**Health Information and Quality Authority**
**Regulation Directorate**

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Pilgrim House Community Ltd |
| **Centre ID:** | OSV-0001916 |
| **Centre county:** | Co. Dublin |
| **Type of centre:** | Health Act 2004 Section 39 Assistance |
| **Registered provider:** | Pilgrim House Community Ltd |
| **Provider Nominee:** | Bridget Ann Ryan |
| **Lead inspector:** | Michael Keating |
| **Support inspector(s):** | Florence Farrelly |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 5 |
| **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 ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

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

| From: | To: |
|---|---|
| 30 January 2015 10:15 | 30 January 2015 18:30 |
| 31 January 2015 09:05 | 31 January 2015 13:00 |

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

| |
|---|
| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 05: Social Care Needs |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 14: Governance and Management |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

**Summary of findings from this inspection**

This inspection was to follow up on the actions generated from recent inspections which took place on the 5 November 2014 and the 17 December 2014. During the November inspection, 15 outcomes were found to be non-compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. While improvement was recognised during the follow up inspection on the 17 December, the Authority remained concerned in relation to the levels of ongoing noncompliance. As a result, this monitoring inspection was scheduled in order to assess progress.

Day one of this inspection was announced, as part of the inspection three members of the workforce were interviewed in-depth including the person in charge and the provider. The inspectors returned unannounced on Day 2, the main reason for which was to interview the remaining two members of the workforce who were rostered for duty that day. However, when inspectors went to the centre the provider informed them that due to an emergency the two staff members rostered were not available

for duty, the provider and the one remaining staff member were in the centre to provide support to the residents.

While inspectors found evidence of some improvement since the previous inspection, inspectors were not satisfied that the provider had demonstrated suitable progress overall to ensure ongoing compliance with the Regulations and Standards. Improvement had been identified under the outcomes of healthcare, communication, social care needs and safeguarding and safety. Little or no changes to the oversight of the safety and quality of the service resulted in non compliances remaining across many outcomes. The outcomes of governance and management, medication management, records and documentation (policy implementation) and workforce remained in major noncompliance.

Detailed findings across all areas are discussed under twelve outcome headings within the body of the report and in the action plan at the end of the report.

Subsequent to the inspection the Authority received notification from the provider indicating their intention to close and cease operating as a designated centre.

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

**Findings:**
While some improvements were noted in relation to this outcome, inspectors found there was non-compliance overall relating to a lack of an effective complaints policy as there was no independent objective person available to residents or their representatives.

Some of the actions since the previous inspection were addressed and provided evidence of some positive changes, such as:
- resident meetings at the beginning of each week were held and documented, and residents' opinions were sought on how they would like to spend their week
- there was greater choices offered in relation to daily activity, routines and practices
- progress had been made in relation to accessing day care services for two of the residents
- intimate care guidelines had been developed for all residents
- individual bank accounts had been opened for all residents, and there was a clear policy on the management of residents finances

Inspectors found that the management of complaints was still in need of improvement in order to be compliant with the Regulations. Since the previous inspection, a copy of the organisational complaints policy was now on site and accessible to staff. While this policy was now available for inspectors to review, the practices in relation to this policy were not clear. For example, the policy described the person who handled a complaint as a complaints officer however, it was not clear who the nominated person to deal with all complaints for the designated centre was. The policy referred to a relative of one of the residents as being the 'independent complaints officer' who dealt with all complaints.

Due to clear conflicts of interest, as a relative and also chairperson of the board of management, the choice of person could not ensure impartiality or an independent person to deal with complaints

Overall inspectors found that further improvements were required in relation to this outcome, and the providers response to the action plan had not been fully implemented.

**Judgment:**
Non Compliant - Moderate

**Outcome 02: Communication**
*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspectors found that the actions identified in the last action plan had been met in order to ensure that individual communication supports required were clearly documented in each resident's personal plan.

Since the last inspection residents had a 'cognitive assessment' carried out by a psychologist to assess their current cognitive ability and assist the provider and person in charge determine the needs of each resident. The inspectors saw evidence in each residents file that while the residents awaiting the results of these assessments, there was adequate documentation outlining their current communication support needs, based on the provider and person in charges knowledge of each resident.

