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<th>A designated centre for people with disabilities operated by RehabCare</th>
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<td>Provider Nominee:</td>
<td>Laura Keane</td>
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<td>Lead inspector:</td>
<td>Geraldine Jolley</td>
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<td>Support inspector(s):</td>
<td>Mary McCann</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, 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 ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
<th>Outcome 06: Safe and suitable premises</th>
<th>Outcome 07: Health and Safety and Risk Management</th>
<th>Outcome 08: Safeguarding and Safety</th>
<th>Outcome 09: Notification of Incidents</th>
<th>Outcome 11: Healthcare Needs</th>
<th>Outcome 12: Medication Management</th>
<th>Outcome 14: Governance and Management</th>
<th>Outcome 17: Workforce</th>
<th>Outcome 18: Records and documentation</th>
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**Summary of findings from this inspection**

This was the first monitoring inspection of this centre. During the inspection, the inspectors met with residents and staff members. Inspectors observed practices and reviewed the documentation including personal plans, medication records, accident and incident reports, policies, procedures and staff rotas.

The designated centre comprises of two houses and is located in a modern housing estate. Both houses were comfortable, well maintained and decorated to a good standard. Service users had personalized their bedrooms and communal areas and told the inspectors they had been able to choose fixtures and furnishings for their rooms. There was garden space, however, this was open and unsecured and did not ensure privacy.

The inspectors found that service users were supported by a dedicated staff team that knew them well and were committed to ensuring their well being. Service users were able to make decisions and choices about their lives and were involved in the running of each house. They could pursue hobbies and activities and had access to day care programmes in the nearby resource centre that they said were varied and
they enjoyed. Some were involved in community activities such as the development of the community garden and the local resource centre. The role of the person in charge was fulfilled by an experienced manager, who had responsibility both for the daily management and governance of the residential service and the resource centre close by.

There was evidence that service users’ healthcare needs were met with support from local general practitioners described as “very good”. Access to specialist referral and advice from allied health professionals was available, recorded in personal plans and adhered to by staff. The inspectors found that there were deficits in some aspects of the assessment of support and care needs. A number of personal support plans had not been reviewed in a timely way and the information on some service users’ support needs did not take in to account the complications of health changes and the time required from staff to monitor and ensure service users had effective and safe support. An example of changing needs was the particular hazard associated with an identified choking risk which was well known to staff who provided high levels of supervision at meal times. There was also significant levels of emotional and psychological support required and provided by staff to some service users. Staff capacity to do this effectively was compromised as there were times when one of the houses had no staff on duty. This meant that support had to be provided by the one member of staff on duty in the other house who already had responsibility for five service users with significant support needs. A door linked the two houses internally to ensure that service users could locate staff if needed. While a staff member was accessible to all service users, a reassessment of support needs was required to ensure that service users have appropriate support systems to achieve their goals and aspirations according to their current needs.

Areas of non compliance identified during the inspection related to risk management, mandatory training requirements particularly fire training, availability and continuity of staff to enable service users to achieve identified goals and improved assessment systems to ensure accurate judgements of service users support needs. These are discussed further in the report and included in the Action Plan at the end of this 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 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:
The inspectors found that service users well-being was maintained by a good standard of evidence based care and support, with opportunities and arrangements in place to improve capacity and quality of life. The inspectors met with the service users in both houses and reviewed a sample of their personal plans. Service users’ preferences and wishes regarding their daily routines were recorded. Service users’ files contained a good range of information that outlined their health, intimate and personal care needs along with their family contacts and relationships.

The personal plans reflected a varied range of needs, capacities and life style choices. The inspectors noted that service users had varied support needs ranging from high levels of independence to high levels of direct support needs described. While the recorded information took account of service users’ psychosocial needs as well as medical and physical health problems, there were deficits in assessments and support plans as some service users support requirements on a day to day basis appeared to exceed the care needs that were documented. The inspectors found that while staff had sufficient knowledge and understanding of a range of supportive interventions appropriate to the service users they were compromised in their capacity to provide the support required due to the staffing model in place. For example one service user had an identified dysphasia problem that has been assessed by the speech and language therapist and required their supervision when eating. However, there were times when no staff were available in the house where she resided. This meant that staff from the house next door had to be vigilant regarding her needs and provide support where required. Some personal plans had not been updated since 2012 and 2013 and required review to ensure they accurately reflected service users current support needs.
There was evidence of interdisciplinary team involvement in service users’ care including nursing, speech and language therapy, and other allied health professional as required. There was also information that conveyed that service users were involved in developing and reviewing their personal plans. Staff were very well informed and could describe daily routines, specialist interventions, choices made regarding family involvement and visitors were noted to provide a high standard of support while respecting service user’s choices and preferences.

