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 Health Service Executive
Centre ID:	OSV-0002452
Centre county:	Monaghan
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Kevin Carragher
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	10
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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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

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

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

Summary of findings from this inspection

The designated centre consists of two community houses, one on the outskirts of Monaghan and one in a rural location between Monaghan and Ballybay. The designated centre is operated by the Health Service Executive (HSE) and has capacity for 10 residents, both male and female. This inspection was carried out in response to an application by the registered provider to the Authority for registration of the centre under the Health Act 2007. This inspection is the second inspection of the designated centre and by the Authority and was facilitated by the person in charge. The provider nominee, nominated the regional head of nursing to receive feedback from this two day registration inspection on his behalf.

The inspector reviewed pre-inspection questionnaires received by the Authority, met with residents, staff and relatives, observed practice, reviewed documentation and assessed progress with completion of the action plans developed from findings of the last inspection in June 2014. The feedback obtained from residents and relatives was, in the main, positive and satisfaction was expressed with the services and care provided with some exceptions as discussed in the body of this report. The inspector observed that staff engaged with residents positively and respectfully on the days of inspection.

Compliance with the legislation was found in five of the eighteen outcomes and substantial compliance in a further three outcomes. Outcomes in substantial compliance referencing minor non compliance with the legislation were identified in relation to communication, medication management and staff education. Moderate non compliance was identified in the remaining ten outcomes, which included residents rights, dignity and consultation, contracts, the social care needs of residents, premises, health and safety and risk management, safeguarding and safety, notification of incidents to the Chief Inspector, the review of the safety and quality of care of residents, governance and management and records and documentation.

While the inspector found that improvements had been made since the last inspection in June 2014 for example, in medication management, staff training and some work had been completed on securing the perimeter of one community house. Action plans not satisfactorily completed were restated regarding contracts for services between residents and the registered provider, notifications to the Authority, staff training, the review of the quality and safety of care provided, care planning and premises including the safety of the external grounds. Whilst residents had person centered plans in place, the inspector concluded from findings that some residents' goals were not sufficiently developmental and personal plans were not fully reflective of involvement from the multi–disciplinary team.

The two houses comprising the designated centre premises required review to ensure residents had access to external safe areas including gardens, the layout and design posed significant accessibility difficulties for some residents due to a deep stairway and uncontrolled vehicular access to a car park located at the back of the community house. In addition, risk mitigation controls in place to protect some residents from risk posed by high level windows impacted negatively on other residents' rights. The privacy and dignity needs of one resident were not assured as a result of an absence of appropriate and suitable en-suite facilities.

The action plan at the end of this report identifies the areas requiring improvement by the provider/person in charge is required to take 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.

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:
The inspector found that residents were involved and consulted about how the designated centre was run. Residents were seen by the inspector to be involved in preparations and in decorating the houses for Halloween on the days of inspection. One resident was assisted to decorate a pumpkin by a staff member, which was displayed on completion. Another resident assisted staff with making pumpkin soup in one house while a resident in the second house was observed by the inspector mixing pastry for an apple pie. There was also evidence that residents were involved in going grocery shopping and menu planning for the community houses with staff. Another resident was facilitated to continue to independently visit family in another part of the country as she did prior to residing in the centre. The inspector reviewed pre-inspection questionnaire feedback from residents and their relatives and spoke to residents and some relatives on the day of inspection. This feedback confirmed that residents were supported to make choices and have control of their daily life.

There was advocacy services available for residents and the details were made available. The inspector found that many residents experienced significant documented communication difficulties. The person in charge confirmed that accredited advocacy services were consulted on behalf of residents and to date residents had required the service. The person in charge and staff told the inspector that they and residents' relatives advocated on residents' behalf when necessary in the first instance.

Assessments of capacity informed the support that residents received including with their personal finances. For residents who were deemed not to have capacity, their

representatives were consulted regarding their finances. As observed on the last inspection of the designated centre in June 2014, staff supported residents where possible to manage their day to day finances. They consulted with their next of kin in relation to details of personal expenses to fund their social activities including shopping trips where necessary. There were procedures in place to guide staff on practices undertaken in the management of residents' finances including daily checks of balances as a safeguard. A record of residents' personal possessions was maintained as seen on the last inspection in the centre in June 2014. Findings on the last inspection supported residents were encouraged to sign a record of their property and possessions. Signatures and dates were missing from some residents' property records reviewed in June 2014 and as such was the subject of an action plan which was satisfactorily responded to by the provider. All residents furnished their own bedrooms. The person in charge stated this was the choice of the residents and their next of kin. However, some information in relatives' pre-inspection questionnaires did not support this information. There was reference to some residents' accommodation being unfurnished or containing unsatisfactory communal furniture on initial viewing of the houses by residents. The inspector was told by the person nominated to receive feedback on behalf of the provider that current furnishings were provided as a result of resident and next of kin choice and all furnishings including communal furnishings provided by residents or their next of kin remains their individual property and is recorded as such. There were facilities available for residents to launder their own clothes if they wished. No residents undertook this activity.

