Chief Inspector as required under Regulation 31 (3). The centre did not provide a 6 monthly 'nil-return report' in the event that there were no incidents in the centre as required under Regulation 31 (4).

Action Required:

Under Regulation 31 (3) (d) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any injury to a resident not required to be notified under regulation 31 (1)(d).

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

Due to a misunderstanding the provider assumed incorrectly that notification began post registration. This has now been clarified and notifications will commence immediately

Proposed Timescale: 15/01/2015

Theme: Safe Services

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

The centre did not provide a 6 monthly 'nil return' report to the Authority.

Action Required:

Under Regulation 31 (4) you are required to: Where no incidents which require to be notified have taken place, notify the chief inspector of this fact on a six- monthly basis.

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

Due to a misunderstanding the provider assumed incorrectly that notification began post registration. This has now been clarified and notifications will commence immediately.

Proposed Timescale: Commenced 15/01/15 Ongoing

Proposed Timescale: 15/01/2015

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:

Medicines in the centre were not stored securely but were seen stored on open bookshelves in a staff room.

The medication keys were not stored securely.

Action Required:

Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

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

Accredited Medication management training taking place over the month of January and February 2015. First date 19th January. This is a two day training event with an assessment of competence post training plus written exam.

Medications are now stored in an appropriate medicine cabinet which is locked.

Medication keys are either on the designated person or locked in a key safe with a coded lock.

Medication Audits have commenced and staff have been instructed in the 7 rights of medication administration 19th Dec 2014

Proposed Timescale: 28/02/2015

Theme: Health and Development

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

Residents had not been risk assessed as to their suitability to self-administer their medication.

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:

Revised Medication Policy now provides for this assessment, training will commence January 19th. Risk assessments will be referenced in their individual support plan and each person will have an Individual Medication Plan.

Proposed Timescale: 28/02/2015

Theme: Health and Development

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

Medicine was not administered as prescribed in the prescription for a PRN (when necessary) medication.

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:

Revised Medication Policy provides procedures for the prescribing, storing administration and disposal of medication. A separate PRN sheet for each individual and clear guidelines on protocols for PRN medication is now in place in each house 5-Jan-2015

Following the medication training all staff will be familiar with and practice safe medication administration in accordance with the centres policy and procedures.

Proposed Timescale: 28/02/2015

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:

Unannounced 6 monthly visits by the provider or a nominated person and the compilation of a report on the quality and safety of care, as required by the regulations, had yet to commence in the centre.

Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and

support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

Informal unannounced visits had been occurring. A formal approach will now commence on 19th /20th/21st/22nd Jan 2015 in centres 1 and 2. Centre 3 will commence on 5th/6th Feb 2015

A) Quality team to be designated to conduct quality audits across all 3 designated centres. The team will consist of RNID, PIC and self-advocates and family member. .This is currently with the self-advocate management committee.

B) In the interim audits have commenced by the PIC and provider nominee. Jan 2015

Proposed Timescale: 30-April-2015 (quality team)

Proposed Timescale: 30/04/2015

Theme: Leadership, Governance and Management

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

The service in the centre was not consistently and effectively monitored such as the lack of robust medication administration audit and the failure to action the findings of the infection control and health and Safety audit which was carried out in July 2014.

Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

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

This will be conducted by the Quality Team.

Informal systems will now become formal. Quality of life survey will be conducted annually and as part of PCP process.

Proposed Timescale: 30/04/2015

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:

The absence of the person in charge for a period of more that 28 days was not notified to the chief inspector by the registered provider.

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:

Due to a misunderstanding the provider assumed incorrectly that notification began post registration. This has now been clarified and notifications will commence immediately.

Proposed Timescale: Submitted Jan 8th 2015 (NF20)

Proposed Timescale: 08/01/2015

Theme: Leadership, Governance and Management

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

The return of the person in charge following an absence of more than 28 days was not notified to the chief inspector by the registered provider.

Action Required:

Under Regulation 32 (4) you are required to: Notify the Chief Inspector of the return to duty of the person in charge not later than three working days after the date of his/her return.