Inspectors were informed by service users and staff that there were a number of options available in relation to activities and work. Service users attended the local resource centre where the inspectors saw there was a varied programme available each day. Some service users had become involved in varied community activities and said they enjoyed meeting people and contributing to the local community.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The two houses that form the designated centre are side by side and located in a modern housing development. There is an interconnecting door which enables service users and staff to move from one house to another. This was not an original feature as both houses had been established to operate independently. Changes to staffing levels and the additional support needs of service users prompted this change which enables services users and staff to move between houses to maximise the resources available.

A good standard of accommodation was provided with the fabric of the building, standard of decoration and condition of equipment noted to be satisfactory. Each service user had their own bedroom and rooms were noted to be personalised reflecting the choices and preferences of the service user. The shared kitchen, dining and sitting areas were attractively furnished and provided adequate space for service users to sit together if they wished. One house had a bedroom that was used to provide sleep-in accommodation for staff and the other house had a room that served as a private sitting area/visitor’s room. While this arrangement considered collectively across the two houses provided service users with private space if the houses revert back to operating independently this facility will not be available. The only space to see visitors apart from bedrooms would be the sitting room which would restrict others use of the room and would compromise privacy as service users would not be able to receive visitors in
private.
Services users had call bells to alert staff that they needed assistance and were able to demonstrate to inspectors how they used these when they needed help.

There was a garden surrounding the houses which was laid to lawn but this was not secure or private and compromised the security of the premises.

**Judgment:**
Non Compliant - Minor

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**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:**
There was risk management in place that promoted the health and safety of service users, staff and visitors. There was an emergency plan known as a service business continuity plan and this was found to inform staff on a range of actions to take should a crisis situation develop. Each manager has a “buddy” who is a colleague that is familiar with their service and able to provide them with support and guidance. There were a range of services and emergency numbers outlined so that staff could access assistance expediently in a variety of circumstances. There were contingency plans in place to ensure staff could remain on the premises during poor weather conditions. Procedures for incident reporting and risk escalation were in place. The inspectors found that a range of risks/hazards had been identified and recorded and these included medication errors and the potential for choking risk. The inspector noted there were systems in place to ensure the transport vehicle used by the service was roadworthy, insured and equipped with appropriate safety equipment.

Hazards identified as posing a risk to service users were identified in their personal plan with appropriate controls to minimise the risk of harm or injury. Residents identified with a risk of choking had been assessed by a speech and language therapist and safety precautions that included cutting up food and ensuring that meal times were unhurried had been put in place by staff. However, the supervision and support provided at meal times by staff and observed by inspectors was not identified as part of the safety precautions in place. The inspectors noted that the support arrangements and duty times currently worked by staff meant that this service user did not have supervision for long periods.

There was a program of annual fire safety training in place. Staff on duty confirmed that they attended training and there was an option of attending training on other facilities belonging to the organisation if required. The inspectors noted from the fire records examined that two support workers who were available on an “as needed” basis had not had training and another member of regular staff was due refresher training. Fire safety
equipment was available and was regularly serviced. Fire extinguishers were noted to have been serviced in January 2014. There were weekly tests of the fire alarm panel and fire drills had been conducted on three separate occasions this year in February, April and July. Service users were involved in fire drills and in April five service users were evacuated.

All fire drills conducted so far had taken place during the day. The majority of bedrooms are on the first floors of both houses and some service users were described as sleeping very soundly or in need of encouragement if they were requested to leave the house very quickly and the risk associated with this had not been identified particularly in the context of one staff on “sleeping-in” duty available at night. It was also unclear if the two service users in the house where there was no staff at night would leave independently if the fire alarm was activated. The risk associated with service users not being able to respond immediately to a fire alert required assessment and the mobility status/record of staff and service users needed to be updated as it was out of date and described the details of seven persons instead of six currently resident in the houses. A fire drill during night time hours had not been conducted to ensure staff and service users were familiar with the fire alert and evacuation procedure when staff numbers were limited to one sleeping in staff.