A policy was in place informing the management of complaints in the designated centre and was reviewed on 17 September 2014. The procedure was displayed in accessible format in both houses. While copied in the residents' guide document, it was not in accessible format. There was a record of complaints maintained and the inspector reviewed a sample of complaints and found that the details of the investigation process lacked detail in some cases. In addition, the complainant's satisfaction with the outcome of the complaint was not consistently ascertained. Residents' right to express any areas of dissatisfaction with the service provided was communicated to them on a one to one basis as stated by staff and confirmed in the residents' records reviewed. There were arrangements in place for independent review of complaints if required within the organisation in the first instance and included details of the ombudsman services as an additional avenue for appeal. The name of the ombudsman was incorrectly referenced in the residents' guide document. Relatives stated that they would make a complaint if dissatisfied to the person in charge and while most relatives expressed satisfaction with this process, not all were satisfied that they were always listened to or that their views on behalf of the resident was adequately addressed. However, relatives also stated that they were satisfied that if they had to make a complaint that it would be dealt with without adverse effect on the resident.

Residents had access to television and radio. Staff-resident interactions were observed by the inspector to be dignified and respectful on the days of inspection. Each resident had their own bedroom and therefore were provided with their own private area. Findings in relation to;
- respect of one resident's privacy and dignity
- limitations of access placed on some residents due to the design and layout of one community house and unsafe external areas and

- restrictions posed on some residents to protect others in relation to freedom to open windows in bedrooms and some communal areas in one house;
were not of an adequate standard on the last inspection in June 2014. On follow-up of progress with the action plans referencing these findings on this inspection, the inspector found that work was in progress. Work underway included progress with installation of an en-suite shower and toilet facility to ensure the privacy and dignity needs were met of one resident currently using a facility off a utility room for personal care and hygiene. This arrangement required the resident concerned to pass through the communal kitchen to carry out personal and hygiene activities. Installation of a gate to provide safe access and prevent vehicular access for parking at the back of one community house was planned but not in place on the days of inspection.

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):
No actions were required from the previous inspection.

Findings:
The designated centre had a communication policy to inform practice in relation to residents with communication difficulties. Residents' personal plans referenced assessment of their communication abilities and identified areas where assistance and support was required to ensure needs were met in this area. The inspector found that residents had varying levels of verbal communication skills. While, some documentation of interest to residents was in an accessible format for example, the complaints procedure, not all documents in place to inform residents were accessible. For example, personal support plans were not fully accessible and the residents' guide document was not in accessible format. However in the absence of adequate accessible format documentation, the inspector found that residents with communication difficulties were supported by staff to communicate utilising methods which promoted their independence and autonomy. For example, use of photographs of dishes on the menu to inform and promote choice, a communication board in communal areas and one to one information giving sessions. The inspector found that while staff were skilled in interpreting gestures and sounds made by some residents, this information was not documented to promote and assist independent meaningful interactions for residents with persons less familiar with their individual communication strategies.
The inspector observed that residents had access to speech and language therapy services. There was documentation to support that residents availed of this service.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
Relatives spoken with by the inspector and who provided feedback in the Authority's pre-inspection questionnaires stated that they were always made to feel welcome in the designated centre. There was a policy available to inform practice in relation to visiting residents and a record of all visitors was maintained as a safeguarding measure. Residents were facilitated to meet their visitors in private if they wished. Visitors were observed on the last inspection of the designated centre to join in with having refreshments with the resident they were visiting. Many relatives also commented on the community houses as being an extension of their families and that they felt their input into the lives of the residents was encouraged and in generally fostered by staff.

The inspector observed from review of residents' personal plans and their feedback in residents' pre-inspection questionnaires that maintaining family contact and spending time with family in their homes was of great importance to them. Many residents went home to the care of their family at weekends or visited for periods during the day. Some residents had daily telephone calls with family members built into their routines and telephone contact was observed by the inspector to be also encouraged at times where family visits could not take place.

Residents were supported by staff to engage in activities in the community. The inspector observed from daily progress notes that residents attended local religious services, bingo and other community occasions. The inspector also observed where one resident was facilitated to go back to the area they lived in as a child and maintain past friendships.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There was a policy available informing admission of residents to the designated centre. Relatives provided feedback that the experience of residents to transition to community living in the houses was satisfactory with opportunity to visit the houses before their final decision to move was taken. However, some relatives of residents said there was inadequate consultation in the transition process with predetermined allocation of accommodation to some residents and subsequent unsatisfactory access to senior decision makers to discuss same. There were no residents in transition to community living on the days of inspection in either community house in the designated centre.

The inspector was told that contracts for the provision of services were in the process of development and viewed documentation available consisting of an agreement of fees to be paid by residents. No details were included outlining additional fees payable by them. While the inspector observed that the significance and content of this document was explained to residents, it did not reference the terms and conditions of their residency. Residents co-signed this document in most cases with a family member.

Judgment:
Non Compliant - Moderate

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:
The inspector reviewed a sample of residents' personal support plans in both houses and found that each resident had a personal plan in place which was completed in consultation with them where possible and/or their significant others. The personal plans reviewed reflected assessment of residents' needs annually with review on a six monthly basis, which informed the annual review process. The inspector observed that areas where residents had support needs were identified using a risk assessment framework process. This assessment process included evaluation of risk in the areas of self, others, property, out in the community and to health with stated concomitant care and supports to be implemented by the service to ensure each resident's holistic needs were met.
Each resident had personal goals developed, derived from their annual personal planning meeting. Personal planning meetings were convened with the resident, significant other, day programme lead and key or/and associate workers. However, documentation did not adequately support that this annual forum was always representative of the multidisciplinary team, for example, where actively involved in residents' care, their GP or dietician did not attend annual review forums. The dietician was not referenced as attending the review meeting of a resident on a weight reducing diet initiated by their service following referral.

