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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Marie Grimes McGrath
Lead inspector:	Julie Hennessy
Support inspector(s):	Geraldine Ryan; Paul Dunbar; Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	1

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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 January 2015 09:30	13 January 2015 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
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 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

This inspection was the second inspection carried out in the centre in response to unsolicited information received by the Health Information and Quality Authority (the Authority) on 16 December 2014. The unsolicited information related to allegations of poor practice and practices that could constitute the abuse of residents in specific units in the designated centre (Group A).

Group A comprises four interconnecting bungalows accommodating 32 residents. This second inspection focused on the remaining two bungalows in the designated centre. The informant had not worked in either of these bungalows and they were not the subject of any direct allegations of abuse. However, considering that these remaining two bungalows form part of the designated centre and the informant had not worked in either of these bungalows, the Authority deemed it necessary to carry out an unannounced monitoring inspection in the remaining two bungalows.

As part of the inspection; inspectors interviewed a number of staff on duty and reviewed documentation pertaining to the areas of concern. Documentation reviewed included daily notes, communication books, personal plans, risk assessments, nutritional information and documentation pertaining to restrictive practices, medication management and behaviours that challenge. Inspectors observed staff

interactions with residents.

In the two bungalows inspectors found further evidence to support a number of allegations that had been made by the informant and also found during the previous inspection of the other two houses in the designated centre. These related to allegations concerning: failure to provide residents with opportunities to participate in activities in accordance with their interests, capacities and developmental needs; failure to ensure that staff members have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour and; failure to provide a safe environment for staff to raise concerns about the quality and safety of the care and support provided to residents. No further evidence relating to the remaining concerns was found on the day of inspection.

At the close of inspection, a preliminary feedback meeting was held with the provider nominee. The Assistant Chief Executive Officer (A/CEO) attended the HIQA Head Office on 22.1.2015 to receive formal feedback and areas that required improvement were discussed at that meeting. These included issues as discussed in the body of this report and in particular, major non-compliances as identified under Outcomes 1: Residents' Rights, Dignity and Consultation; 5: Social Care Needs; 6: Safe and Suitable Premises; 8: Safeguarding and Safety; 14: Governance and Management and 17: Workforce.

The Authority acknowledges that since a meeting between the Authority and the provider on 22.12.2014, the provider has taken a number of steps to address the concerns received and to demonstrate responsiveness. For example, the provider has engaged with the Authority and has submitted an action plan to address the non-compliances identified in the previous inspection.

Inspection findings including non-compliances are discussed in the body of the report and in the action plan at the end of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
There were policies and procedures in place for the management of complaints. However, improvements were required to the complaints procedure; the provision of independent advocacy services and opportunities available to residents to participate in meaningful activities. Inspectors found that the failure to provide opportunities to residents to participate in meaningful activities was at the level of major non-compliance.

There were policies and procedures in place for the management of complaints and these were also available in an easy to read version. However, some of the information in the complaints procedure was inaccurate as it directed complainants in the first instance to the provider nominee; the provider nominee confirmed that this was not accurate as complaints were normally made in the first instance to the house manager. The complaints log detailed the nature of the complaint and included the timeframe for resolving the complaint and the resolution. Complaints were also discussed at staff meetings.

Staff were not aware of independent advocacy services available to assist residents if they wished to make a complaint.

Inspectors found that the opportunities available to residents to participate in meaningful activities were limited. Activities were not based on an assessment of residents' interests, capacities and preferences. Available activities were limited in range and scope. For example, one of the units in the centre had eight residents who were wheelchair users. Staff told inspectors that staffing levels were not sufficient to facilitate outings, particularly at weekends. Activity logs maintained for residents further

supported the finding that activities were limited. For example, logs viewed in one unit indicated that residents' activities on weekends would sometimes be limited to a walk within the grounds or even just the internal courtyard of the centre. In another unit, logs indicated that one resident participated in only two activities over the course of a full week and another resident participated in only one activity in an entire month. Inspectors spoke with the person in charge and staff who confirmed that access to activities for residents, particularly at evenings and weekends, either were not adequate or required improvement. This was also a finding in the single-issue inspection in December 2014. The A/CEO outlined steps that had recently been taken to begin to address this issue, including the assessment of each resident's activities as part of a broader clinical review.

Judgment:
Non Compliant - Major

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 found each resident had a personal plan and that new plans were being rolled out across the service. However, inspectors found a number of significant gaps in relation to meeting the social care needs of residents in the centre. The placement of residents in the centre and the mix of residents within the centre did not meet the needs or expressed wishes of a number of residents. The personal planning review process required improvement. Inspectors found this failure was at the level of major non-compliance. This was discussed with the provider nominee at the close of inspection.