The houses were well maintained both internally and externally. All areas were found to be clean, comfortable and welcoming. There was a good standard of décor throughout and very high levels of personalisation evident in residents’ bedrooms. Chemicals were stored securely. Infection control practices in relation to hand hygiene were in place and observed by staff. There was a range of polices to guide staff in best practice. There were no service users who required assistance with mobility. The inspectors were told that all staff were up to date training in the safe moving and handling of residents should this be needed.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
Inspectors found that measures were in place to protect service users being harmed or
suffering abuse. A detailed policy was available for the prevention, detection and response to allegations of abuse. It included information on the different forms of abuse and the responsibility of to report if they suspected any form of abuse as well as the procedure for managing an allegation of abuse. The document was noted to have been due for review in 2012 but the updated version was not yet available. Staff were aware of the personnel in the statutory services that had to be informed. The person in charge confirmed that no allegations of abuse had been reported.

Staff interviewed confirmed that they were aware of the safe guarding policy, and could describe to inspectors the procedures in place for reporting and investigating allegations or suspicions of abuse. They had received training and information on this topic but records conveyed that some staff had been trained in 2010 and the inspectors concluded that refresher training was required to ensure that staff had up to date guidance that reflected current good practice. Service users told inspectors they felt safe, could talk to staff and conveyed that they felt secure in the presence of staff. A procedure was also available on the provision of personal care to service users which included guidance on respecting residents’ privacy and dignity.

The inspectors observed that staff interacted with service users in a positive, friendly manner that was respectful. There was a policy to guide staff on the delivery of personal and intimate care and a policy on responding to behaviour that presented challenges. Staff confirmed that there was access to a behaviour therapist employed by the organisation and also good working relationship with allied health professionals in the Health Service Executive had been established so that service users could achieve positive outcomes. There were no restrictive practices in use.

**Judgment:**
Non Compliant - Moderate

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**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:**
The person in charge was aware of the notifications she was required to provide to the Authority.

**Judgment:**
Compliant

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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 were satisfied that service users' health care needs were met and that input from medical services and allied health professionals was available as required by service users. Staff described an excellent working relationship with the local general practitioners and an out of hour’s service was also available. Access to services such as physiotherapy, speech and language therapy, occupational therapy, dental, chiropody and dietetics are available through referral to the HSE.

Staff support service users to access community health services as/when required. Health promotion initiatives were also in place. The inspectors saw that services users were encouraged to follow healthy diets and that weight management and exercise programmes were in place. Service users described the interventions and individual help provided by staff in very positive terms.

Inspectors discussed food and nutrition with staff and service users and found that measures were in place to ensure high nutritional standards were in place. Service users cooked their meals with the assistance of staff and had meals out while shopping or as part of social programmes. Snacks and drinks were freely available and there was a good supply of food from which to prepare snacks and meals.

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:
A medication management policy was in place to guide practice and included the arrangements for ordering, prescribing, storing and administration of medicines to service users, however this was not fully centre specific as it did not include the varied arrangements made to meet service users needs. Some service users could manage their medication without any assistance while others needed varied levels of support. Medication was supplied in different formats but these arrangements were not fully described in the procedures.
The staff on duty displayed a good working knowledge of the medications in use and could describe the assessments completed to determine that service users were competent to manage their own medication. There was an emphasis of promoting independence in this area and local doctors were very supportive to service users and staff with all these initiatives.

All service users had their own secure medication box in their room. The inspectors reviewed the medication prescription and administration records. Staff said the format of these required change and were exploring options with local doctors. The charts in use were not specific to the service and lacked some of the required information such as the address of the service and service users’ dates of birth. The maximum dose prescribed for “as required” (PRN) medications to be administered in a 24 hour period was not outlined on some charts.

Inspectors observed that medications were stored appropriately, and there were no medications that required strict control measures (MDA’s) at the time of the inspection. There was a system in place for the reporting and management of medication errors. Staff the inspectors talked to knew the process they had to follow if they made an error. There had been two medication errors one in February and one in July 2014. Both related to a medication item that was not taken and both matters were investigated by the person in charge and measures to ensure that further errors did not arise were put in place. These included competency assessments and consideration to provide further training.