Progress with achievement of goals was reviewed on a monthly basis. The inspector found that not all personal goals agreed with residents were achievements to aspire and work towards. Some areas identified as goals did not reference areas for residents to aspire towards as they were already part of their routine. For example, one resident's goal was to continue visiting and staying overnight with family however; this activity was documented as being well established with strong family supports in place. In addition, some resident goals were documented in broad terms and were not sufficiently narrowed down in achievable terms or in terms to enable measurement of progress. For example, one resident's goal was stated as 'continue to access amenities' and 'attend new places and new activities'. Progress notes referenced that this resident had accessed many amenities and had participated in new activities. However, there insufficient evaluation done to indicate how many amenities or new activities would need to be accessed to satisfy achievement of this resident's personal goal. Therefore, in the absence of meaningful developmental goals, some residents' personal ambitions were not sufficiently supported to enable them to function at or work towards reaching their potential in all aspects of their lives by the service.

Apart from day programmes residents enjoyed day trips supported by staff, attending local social events, cinema, eating out, home visits and swimming among numerous other events. The inspector found from communicating with residents and from review of their documentation that great personal enjoyment was gained from engaging in socialisation activities and living in a community setting.

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

Findings:
The designated centre consists of two community houses, one located on the outskirts of the town of Monaghan and the other in a rural setting between Monaghan and Ballybay. Both houses had accommodation for five residents over two floors. One house is a dormer style bungalow and the other house is designed as a split-level two storey premises. As found on the last inspection of the designated centre in June 2014, both community houses required review to ensure they were suitable for their stated purpose in terms of design and layout to meet the needs of some residents currently residing in these houses.

The first community house is the home of five female residents and has one staff sleepover room. All residents' bedrooms have en-suite toilet, shower and hand basin facilities with the exception of one resident's bedroom. The resident in this bedroom was required to use the only other toilet and shower facility in the house which was located off the utility room accessed through the communal kitchen/dining area. This arrangement did not meet the privacy and dignity needs of this resident. In addition, this resident had expressed dissatisfaction with same as documented in her personal support plan and highlighted same in pre-inspection questionnaire feedback. This finding was the subject of an action plan from the last inspection of the designated centre in June 2014. The inspector found on this inspection that structural reconfiguration plans were in place to install an ensuite but work had not commenced to date. As such this resident continues to be subject to an unsatisfactory arrangement in relation to meeting her personal and hygiene needs. The perimeter of the site was securely fenced. However, part of the garden area available for use by residents was not of a satisfactory standard and posed a risk of injury to residents in its current state due to an uneven surface which had deep holes in it masked by overgrown surface vegetation.

The second community house is a split-level building, accommodating five residents over two floors. Findings on the days of this inspection supported ongoing negative outcomes for some residents from limitations imposed on their independence due to the layout

and design of this house. Communal day-time accommodation and two residents' bedrooms were located on the upper floor level and as such windows to the back and side of the building are located at a high level up from the surrounding exterior ground surface. These windows were locked with the exception of one window located over the kitchen worktop, access to which was exclusively controlled by staff during the last inspection of the centre in June 2014 and during the days of this inspection. These windows were locked as a control to protect some residents and as such impacted on the freedom and of others to control opening of their windows. This finding is discussed further in outcome 8. There was evidence of plans for installation of a gate to close vehicular access to the back of the community house and in doing so, provide a safe outdoor area for residents.

The inspector saw where two residents were given keys to promote their access to the community house and to lock their bedroom doors if they wished. Two resident's bedrooms on the lower floor level and one bedroom on the upper floor level have en-suite shower, toilet and hand washing facilities. A communal toilet/shower facility on the upper floor level was provided to meet the needs of residents without access to en-suite facilities in their bedrooms.

Inspectors saw that the communal areas in both community houses were well decorated in a domestic style, in good repair and were homely with photographs of residents displayed. Residents' bedrooms were personalised and decorated to suit their individual preferences. Some residents used their own money to furnish bedrooms and en-suites to their own tastes and choose to sleep on a double or single bed. Each resident had their own bedroom in both community houses. There was evidence that equipment was serviced and maintained at appropriate intervals.

As part of the application for registration documentation, the registered provider submitted a declaration from a suitably qualified person with experience in planning and construction stating that the premises is in compliance with all statutory requirements relating to the Planning and Development Act 2000 – 2006.

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

Findings:

The inspectors found that improvements were required to ensure the health and safety of residents, staff and visitors was satisfactorily promoted and protected in the designated centre on the days of this inspection. On the last inspection of the designated centre in June 2014, health and safety was informed by an organisational policy which was overdue for review, dated 2009 and as such was the subject of an action plan. The inspector found on this inspection that there was a corporate risk statement dated 2014 which informed a safety statement for the region and for the designated centre dated 15 October 2014.