**Judgment:**
Compliant

**Outcome 03: Family and personal relationships and links with the community**
*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The action identified in the previous inspection report had been satisfactorily implemented to ensure that the residents personal plans now identified residents wishes in relation to access to the wider community as best as possible.

Residents had regular access to family, and their plans provided evidence of consultation with family. Activity reports also reflected increased access to the wider community. There were also longer term plans to provide for access to day services for some residents in other disability services, and funding had been secured in recent days for two residents to access a day service for up to 3 days per week.

**Judgment:**
Compliant

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

**Findings:**
Inspectors were satisfied that residents' social care needs were now being identified in the designated centre. Personal plans were now identifying services and supports to be provided to residents' to achieve a good quality of life and to realise their goals. Some improvement was required to ensure plans and goals were outcome focused and to ensure that each person's goals were individually chosen.

Changes had been made to the care planning documentation that was used for each resident and these changes resulted in a clearly documented plan for each resident. There was evidence of the involvement of residents and their representatives (where possible) within these plans and they did not consider how they enhanced the lives of residents. In general there was one social goal chosen for each resident relating to gardening, meal preparation or exercise. Residents shared one of these goals. In addition, 'social care plans' as they were referred to were in effect reports of activities that had taken place such as day trips or weekend breaks. Subsequent 'social care programme reviews' were again effectively a report on the activity from the perspective of how staff felt the activity benefited the resident.

Overall, while there was significant progress in the 'personal planning process' the documentation referred to activity that had already taken place. Therefore, there was limited evidence of the actual planning for social goal attainment and there was no consideration of how effective the plans were in meeting the needs of residents and to offer them alternative choices should they decide not to participate in what was offered.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Overall it was found that efforts had increased to ensure that the health and safety of residents' visitors and staff was protected and promoted. Associated policies were now in place to guide practice such as a relevant safety statement, accident and incident recording, a policy on the response to emergencies and an infection control policy. In the main, these policies were found to be concise and centre specific. A policy on risk management had also been developed since the previous inspection, and related environmental and individual risk assessments had been developed.

Staff had completed fire safety training and there was a procedure identified for the safe evacuation of all residents and staff. Fire drill were taking place on a regular basis, and personal emergency evacuation plans (PEEP)'s had been developed for each of the residents.

**Judgment:**
Compliant

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspectors were reassured that a number of agreed actions identified in previous inspections in the area of safeguarding vulnerable adults were now in progress. For example, confirmation that a training course in safeguarding vulnerable adults was

booked for early February was provided to the inspectors. In addition, most staff had completed a training course in positive behaviour support in January and the remaining staff member was due to complete this course in February 2015. Policies on restrictive practices and positive behaviour support had also been developed.

An individual guideline had been put in place to provide support to one of the residents who may present with difficult behaviour and this provided clear guidance and was focused upon least restrictive alternatives. This documentation had changed since the previous inspection and was now written in a very person-centred way, focused upon encouraging a supportive environment to this resident.

There was a policy developed on personal care which was centre specific and provided guidance to staff on developing intimate care plans and in following best practice in relation to supporting resident's personal care requirements. Individual care plans had been completed, which provided clear guidance on the personal care support requirements of each individual and focused upon supporting independence in this regard.

**Judgment:**
Compliant

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors were satisfied that the actions identified in the previous inspection report had been fully addressed under this outcome.

Inspectors found that residents had good access to a general practitioner (GP) and evidence was found indicating residents had attended specialist consultants in acute services. This included the follow up medical treatments in specific areas such as diabetes and epilepsy since the previous inspection. Health care plans now documented clear guidance for staff in relation to any health care interventions or supports required.

In general, it was identified that residents were medically well and therefore did not require the support of medically trained practitioners on a day to day basis. However, inspectors remained concerned that staff did not receive any specific training or guidance on specific health conditions that residents had in areas such as blood glucose monitoring (This non compliance is actioned under Outcome 17: Workforce).

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

**Findings:**
This outcome remained as a significant concern to inspectors as it remains in major noncompliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (children and Adults) with Disabilities) Regulations 2013. Additional noncompliances under this outcome were also identified during this inspection relating to the transcribing of medication and persistent drug errors relating to an inconsistency between prescribed dosages on prescriptions, and the amounts administered. Some medications reportedly given to residents by staff had also not been signed for, and inspectors also witnessed the administration sheet being signed hours after medications had been administered.