**Judgment:**
Non Compliant - Moderate

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**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 clearly defined management structure that identified the lines of authority and accountability for the operation and management of the service. The person in charge (PIC) was suitably qualified, skilled and experienced to meet the requirements of the role. Inspectors found that the PIC was knowledgeable about the requirements of the regulations and standards and had knowledge of the support needs and person centred plans for service users. She also had responsibility for the resource centre where day time social and recreational activities took place.
The PIC was employed full-time to manage the two houses which comprise the designated centre and the day service. She usually worked 09:00 hrs to 17:30. She knew the service users well as she met them daily in the resource centre and also at regular meetings where individual and day care objectives were discussed. The PIC had worked within the centre since 2006 and had a range of qualifications relevant to her role. She was supported in her role by the two programme supervisors in the resource centre and there was an established arrangement for staff and management meetings. She reported to a Regional Manager who reported in turn to the Director – Health and Social Care who is based at the organisation’s head office and is the nominated provider on behalf of the organisation. Records confirmed that there was commitment to ongoing professional development and regular training.

The inspectors found that there were aspects of the management structure that required review to ensure appropriate compliance with legislation. The PIC had been absent for a period in excess of 28 days which had not been reported to the Authority as required by regulation 32- Notifications of periods when person in charge is absent. The inspectors found that the arrangements to manage the service in the absence of the PIC required improvement as one of the medication errors referred to in outcome 12 had not been investigated until the PIC had returned to duty.

Judgment:
Non Compliant - Minor

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:
Staff members on duty were aware of the purpose of the inspection, welcomed the inspectors and introduced them to service users. There was a relaxed and comfortable environment in the houses. Staff described their duties clearly and during the early evening this included helping with the preparation of evening meals and providing assistance at meals to service users with particular vulnerabilities such as safety concerns or swallowing problems. Staff were keen to ensure that service users wishes were respected and that targets they had set for particular days were achieved such as helping service users do their own shopping. However, where support was required to do this, the inspectors observed that staff were under pressure to complete the task in the duty time available to them. For example, in one house the evening meal had to be prepared, consumed and the shopping trip completed between 17.00 and 20.00 hours.
as that was the time period the staff member was on duty in that house.

Both houses operated as one unit as described in the outcome on premises. In addition to the member of staff who came on duty for the three hour evening period there was a second staff who came on duty at 16.30 hours and was available during the evening to support service users and available on an “on call”/“sleep in” basis during the night. The allocation of staff was based on 100 hours of support for eight services users in both houses. This allocation required review as there was evidence that the current deployment model did not facilitate adequate choice for service users or allow for the support needs of some service users to be met in a safe consistent way. For example, service users who may need support to go out in the evenings may not be able to do so if other service users did not wish to go out and one service user expressed the view that they were times when they were lonely and went next door for company. A staffing roster showing staff on duty was available, however, hours allocated by the PIC to this centre were not reflected in the roster.

Inspectors observed that staff addressed the service users respectfully and chatted to them as they returned from their day time activity and during the preparation ion of the evening meals. Service users said that staff made themselves available to talk to them and also said they did not have to wait an excessive time for assistance when they needed help.

Inspectors found, through talking with staff, that there was an on-call arrangement in place and that staff had ready access to the contact details.

Judgment:
Non Compliant - Moderate

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:
All the polices required by the regulations were available. Many of the policies contained detailed information to guide staff, however, some policies were not centre specific and did not describe the specific arrangements that were in place in the centre including the medication policy. As described earlier, the adult protection policy required updating in
The inspectors reviewed the recruitment practices and found there was a system in place to ensure the required documentation for staff employed in the centre was in place. The inspectors reviewed three staff files and found that while most of the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Service users in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 were in place evidence of qualifications as described in files was not always available.

**Judgment:**
Non Compliant - Minor

### 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:**

Geraldine Jolley  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
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<td>20 August 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26 November 2014</td>
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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 05: Social Care Needs

Theme: Effective Services

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

Personal plans were not reviewed in a timely manner and some had not been reviewed since 2012.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are

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:
• August – October: staff completed review on residents’ personal plans.
• All residents’ plans will have been updated following review by 31st January 2015
• Staff attended training on ‘Support Plans and Action Planning’ on 30th October 2014.