The risk register was found to be incomplete on the last inspection and an action plan to address deficits was forwarded by the Authority following same. Deficits in identification of all potential hazards to residents' safety with concomitant controls to mitigate risks were incomplete on this inspection. Specific unassessed risks highlighted on the last inspection were in the most part assessed with plans to enhance controls at an advanced stage. However, the inspector found that although these risks were assessed, some controls to mitigate same were not satisfactorily implemented and included;
- car parking at the back of one community house continued on the days of inspection while risk assessment confirmed risk was present to residents, no action was taken on the days of inspection to eliminate car parking arrangements at the back of the centre pending installation of a secure gate to a measure to protect the area for residents in the interim,
- there was a heavy algae growth on part of the ground surface at the back of one community house on the route to the garden, the inspector was told that due to inclement weather conditions residents did not tend to access this amenity during winter months.
- risk posed by high level windows on the back of one community house was assessed as 'high' with controls in place and as such required review to ensure risk was sufficiently mitigated. The inspector found that a resident in one community house climbed onto the kitchen worktop three times between 18 August and 05 September 2014 and successfully disengaged a window lock on one occasion.

In addition new unidentified risks found on this inspection included but were not limited to risks posed by;
- an uneven garden surface, masked by overgrowth of surface vegetation
- a damaged manhole cover to the front of the centre
- an area at the top of the stairway in one community house was dark with reduced visibility in the absence of artificial light,
- uneven floor levels from the first floor onto a concrete back stairway did not have adequate alert notification displayed in an area of reduced visibility.

Although, each resident was assessed by a physiotherapist as having capability to access the deep descending stairs, some residents could not do so safely without supervision of staff at all times.. As staff supervision 'at all times' was required for safe use of the stairs by some residents, the stairs negatively impacted on their freedom to independently access all areas of the house including access to a safe external area. This finding is discussed further in outcomes 1 and 6.

Policies absent on the last inspection to inform management of residents at risk of leaving the centre unaccompanied and residents who engaged in self harm activities

were since developed and were available on this inspection. The policy on missing service users was implemented on 19 September 2014. Residents at risk of leaving the centre unaccompanied had profiles completed to assist emergency services to expedite their safe recovery.

A policy document informing fire safety prevention and management was dated March 2011 on inspection in June 2014 and has since been reviewed to accurately inform emergency fire procedures in response to an action plan forwarded by the Authority to the provider. Annual staff fire safety training was carried out and fire evacuation drills were completed on a three monthly basis. Fire drills had been completed to ensure staffing was adequate to assist residents' safe evacuation at night time. Fire exits were clear and procedures were in place for residents, staff and others to evacuate the building if necessary. However, directional signage was not adequate on the first floor of one community house. The inspector observed that signage displaying the direction of emergency exit was not visible on exiting some residents' bedrooms on the first floor. Fire equipment was serviced as required. Each resident had a personal emergency evacuation plan. The inspector observed where a ski-pad was put in place for one resident to expedite their safe evacuation and arrangements were in place for ready access to same if required. The inspector observed installation of break-glass key boxes located adjacent to fire exits, missing on the last inspection in June 2014 to open locked external doors. The inspector saw evidence where residents participated in fire training with staff.

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

Findings:
The designated centre has a policy in place informing the protection of vulnerable adults with a disability, dated January 2014. Additional supports available to residents in the event of an allegation or suspicion of abuse such as social work and advocacy services were documented in the policy since the last inspection in June 2014. The inspector

confirmed that all staff had received training in the prevention, detection and response to abuse of adults with a disability and staff spoken with by the inspector were aware of the appropriate action to be taken in the event of an allegation or suspicion of abuse. The inspector was informed by the person in charge that there had not been any allegations of abuse in the designated centre. Residents and relatives confirmed in the Authority's pre-inspection questionnaires that they felt safe. Residents spoken with on the days of inspection also confirmed their feelings of safety.

The centre maintained a restrictive practice record. Review of PRN (as required) psychotropics used for episodes of residents' agitation required improvement in terms of documentation of evaluation of appropriateness and recording of alternative proactive mechanisms used to de-escalate behaviours before administration. There were instances where physical restraint and environmental containment was intermittently utilised with residents exhibiting behaviours that placed them or others at risk of injury. The inspector found that appropriate reviews were conducted following the implementation of these practices to ensure that they were in line with best practice and utilised when all other less restrictive strategies were exhausted or were deemed ineffective. A policy was available which was reviewed since the last inspection and dated 22 September 2014 to inform restrictive practices. Behavioural management guidelines dated 12 June 2014 were also in place to inform practice and staff had received training in PMAV (Professional management of aggression and violence). Positive behavioural support plans were in place for residents who presented with challenging behaviours informing proactive and reactive strategies for these residents. This documentation evidenced improvement since the last inspection in June 2014. Equipment recommended for use in the event of an incident was identified in assessment documentation as a buffer/protective tool. The risks associated with use of this equipment were assessed with documented controls in place including staff training on appropriate use of this equipment.