Inspectors reviewed residents' files, including personal plans for a number of residents and discussed social care needs with staff and residents, where residents had the capacity to do so.

Residents' files included a range of information including personal information, plan of care, personal plans, a multi-element intervention plan and a record of multi-disciplinary

input (MDT) input.

Inspectors found that each resident had a personal plan, as required by the Regulations. However, inspectors found significant gaps in the documentation contained in the residents' files. Documentation was not easy to retrieve, disjointed and in some cases, out-of-date and in poor condition. For example, one resident displayed behaviour that challenges yet staff were not readily able to locate this information in the personal plan. This will be further discussed under Outcome 8: Safeguarding and Safety. The format of the plan was unwieldy and personal plans were not clearly informed by an assessment of the residents' needs, risk management plans and health plans. Some personal plans were in an accessible format, while others were not. Inspectors found that the provider was in the process of addressing these gaps. New files, including personal plans, were being rolled out across the service. Inspectors reviewed a sample of the plans in process and found that they addressed many of the gaps relating to documentation. For example, the new files contained a specific tool which was used to document each resident's assessment of their health, personal and social care needs, abilities and wishes. The information contained in the tool was informed by multi-disciplinary input where required. Plans had been completed for some identified needs, supports or risks. For example, a detailed communication plan and information was in place for a resident with communication needs. However, the inspector noted that following the previous monitoring inspection of this centre in May 2014, the person in charge had committed in the action plan to completing new personal plans for residents by 17 December 2014 and had failed to do so.

The system in place for the review of personal plans did not meet the requirements of the Regulations. A monthly review of the progress made in relation to each resident's personal plan was in place within the service; however this had not been completed for all residents. Personal plans were reviewed on an annual basis and involved the multi-disciplinary team, as required by the Regulations. The review also included the person in charge, the key worker and relevant allied health professionals. Staff described how family members were invited to participate in the annual review of the personal plan. However, family involvement in the review process was not formally documented.

Inspectors found that MDT input was not fully implemented as part of the personal planning process. For one resident, documented MDT input from 30.6.2014 stated that the designated centre did not meet the resident's needs, nor was the mix of residents within the centre suitable for that resident. Inspectors found that the failure to provide suitable and appropriate accommodation for the resident had a negative impact on that resident's quality of life. For example, while the resident's personal plan stated that the resident likes space and dislikes being confined, the centre did not provide for such space. Also, the mix of residents within the house was not suitable in terms of age and gender and as a result, was failing to meet that resident's social and emotional needs. In addition, the resident's personal plan specifically stated that it was the resident's wish to live with peers of his/her own age and this wish had not been met. In another house, the house manager stated that two residents had been identified as being ready to live in a community-based setting. The provider nominee confirmed in the feedback session that there were no concrete plans in place to facilitate such a move. The A/CEO subsequently provided an explanation to inspectors that the deteriorating health condition of one resident had resulted in the delayed move for one of the two residents.

The findings that the designated centre failed to meet the needs of all residents and the mix of residents within the centre was not suitable for one resident were discussed with the provider nominee at the close of the inspection. The provider nominee confirmed that there was no specific plan in place to find more suitable and appropriate accommodation for these specific residents.

Residents' goals were documented and progress was reviewed. Where goals were not achieved, this was also documented. The inspector observed in one file that a number of goals (6 of 18) had not been achieved for the previous year. The supports required for residents to meet such goals (including previously unmet goals) were not specified, as required by the Regulations.

Staff outlined a number of ways in which family contact was encouraged, supported and facilitated. For example, a party had been organised for a resident's birthday and was attended by the resident's family. In one file, the inspector noted that persons important to the resident and their contact details and pictures were clearly documented. The resident's likes, dislikes, dreams, goals and support services were also outlined and were individual and specific to that resident.

Judgment:
Non Compliant - Major

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:
Inspectors found that the design and layout of the centre was not suitable for its' stated purpose and did not meet residents' individual or collective needs in an acceptable way. The poor design and layout of the premises impacted on an individual resident's need for space and did not meet other individual resident's mobility or privacy needs. Parts of the premises were in a poor state of repair and posed a potential risk of infection. Inspectors found that the failure of the premises to adequately meet the individual and collective needs of the residents was at the level of major non-compliance. This was discussed with the provider nominee during the course of the inspection. This was also a finding in the previous monitoring inspection of this centre in May 2014. The provider

has not satisfactorily responded or produced a satisfactory plan to address this failing to date.