**Proposed Timescale:** 31/01/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some personal plans did not convey accurately the support needs of service users and did not take into account changes in health care needs that required additional support and supervision.

**Action Required:**
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
• August – October: staff completed review on residents’ personal plans.
• All residents’ plans will have been updated following review by 31st January 2015
• Staff attended training on ‘Support Plans and Action Planning’ on 30th October 2014

**Proposed Timescale:** 31/01/2015

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The garden area was not secure and the arrangements externally did not provide privacy or security for service users.

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

Please state the actions you have taken or are planning to take:
Secure fence now erected on both properties providing privacy and security for residents.

**Proposed Timescale:** 30/10/2014
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:
Some clinical indicators of risks that had been identified did not have the full range of safety support measures that were required outlined to guide staff and there were times when service users in one house had limited access to staff.

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

Please state the actions you have taken or are planning to take:
• Risk assessments regarding choking to be reviewed regarding the two service users highlighted in this report
• Potential alterations to building as above to facilitate increased support with existing resources following review.

Proposed Timescale: 31/01/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not had fire training within the required intervals including staff who worked alone. Fire drills including evacuation had been conducted during the day however none had been conducted during the hours of darkness when staff was limited to one sleeping in staff.

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

Please state the actions you have taken or are planning to take:
• All staff have undertaken Fire Warden training service specific on 20th November 2014
• Fire risk assessment reviewed 17/11/14
• Night time fire drill to take place by 31st December

Proposed Timescale: 31/12/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire safety information had not been updated since the discharge of a service user and the information available indicated that seven service users occupied the premises which created an additional hazard should a critical situation arise.

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

**Please state the actions you have taken or are planning to take:**
- Personal Emergency Evacuation Plans to be reviewed following potential structural changes to houses by 31st January 2015
- Mobility status of staff and service users has been reviewed and updated.
- Review fire evacuation plan following changes to alarm system and fire connecting door to be completed by January 31st 2015.

**Proposed Timescale:** 31/01/2015

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**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:**
The policy on the protection of vulnerable adults had not been updated in line with the organisation's timeframe and some staff had not had refresher training on this topic since 2010.

**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:**
- Updated Policy dated January 2013 now in place
- 2 Staff will have completed training by 9th December 2014.
- Remaining staff will have completed training by January 31st 2015

**Proposed Timescale:** 31/01/2015

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**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had received training on adult protection however this required an update as some staff did not have training since 2010 according to training records.

**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:
• 2 Staff will have completed the required training by 9th December 2014.
• Remaining staff will have completed this training by January 31st 2015 (next scheduled training).

Proposed Timescale: 31/01/2015

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:
The medication policy and associated procedures required review to outline the arrangements in place for the management of all aspects of medication use.

The administration records required review to include the address of the centre and the dates of birth of service users.

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:
• All Kardex’s reviewed.
• All Kardex’s now include date of birth and address of service.
• Individual medication procedure now in place.

Proposed Timescale: 31/12/2014

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure and arrangements in place to cover the absence of the person in charge required review to ensure that staff covering any absence of the person in charge have appropriate authority and accountability.

Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.
Please state the actions you have taken or are planning to take:
• Regional Manager available to staff by telephone or on site as required.
• Programme Supervisors available to support staff
• A PIC Manager in another service in the region has been nominated to take responsibility for service in absence of PIC

Proposed Timescale: 28/08/2014

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff deployment model and numbers of staff available did not reflect the support needs of service users.
The documented assessed needs of service users did not convey the current level of support required in accordance with changing needs.

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

Please state the actions you have taken or are planning to take:
• Following this inspection a joint assessment with HSE has been carried to review changes in support needs, of individual service users HSE response/action plan expected by 31st December 2014

Proposed Timescale: 28/02/2015

Outcome 18: Records and documentation
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The adult protection policy required review in line with the organisations own arrangements which indicated it was for review in 2012.

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:
• Previous Adult Protection Policy now removed and reviewed Policy (January 2013) in place.
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Information as outlined in schedule 2 as required was not available including evidence of staff qualifications.

**Action Required:**
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:**
- All information as outlined in schedule 2 including evidence of staff qualifications are now contained in each staff file.

| Proposed Timescale: 14/09/2014 |