Findings in relation to limitations on free access by residents to all parts of their home and to a safe outdoor space were also the subject of an action plan from the last inspection. There was evidence that locking of a door between two floor levels on the last inspection in one of the community houses had been reviewed and ceased with alternative arrangements in place including additional staff supervision.
Upper floor windows in bedrooms and communal areas were permanently locked in one community house as a control to protect some residents. However, there was no documentation to support that the impact of this measure on the freedom of other residents had been reviewed or that this arrangement was to their satisfaction.

Judgment:
Non Compliant - Moderate

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

Findings:
The inspector reviewed the incident/accident log and observed that all notifications of accidents to residents were complete. All incidents of environmental and physical restraint were notified. The inspector observed incidents of environmental containment recorded in residents' documentation and use of PRN psychotropics to manage agitation not recognised as restraint and notified in completeness as required by Regulation 31.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
All residents in the designated centre were at home in both community houses they resided in on the days of inspection. The inspector was told that all ten residents from the two houses in the designated centre attended day activation services, occupational and educational programmes. Residents were supported by staff to engage in activities that reflected their capabilities and interests. The community houses each had designated transport vehicles. Some residents were transported on transport from the day service they attended. The inspector observed that residents enjoyed attending their day programmes and these programme provided a structure to the residents' day. Residents' documentation reviewed by the inspector supported where staff worked to ensure residents were facilitated and empowered to attend these services.

As discussed in outcome 5, there was evidence in residents' documentation, feedback in pre-inspection questionnaires completed by residents and relatives and from residents spoken with on the days of inspection that they had busy social lives and were facilitated to experience and enjoy new and varied activities to meet their interests and capabilities.

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

Findings:
The inspector found that the healthcare needs of residents reviewed on the days of this inspection were generally met. Residents were facilitated to attend healthcare outpatient specialist appointments in acute service facilities, GPs and allied health specialists, assisted by staff or by family members. GP and allied health professional consultation was facilitated in the GP surgery/local health centre. Residents' documentation referenced appropriate referral for routine health monitoring and care for episodes of acute illness.

A risk based assessment framework was in use to identify residents' needs which required support and intervention by staff to mitigate potentially negative outcomes from non addressed needs. The risk assessments informed interventions and supports to be provided by staff, the service and additional/adaptive equipment in response to individual levels of capability and safety awareness to promote each individuals potential health and social functionality and quality of life. An action plan was forwarded to the provider and person in charge requiring identification of residents' needs with development of corresponding care plans following the last inspection of the centre in June 2014. The inspector found on this inspection that this area although improved in some areas, was not adequately completed. From the sample of residents' care records reviewed on this inspection, the inspector found that all resident had up to date care plans developed. However, some residents did not have corresponding care plans to inform management of some assessed needs. For example, a resident with a skin condition did not have a corresponding care plan to advise staff on interventions to promote management of symptoms. The care plan of another resident with pain required improvement to include reference to use of an accredited pain assessment tool to ensure her pain was effectively assessed and monitored.

On the last inspection, the inspectors found that interventions informed by treatment protocols and policy documents were not consistently reflective of best practice in epilepsy care. On this inspection, the inspector found that this area of care was now satisfactorily managed and informed by individual medication protocols and up to date evidence based best practice information.

Residents were offered a choice of foods that were freshly cooked. The inspector observed a meal prepared for residents and saw that it was well presented and wholesome. Some residents were in receipt of specialist diets. The inspector observed that residents in receipt of modified consistency foods were reviewed by a dietician and appropriately referred for review by a speech and language therapist. One resident with a dental condition impacting on their ability to masticate food was reviewed by dental services every six months. Residents at risk of unintentional weight loss were appropriately monitored and reviewed by a dietician. While staff in both community houses in the designated centre had attended food hygiene training since the last inspection in June 2014, they had not received instruction to inform comprehensive menu preparation for residents with specific dietary requirements. For example, residents at risk of weight loss, constipation and obesity and with diabetes. Individual records of actual dietary intake by residents with specific dietary requirements were not clearly recorded in terms to facilitate comprehensive evaluation of the effectiveness of nutritional interventions in place. Residents ate their meals together and reported that they enjoyed the food provided. Staff were observed supporting residents who needed assistance with eating their meals in a dignified and respectful manner

Residents were supported with health promotion activities including exercise such as going for walks with staff and were offered vaccination for Influenza.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
An approved operational policy advising on medication management practice and procedures in the designated centre dated June 2014 was available on the days of inspection. The medication management policy reflected practice. Review had taken place of inadequate practice found on the last inspection in June 2014 regarding

administration of medication by care staff, in the absence of a policy document or adequate training in medication administration. The inspector found on this inspection that all medications were administered by registered nurses.

The inspector reviewed a sample of prescriptions and medication administration sheets in one of the community houses and found that prescribing and administration procedures and documentation was satisfactory and met required professional and record-keeping standards. Medication stock was checked monthly by staff and medication for return was labelled as such to ensure it was not returned inadvertently to stock. There was no record of medication audits completed by the residents' pharmacist or that a pharmacist of the residents' choice or acceptability was made available to them. None of the residents undertook self-administration of their medications however, there was evidence that residents had assessments completed to ascertain if they were in a position to self-medicate.