The nominee provider transcribes medication onto a page which outlines the time, dose and name of the medication to be administered. This related to changes to units of insulin prescribed for one resident, where the provider was guided by nursing staff from an acute hospital over the phone. This practice is not outlined in their policy on medication management and was not outlined with recognised best practice. In addition, one resident's prescription was out of date as the prescription on file, used to guide the practice of administration was dated 23 April 2014.

In summary, medication management practices were poor and the policy which was implemented in January 2015 was found not to be guiding practice in the following areas:

- transcribing of medication
- use of out of date prescriptions
- dosage not matching prescribed dose
- post-signing administration of medications

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

**Findings:**
Inspectors found that there was a lack of effective management, supervision or systems in place to support and promote the delivery of safe, quality care services. While they had now proposed a revised management structure, nominating a separate provider and person in charge, there remained a lack of oversight as these persons were effectively operating as staff members, management and board members.

The person in charge had begun the process of removing herself from the position of chairperson of the board, and had asked a parent of a resident to undertake this role. Some discussion had also taken place between the provider and person in charge in relation to identifying other persons to sit on the board. However, the inspectors remained concerned as to the reliance upon a small number of people effectively carrying out all of the roles with no effective oversight or lines of accountability or authority in practice. While some improvement was identified in relation to the running of the centre, as identified within this report, findings from this and previous inspections leave the inspectors with significant concerns in relation to the ongoing governance and management of the centre.

As identified during the previous inspection(s) the person in charge remained without a vetting disclosure on file as required under Schedule 2 of the regulations. The previous action plan stated that this would be in place by the 31 January 2015. This had not been achieved for her or for 3 of the remaining 4 staff members.

The person in charge and the provider demonstrated an understanding of their statutory responsibilities and showed a good awareness of the regulations. The person in charge did not hold any relevant qualifications as required within the Regulations.

**Judgment:**
Non Compliant - Major

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The previous inspection had identified that there was insufficient transparency in the planning and deployment of resources in the centre. Plans were now in place with evidence provided, that funds were to be separated with increased transparency in the allocation of resources. In addition, residents were now provided with separate, individual bank accounts, and what they were being charged by the centre was now apparent.

However, while it was now clear that many of the residents actually had adequate resources, there was a plan in place to demonstrate how the overall resources were going to be deployed and prioritised to meet the needs of residents.

**Judgment:**
Compliant

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

**Findings:**
This centre operates as a community and did not refer to themselves as staff, with residents and support staff living together for more than twenty years. However, as was highlighted during the previous inspections, this is a designated centre and therefore subject to all of the conditions of the Regulations. As referred to previously, the centre continued to operate without basic safeguarding procedures such as Gardá vetting which was a major concern to the Authority. During the previous inspection documentation was provided to show that all staff had applied for vetting disclosures and the person in charge remained confident that they would be in place by 31/01/2015. However, as of the 31/01/2015 a vetting disclosure had only been obtained for one of the 5 members of the workforce. A file was now in place for each member of the workforce as required by Schedule 2 of the Health Act 2007, however, there were no references provided for some of the staff.

There had been no attempts to provide education and training to the workforce in order to meet specific needs of residents. For example, no staff had any related qualifications and while there was a plan in place to provide mandatory training for all staff in the coming months, there was no training plan in place to meet specific needs of residents in areas such as health care and medication management as identified on previous inspections.

There was a staff rota operating which identified who was in charge at any given time. There was no record of any supervision of staff based upon their community ethos however, this has contributed to a lack of accountability for care and did not identify areas where staff could improve practice.

Staff knowledge of residents was demonstrated as all staff had an intimate knowledge of each one of the residents. It was also determined that there was consistency within the care provided to residents, as three staff were on duty at all times from a pool of five and they were all well known to residents.

**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
It was identified that the actions from the previous inspection(s) had been addressed in relation to policy development and maintaining records in relation to each resident as specified in Schedule 3 of the Regulations. Policies and procedures as per Schedule 5 of the Regulations were now developed. However, as had been highlighted elsewhere in this report, policies were found to be not informing practice in areas such as medication management. Other policies were not providing clear guidance, such as the lack of access to independent person to investigate complaints, within the complaints procedure. In addition, inaccurate or misleading information was contained in the admissions policy which was highlighted to the person in charge and provider during the inspection.