The centre forms part of a congregated setting. The centre did not adequately meet the individual need for space of one resident nor did it provide suitable communal space for all residents. Inspectors observed times during the day during which a number of residents were together in the communal space (the combined living/dining room) and observed that the communal accommodation provided was very limited in terms of space for the number of residents residing in that unit.

In one unit, one resident's individual needs determined that s/he required space, which was also relevant to support that resident to manage their behaviours that challenge. Inspectors found that this need for individual space was not met by the congregated setting. This was previously discussed under Outcome 5: Social Care Needs.

The house manager confirmed that two residents had been identified as being ready to move from the congregated to a community-based setting. The provider nominee confirmed in the feedback session that there were no concrete plans in place to facilitate such a move.

There were four units (bungalows) in the centre which were all of a similar size and layout. The ground floor of each unit comprised a kitchen, an open living room/dining space, one very small 'quiet room', eight bedrooms, one shower room, one bathroom (with accessible bath), a toilet, a staff/visitor toilet and a storage room. The first floor contained the laundry facilities, a staff toilet and staff bedroom.

Inspectors found that some parts of the premises could no longer be effectively cleaned, in particular in relation to the bathroom flooring and tiles, the floor in the sluice room and the shower unit. Also, the infection prevention and control systems in place were not sufficiently robust as parts of the premises had not been cleaned to an acceptable standard. These findings presented a risk of infection to residents and are further discussed under Outcome 7: Health Safety and Risk Management

All units in the centre had limited storage space. Inspectors noted one sluice room was in use as storage for five showers chairs. The store room had limited space and was full to the point of being inaccessible. Among the items noted in this store room were a chest freezer, coat hanger, hoists, a locker, various items of clothing, a chair, and three baskets of clothes.

Inspectors observed that the physical design of the centre was poor. Although the bedrooms were all single rooms and all downstairs, a number of the bedrooms were significantly limited in size. Four of the bedrooms had a distance of 90cm between the sink unit and bed. Given the level of physical needs of the residents in one unit, the bedroom sizes presented significant challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces. This is further discussed under Outcome 7: Health and Safety and Risk Management.

The failing in relation to the premises was also a finding in the previous monitoring inspection of this centre in May 2014, where it was found that all of the requirements of

Schedule 6 of the Regulations had not been met. Examples of failings cited in that inspection report included that some rooms were not of a suitable size and layout for the needs of residents, suitable storage was not provided and the shower room did not meet a suitable standard. One of the actions committed to by the provider in the action plan following that report was that refurbishment of the shower rooms would be completed by 31 October 2014; the provider failed to meet this timeframe.

Staff told inspectors that re-decoration had been carried out in some of the units in the past year. Inspectors in one unit noted that the communal area and bedrooms were tastefully decorated and homely. There was adequate heating and ventilation in all areas of the centre. However, there was limited natural light in most of the bedrooms due to the design and layout of the units.

Residents had access to equipment which was appropriate to their needs. Residents who required transfers had access to hoists in communal areas and in their own bedrooms. There was evidence of assessment of residents for new equipment which would improve their comfort. For example, one resident was recently assessed for a chair to use in the communal room. This assessment was carried out by the occupational therapist and staff confirmed that the chair was currently on order for the resident.

Judgment:
Non Compliant - Major

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:
There were polices and procedures in place for the management of risk, the recording and reporting of incidents and in relation to emergency management. However, policies and procedures were not fully implemented and improvements were required in relation to the prevention and control of infection and the assessment and management of risk.

The inspector spoke with nursing and care staff in relation to the principles of infection prevention and control. The organisation had an infection prevention and control committee and an auditing system in place. Inspectors viewed training records that indicated that the majority of staff had received combined hand hygiene and infection control training, although a small number of staff had not received this training within an acceptable timeframe (within the previous two years) and one staff member had never received this training. This is further discussed under Outcome 17: Workforce and

in the associated action. The monitoring and supervision of infection control measures in place in the centre was not adequate. This was evidenced by a number of findings. Inspectors found that cleaning schedules were not consistently completed. The person in charge informed inspectors that the centre was not subjected to a deep clean. Some staff were unaware of the cleaning practices and could not clearly explain the infection control measures in place. Other staff said that laundry and cleaning were completed either on a 'clean as you go' basis or whenever staff got the chance. Other staff were not able to describe any specific cleaning procedures that they followed.