The inspector observed staff completing monitoring procedures prior to administering some medications, for example, measurement of a resident's blood glucose level prior to administering medication to control same. Medication was stored securely in the designated centre with each resident's medication individually segregated. There was no refrigerator available dedicated for the storage of applicable medications if required. However, there were no medications requiring refrigeration storage on the days of inspection. There were no medication errors recorded and arrangements were in place for recording and addressing same if necessary.

A weekly audit of PRN (as required) medications was completed; however documentation referencing review of use of PRN psychotropic medications required improvement in terms of assessment of appropriateness. This finding is discussed further in outcome 8.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The statement of purpose and function was available for the designated centre and dated 07 August 2014. It accurately describes the aims and objectives and ethos of the

designated centre and the services provided to residents. However, the statement of purpose was not clearly demonstrated in practice with regard to the layout and design of the accommodation provided for some residents in terms of independent access to safe external areas including gardens for residents and provision of facilities to ensure all residents' privacy and dignity needs are met while carrying out personal care and hygiene activities. This finding is discussed in outcome 6.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
There is a management structure in place in the designated centre at local, regional and organisational levels. The provider nominee is the regional disability services manager with responsibility for services in Cavan and Monaghan. The person in charge reports directly to and is supported by a regional head of nursing who provides support to all persons in charge of designated disability centres in Cavan and Monaghan. There were systems in place to ensure that the service provided is safe and has positive outcomes for residents. The person in charge met with staff in each of the designated centres on a regular basis. The person in charge met with the head of nursing on a weekly basis in addition to day to day telephone contact. The head of nursing met on a regular basis with the provider reporting matters arising in the designated centre. The provider told the inspector that learning from issues arising in any of the designated centres is applied to all designated centres in the region. While meetings were taking place, this process could be strengthened with established minute taking in addition to a forum for the persons in charge to meet at a regional level with the provider nominee.

The inspector found that auditing had commenced to ensure that the quality of care was monitored and developed but was at an early stage. To date, medication management and infection prevention and control procedures were audited in 2014. There was no auditing schedule in place. While audits completed comprehensively captured areas for improvement, some relevant areas reviewed were considered 'not applicable' by the auditor. For example, availability of a medication refrigerator, evidence of a process for

reporting untoward incidents in relation to infection prevention and control. Areas of deficit identified in audits completed had been auctioned and subsequently reviewed by management. The improvement was also confirmed by the inspector. However, there was no quality improvement plans developed to inform how deficits found would be addressed to include actions to be taken, person responsible and completion dates. Annual review of the quality and safety of care was not undertaken to date.

Records of practice procedures such as restrictive practices had been followed up by review to ensure appropriateness and that the least restrictive procedure was utilised for the shortest period of time since the last inspection. However these records did not include adequate review of PRN psychotropic medication administered as required by Regulation 7 (5).

Arrangements to 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 was not in place.

The person in charge is a registered nurse who has responsibility for the service provided in the two community houses in the designated centre. The person in charge commenced in her role within the organisation in 2014 and has worked as a manager of the centre for 14 years. She has completed a postgraduate course in management. She demonstrated sufficient knowledge of her statutory responsibilities and ensured systems were in place to ensure that she could meet same. For example, a number of deficits identified during the last inspection that were the responsibility of the person in charge was satisfactorily completed as found by the inspector. There was evidence to support appropriate escalation through the organisations' management with positive outcomes for residents in terms of safer evidenced based best practice and standards.

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):
No actions were required from the previous inspection.

Findings:
There were arrangements in place for management of the designated centre in the absence of the person in charge. There has been no instances where the person in charge has been absent from the designated centre for more than 28 days. The provider

is aware of the requirement to notify the Chief Inspector one month prior to an expected absence or within three working days in the event of unplanned absence.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
The inspector reviewed the adequacy of resources provided to ensure the effective delivery of care and support was in line with the stated purpose of the designated centre. The inspector found that improvements were required to ensure the service was resourced to meet the needs of each resident residing in the two community houses comprising the designated centre. This finding is discussed in outcome 6.

Staff spoken to stated that the staffing levels available were suitable to meet the needs of residents. Most relatives stated that they felt that the staffing levels were adequate however some stated that additional staff would be beneficial to enhance the quality of life for residents in both houses in the designated centre and day services. The inspector observed where additional staff was scheduled to improve supervision arrangements in the house during the day since the last inspection.

There was transport available to support residents to engage in activities in the wider community. Residents had transport risk assessments completed. The transport vehicle reviewed used by one of the community houses had up to date insurance and was adequately maintained with a current NCT certification of road worthiness which was viewed by the inspector.

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

Findings:
The inspector found there was sufficient staffing available to meet the needs of residents on the days of inspection. Some residents required one to one input to complete recreational activities which the inspector observed was provided. The staffing levels on the days of inspection reflected the duty roster. A staff duty roster was available in each of the community houses in the designated centre, a copy of which was provided to the inspector. On review of same, the inspector found that the day to day nurse in charge was clearly indicated. Times of duty were not entered using a 24hour clock format. No shift lap-over time was available to facilitate comprehensive hand-over of residents' care and progress from one shift to the next. Arrangements were in place for provision of additional staffing resources if required to support residents. A staff member slept overnight in the centre to support the staff member on duty if necessary in one of the community houses in the designated centre.