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

Due to a misunderstanding the provider assumed incorrectly that notification began post registration. This has now been clarified and notifications will commence immediately

Proposed Timescale: Submitted Jan 13th 2015(NF 21)

Proposed Timescale: 13/01/2015

Theme: Leadership, Governance and Management

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

The registered provider did not give notice in writing to the chief inspector of the procedures and arrangements for the management of the designated centre in the absence of the person in charge. There are specified procedures for the contents of this notice under Regulation 31 (2) (a) (b) and (c), which were not followed in line with the provider's statutory duty.

Action Required:

Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.

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

Due to a misunderstanding the provider assumed incorrectly that notification began post registration. This has now been clarified and notifications will commence immediately.

Proposed Timescale: NF 20/21 Submitted Jan 8ht /13th NF 30 to be submitted 19/01/15

Proposed Timescale: 19/01/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The centre had not maintained a planned and actual roster which was available for viewing by inspectors during the inspection.

Action Required:

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

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

Staff rota template has been developed and distributed to each house. PIC will monitor rotas on a weekly basis and liaise with SCL/SCW with regard to staffing issues. Visual and written staff rotas are on display in each house for inspection.

Proposed Timescale: 20/11/2014

Theme: Responsive Workforce

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

In the sample of staff files checked all the information required under Schedule 2 of the regulations were not maintained for staff: For example photographic identification and a full accounting for a gap in employment.

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:

HR to review files and complete, in particular gaps in CV and reference validation. All files will be updated by 1 th February 2015

Proposed Timescale: 13/02/2015

Theme: Responsive Workforce

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

Staff were not afforded access to appropriate training, mandatory and refresher training as outlined under outcome 7; Health and Safety: outcome 8: Safeguarding and Safeguarding and Safety and outcome 12: Medication Management.

This included:

- fire safety training:
- prevention of abuse training:
- positive behaviour support:
- challenging behaviour training:
- medication management training.

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:

Hr is developing a training schedule. This will be monitored by the Residential Manager and PIC. Training has commenced and will be completed by July 31st 2015. Updated training will be highlighted and delivered as required .

Proposed Timescale: 31/07/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

All the policies required under schedule 5 of the regulations were not adopted and implemented in the centre such as, the medication policy, the policy on restrictive procedures and the policy on risk assessment.

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:

Policy development and review group currently working on updating and reviewing policies.

Medication Policy roll out and training to commence January 19th 2015 and will be complete 28th February 2015

Roll out of updated policies and training required for such policies as appropriate will commence in line with schedule from HR. Schedule to be completed by HR by 20th February 2015. Roll out and training for staff and the people we support by Dec 1015

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

Staff were not aware of the contents of the policies in the centre such as, the medication policy, the policy on restrictive procedures and the policy on risk assessment.

Action Required:

Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

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

All updated policies are available to staff on the server and a hard copy is kept in the centre. Easy to read versions of all appropriate policies are also available in the designated centre

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

All the policies seen by the inspector were not up to date or reviewed regularly to reflect best practice such as, the medication policy, the policy on restrictive procedures and the policy on risk assessment.

Action Required:

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

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

Policy development group will review all policies. policies are also reviewed by the self-advocate" action forum" This can take time as we must go at the pace of our self-advocates. We also aim to have an easy to read version of all relevant adult services

policies.

We are focusing on the following policies as a matter of urgency:

- Medication Management
- Risk Assessments
- Restrictive procedures
- Vulnerable adult policy in line with National policy issued on Dec 2014

Proposed Timescale: 31/12/2015

Theme: Use of Information

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

The records required to be maintained under Schedule 3 (3) (h) and Schedule 3 (3)(k) were not maintained in the centre with reference to medication management failings outlined under Regulation 12.

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:

Medication errors reported on computerised system "Xyea", These reports and actions are now being printed off as hard copy and maintained on the person's file in the centre.

Proposed Timescale: 06/01/2015

Theme: Use of Information

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

All the records required under Schedule 4 of the Regulations were not maintained for examples records of notifications to the Authority, Schedule 4 (10) (a) to (m) as appropriate and Schedule 4 (11) concerning the duty roster.

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:

Record of notifications and duty roster will be maintained by the PIC or provider nominee as appropriate.

These notification will be held in designated centres as appropriate in hard copy.

They will also be held centrally in hard and soft copy.

Proposed Timescale: 6- Jan 2015 –Ongoing

Proposed Timescale: 06/01/2015