**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:*

Michael Keating
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Pilgrim House Community Ltd |
| **Centre ID:** | OSV-0001916 |
| **Date of Inspection:** | 30 January 2015 |
| **Date of response:** | 25 February 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:**
There was no independent objective person available to residents to deal with their complaints.

**Action Required:**
Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not

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

involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

**Please state the actions you have taken or are planning to take:**
Given our recent decision to cease operations we did not find anyone to fill this role for a number of months so our current complaints officer will continue to fill that role until the point of closure.

**Proposed Timescale:** 01/02/2015

**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:**
Reviews of the planning process do not assess the effectiveness of the residents' personal plan.

**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:**
The 'staff', residents and their families have been deeply involved (and will continue to be) in assessing the effectiveness of each person's plan as they take into account enormous changes in each individual's life right now, given our decision to cease operation. Great sensitivity is being shown to each individual and the effects of these changes are being closely monitored.

**Proposed Timescale:** 02/02/2015

**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:**
There were unsafe medication practices identified relating to transcribing medications, use of out of date prescriptions to guide administration, inconsistencies in dosage and administrative drug errors (post signing for medications administered).

**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:**
1. Transcribing sheets have now been rectified.
2. Prescriptions in question have been rectified by the GP and copies ordered for our files.
3. Inconsistencies in dosage have now been rectified.
4. Current practice ensures that there is no post-signing for medications administered.

**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:**
The person in charge did not hold the appropriate qualifications and did not demonstrate an adequate skill base to meet the specific needs of residents.

**Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
Due to the evolving situation the organisation does not foresee any change in this in the next number of months.

**Proposed Timescale:** 31/08/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some of the information in relation to Schedule 2 of the Regulations was not in place for the person in charge.

**Action Required:**
Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

**Please state the actions you have taken or are planning to take:**
1. Documentation re: appropriate qualifications not in place and do not foresee any change in this in the next number of months.
2. Garda clearance now in place.

**Proposed Timescale:** 30/01/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was a lack of oversight within management systems to ensure the service is being effectively monitored.

**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:**
There will be no further actions in this regard as the next number of months will be focussed on the transition process which requires much management, time and focus (as per Plans submitted to HIQA).

**Proposed Timescale:** 31/07/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no attempts to performance manage members of the workforce and the system that had been put in place did not provide for professional accountability and guidance.

**Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
Again there will be no further action on this given our decision to close. However, everyone will be working to ensure that the highest standards of care consistently in operation in the centre over 25 years will continue to be there and that will be evidenced as well in the sensitivity with which the transition process is dealt with.

**Proposed Timescale:** 31/07/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff files did not contain all of the documentation as required by Schedule 2 of the Health Act 2007.

**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:**
1. The central issue in our decision to close is that there have never been any staff in our organisation, we are volunteers. After much work in meeting standards in the past eight months we sadly, came to the view that our voluntary ethos is no longer compatible with the current regulatory framework. Hence, we will not have any more information in the 'staff' files.
2. Garda clearance is in place for three of the four 'staff' and the final clearance is currently being processed.

**Proposed Timescale:** 31/08/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no supervision systems in place which resulted in a lack of accountability and authority within the centre.

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

**Please state the actions you have taken or are planning to take:**
This non-compliance once again highlights the issues to do with being a staff vs voluntary model. We have always been accountable to the HSE and to the families and indeed to one another but this 'system' of accountability does not fit into the current regulatory framework. However we will continue to be accountable to the HSE, the families and to HIQA as we move through this transition process to the point of closure.

**Proposed Timescale:** 31/07/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not provided with access to suitable training to meet the assessed needs of residents in areas identified such as meeting specific health care needs, person centred planning and medication management.

**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:**
As we are ceasing to operate there will be no further training in the next number of months.

**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:**
While policies and procedures as listed under Schedule 5 of the Regulations had been prepared in writing, there was evidence to suggest that some were not implemented in practice as identified within under this outcome.

**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 is now guiding practice in relation to Medication Management.

**Proposed Timescale:** 28/02/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inaccuracies were found within the policy on admissions which referenced the support of another organisation in their admission procedures which could not be substantiated.

**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:**
This reference to the support of another organisation in the Policy on Admissions has been removed.

**Proposed Timescale:** 11/02/2015