From the sample of staff records reviewed, staff had received mandatory training in the protection of vulnerable adults with a disability, fire safety and safe moving and handling procedures. Additional training had also been provided in PMAV (professional management of aggression and violence), food safety and hand hygiene. Some staff had completed additional training in medication management, cardiopulmonary resuscitation and completion of a first time manager development programme. Training was required by staff involved in residents' food preparation to ensure the needs of residents requiring special diets to meet their needs as discussed in outcome 11.

Of the sample of staff records reviewed, the information maintained was as required by Schedule 2 of the regulations. While all staff were adequately supervised on the days of inspection, performance management/appraisal of staff had not formally commenced and is discussed in outcome 14. Up to date recruitment policies were available to inform human resource management.

Judgment:
Substantially Compliant

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:
The inspector found that operational policies as required by schedule 5 of the Regulations to inform practice were complete and available to staff and for review by the inspector on the days of inspection. Provision of some of these policies was the subject of an action plan from the last inspection in June 2014.

There was a directory of residents residing in the centre which referenced all required information. A record was maintained of each time a resident did not reside in the designated centre due to over-night stays with family members.

The records as required under Schedule 4 of the regulations were not complete. Records of the food provided for each resident was not maintained in sufficient detail to enable determination whether dietary intake was satisfactory in relation to specialised diets prepared for residents. There was a residents' guide in place in the designated centre. It was not in accessible format but contained required information.

Records as required by schedule 3 of the regulations were not complete in relation to use of PRN chemical psychotropics to modify residents' behaviours including rationale for use and the interventions to manage the behaviour. Some residents did not have a corresponding care plan developed and documented to meet some assessed needs.

As part of the application to register the register provider provided evidence that the organisation was adequately insured against accidents or injury to residents, staff and visitors.

Judgment:
Non Compliant - Moderate

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:

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Regulation Directorate
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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002452
Date of Inspection:	29 and 30 October 2014
Date of response:	06 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:
The privacy and dignity needs were not adequately met for a resident currently accessing a shower/toilet facility through a communal kitchen/dining room and a utility room for personal care and hygiene.

Action Required:

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

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
An ensuite (shower & toilet) facility has now been installed for this resident to ensure that each resident's privacy and dignity is respected on the 12th December 2014.

Proposed Timescale: 12/12/2014

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of the complaint investigation process lacked detail in some cases and the complainant's satisfaction with the outcome of the complaint was not consistently ascertained.

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

Please state the actions you have taken or are planning to take:
Complaints log reviewed for Disability Services in November 2014. All staff instructed to record in detail the complaint made 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.

Proposed Timescale: 31/01/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all documents in place to inform residents were in accessible format.

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

Please state the actions you have taken or are planning to take:
To assist and support each resident at all times to communicate in accordance with the residents' needs and wishes all person centred plans to be reviewed and amended to reflect same.

Residents guide to be reviewed to ensure it is accessible to all residents.

Proposed Timescale: 27/02/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Contract of service provision documentation did not reference the terms and conditions of residents' residency including additional expenses.

Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
Contracts of care have been issued to all residents and their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Proposed Timescale: 27/02/2015

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:
Residents' annual personal planning process forum was not reflective of input from all members of the multidisciplinary team involved in their ongoing care.

Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
An invitation will be extended to all relevant multidisciplinary members for resident reviews with immediate effect.

Proposed Timescale: 03/02/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents' had meaningful developmental goals and some residents' personal ambitions were not sufficiently described to enable them to function at or work towards

reaching their potential in all aspects of their lives by the service.

Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
A review of each residents person centred plan will be conducted which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Proposed Timescale: 27/02/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout and design of one community premises did not meet the aims and objectives of the service and needs of residents due to limitations on access posed by
- a deep descending stairs
- the absence of a safe external area due to vehicular traffic.
- high level windows on bedrooms and in some communal area were permanently locked.

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:
The premises identified as not meeting the aims and objectives of the service and needs of residents due to limitations on access posed by a) the absence of a safe external area due to vehicular traffic the following has been implemented.
1. External wooden fence erected at the rear of the premises to ensure safety.
2. Safeguarding fence and gates erected at the front of the premises to allow residents to independently access front and rear of premises.
B) High level windows on bedrooms and in some communal area were permanently locked. The following has been implemented.
1. Physical risk assessment reviewed and updated on 20.01.15 in relation to locked windows in both communal and bedroom areas.
C) A deep descending stairs. The following as been implemented.
1. Physical risk assessment developed in relation to stairs on 02.01.15
2. Individual risk assessments completed with occupational therapy input and are reviewed on an ongoing basis.

Proposed Timescale: Complete

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate shower and toilet facilities were not provided to meet the needs of one resident residing in the designated centre.

Permanently locked windows in one community house did not facilitate some residents to ventilate their bedrooms or some communal areas if they wished.

Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
An ensuite (shower & toilet) facility has now been installed for this resident to ensure that each resident's privacy and dignity is respected on the 12th December 2014.

Physical risk assessment reviewed and updated on 20.01.15 in relation to locked windows in both communal and bedroom areas to reflect ventilation of rooms.

Proposed Timescale: Complete

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:
Controls stated to mitigate risks were not implemented;
- car parking at the back of one community house continued on the days of inspection while risk assessment confirmed risk was present to residents, no action was taken on the days of inspection to eliminate car parking arrangements at the back of the centre pending installation of a secure gate to protect the area for residents in the interim,

- there was a heavy algae growth on part of the ground surface at the back of one community house on the route to the garden,

- risk posed by high level windows on the back of one community house was assessed as 'high' with controls in place. However, ongoing significant risk continued for one resident and impacted negatively on independence of others.

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:
A secure gate to protect the area for residents has been erected at the front of the premises to allow residents to independently access front and rear of premises.
Algae growth removed and this will be monitored on an ongoing basis.

Proposed Timescale: Complete

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Unidentified and unassessed risks found included
- an uneven garden surface which was also hidden by overgrowth of vegetation
- a damaged manhole cover to the front of one community house.
- an area at the top of the stairway in one community house was dark with reduced visibility in the absence of artificial light
- uneven floor levels from the first floor onto a concrete back stairway did not have adequate alert notice displayed in an area of reduced visibility.

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:
In relation to the unassessed identified the following has been implemented
1. New manhole purchased and replaced.
2. Notice erected to alert residents to reduced visibility in the absence of artificial light. New light ordered for area.
3. Fence to be erected in garden to ensure no access to this area.

Proposed Timescale: 27/02/2015

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:
Review of PRN psychotropics used for episodes of residents' agitation required improvement in terms of documentation of evaluation of appropriateness and recording of alternative proactive mechanisms used to de-escalate behaviours.

Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
All staff advised to record all alternative proactive mechanisms used to de-escalate behaviours before administration of PRN medication with immediate effect. (03.02.14)

Proposed Timescale: Complete

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:
Not all incidents of containment and restrictive practices were notified.

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 notifications for the last two quarters of 2014 re submitted. All staff advised of what is required for notification returns.

Proposed Timescale: Complete

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have corresponding care plans to inform management of all their assessed healthcare needs.

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

Please state the actions you have taken or are planning to take:
All person centred plans to be reviewed to provide appropriate health care for each resident.

Proposed Timescale: 27/02/2015

Theme: Health and Development

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

Dietary intake by residents with specific dietary requirements was not clearly recorded in terms to facilitate comprehensive evaluation of the effectiveness of nutritional interventions in addressing dietary needs identified.

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

Please state the actions you have taken or are planning to take:
Nutritional Training provided to 95% of staff in the centre. Remaining 5% of staff is scheduled for March 2015. All person centred plans reviewed to ensure residents with specific dietary requirements are clearly recorded to facilitate comprehensive evaluation of the effectiveness of nutritional interventions in addressing dietary needs identified.

Proposed Timescale: 31/03/2015

Outcome 12. Medication Management

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that a pharmacist of the residents' choice or acceptability was made available to them.
There was no record of medication audits completed by the residents' pharmacist.

Action Required:
Under Regulation 29 (1) you are required to: Ensure that a pharmacist of the resident's choice or a pharmacist acceptable to the resident, is as far as is practicable, made available to each resident.

Please state the actions you have taken or are planning to take:
Pharmacist for residents contacted on 15/12/15. Arrangements made for the pharmacists to visit on site twice yearly and audit medication management. Pharmacist also available to talk to residents if requested. First site visit on

Proposed Timescale: 18/03/2015

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:
Not all areas of the service were adequately monitored to ensure that the service including accommodation was safe, appropriate to residents' needs, consistent and effectively monitored. Quality improvement plans were not developed to ensure all areas of deficit were addressed.

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:
A management system has been put in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Proposed Timescale: Complete

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements to 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 was not in place.

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:
Clinical Supervision commenced on the 21/01/15 with the person in Charge of this Centre. A plan to clinically supervise all staff has been devised and will commence on 01/03/15

Proposed Timescale: 01/03/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Annual review of the quality and safety of care was not undertaken to date.

Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
Senior Management in consultation with the Person in Charge has devised a system to review the quality and safety of care and support in the designated centre. The centre is currently training in this system and will have a review conducted by 19/03/15

Proposed Timescale: 19/03/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training was required by staff involved in residents' food preparation to ensure they were knowledgeable in food preparation for residents requiring special diets to meet their needs.

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:
Training for remaining 2 staff that is presently on maternity leave has now been scheduled for the 18/3/14.

Proposed Timescale: 18/03/2015

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 records as required under Schedule 4 of the regulations were not complete. Records of the food provided for each resident was not maintained in sufficient detail to enable determination whether dietary intake was satisfactory in relation to specialised diets prepared for residents.

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:
Since inspection 95% of the staff has received nutritional training. The remaining 5% are scheduled to receive this training by 31/03/15.
All person centred plans have now been reviewed and adapted to ensure that records of the food provided for each resident was not maintained in sufficient detail to enable determination whether dietary intake was satisfactory in relation to specialised diets prepared for residents.

Proposed Timescale: 31/03/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records as required by schedule 3 of the regulations were not complete in relation to use of PRN psychotropics to modify residents' behaviours including rationale for use and the proactive interventions to manage the behaviour.

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 records have known been changed in relation to use of PRN psychotropic's to reflect what interventions have been used to manage the behaviour prior to the administration of PRN psychotropic's.

Proposed Timescale: Complete