As previously mentioned in the context of the premises under Outcome 6: Safe and Suitable Premises, some parts of the premises could no longer be effectively cleaned and this presented a potential risk of infection to residents. Also, parts of the premises had not been cleaned to an acceptable standard. In one unit, inspectors observed and found that: a number of the bathrooms had flooring and tiling which was in a state of disrepair; a toilet was visibly unclean and coated in a grimy substance; a shower unit was rusty and appeared visibly unclean; a shower screen was visibly unclean and coated in a grimy substance; flooring in the sluice room in a state of disrepair; flaking paintwork surrounded the roof light in the sluice room; the janitorial unit in the sluice room was visibly unclean; four mop buckets were visibly unclean and; the floor in the laundry room was dirty. In the second unit, the kitchen floor was visibly dirty and sticky and the kitchen countertop and edges were dusty and unclean.

Inspectors viewed risk assessments in relation to different assessed risks including fire, hot water, slips trips and falls, manual handling, hot water, and smoking. Individual risk assessments were completed for residents including in relation to self-injurious behaviour, compromised skin integrity and fall from a bed. Inspectors found that the organisation's risk management policy was not being implemented in full as a number of risk assessments were not current. While the organisation's risk management policy requires risk assessments to be updated annually or more frequently as required, inspectors found that a number of risk assessments had been completed in 2011 with no subsequent review. Improvements to aspects of the risk management system was also finding in the previous monitoring inspection in May 2014.

There were incident reporting guidelines in place that were in date. Incidents were being recorded and reported.

Inspectors reviewed the measures in place in the centre to respond to fire. There were monthly fire drills and records were maintained of each occasion they were carried out. Staff informed inspectors that a night-time fire drill is carried out once per year. The fire evacuation procedure was present in the centre and there was also a notice available detailing each residents' requirements in the event of a fire evacuation. The mobility and cognitive abilities of the residents had been accounted for in the evacuation plan. Fire exits were clear of obstruction.

Records were kept of daily and weekly fire checks carried out by staff. The fire panel was checked daily but there were some gaps in the documentation of these checks. For example, the check sheet reviewed in one unit showed a check on January 1 2015 with no subsequent check until January 7 2015. The centre had up-to-date servicing records for the fire alarm system and the emergency lighting system. A copy of the servicing

record for fire equipment was unavailable for review. Staff informed inspectors that this was due to the document being archived. Training records indicted that all staff had received mandatory fire training. Inspectors spoke with a number of staff and found that they were able to describe what to do in the event of a fire.

Inspectors reviewed staff training records and found that staff had received up-to-date manual handling training in for residents. There were measures in place to assist with residents' mobility including ceiling tracker hoists, profiling beds, electric wheelchairs and an assisted bath. However, inspectors found that a number of bedrooms and the shower room provided inadequate space to ensure that staff could move and handle residents safely. Inspectors spoke with staff who confirmed that they could not apply a number of the techniques taught to ensure safe moving and handling due to space constraints. This was also a finding at the previous monitoring inspection in May 2014. This was previously discussed under Outcome 6: Safe and Suitable Premises and in the associated action.

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:
Inspectors found further evidence to support the following allegations: failure to provide residents with opportunities to participate in activities in accordance with their interests, capacities and developmental needs; failure to ensure that staff members have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour and further information in relation to the failure to provide a safe environment for staff to raise concerns about the quality and safety of the care and support provided to residents. These failings are at the level of major non-compliance.

Inspectors interviewed staff across the two units included in this inspection, observed staff interactions with residents and reviewed relevant documentation pertaining to the

protection of vulnerable adults, behaviour that challenges, restrictive practices and intimate care.

Staff members were interviewed about each area of concern. General background, training and skill set were established.

Inspectors found further evidence to support the following allegations: failure to provide residents with opportunities to participate in activities in accordance with their interests, capacities and developmental needs; failure to ensure that staff members have up to date knowledge and skills appropriate to their role to respond to behaviour that is challenging and to support residents to manage their behaviour and; further information in relation to the failure to provide a safe environment for staff to raise concerns about the quality and safety of the care and support provided to residents. These three areas are further described below. No further information relating to the remaining concerns was found on the day of inspection.

The majority of staff interviewed said that staffing levels in the centre were not adequate. Staff cited specific examples of negative impacts for residents as a result. For example, several staff specifically stated that staffing levels had an impact on their ability to facilitate activities for residents, particularly at evenings and at weekends. One staff said that staffing was such a problem that even bringing residents for a walk within the campus was a problem and that walks were often confined to the indoor courtyard as a result. This was previously discussed under Outcome 5: Social Care Needs and in the associated action. The provider had taken steps to increase hours allocated to house managers specifically since the previous inspection. Staffing issues are further discussed under Outcome 17: Workforce and in the associated action.

Inspectors found some limited further information to support the allegation that staff were not supported to raise concerns about the quality and safety of the care and support provided to residents.

Inspectors found further evidence to support the allegation that staff members did not have up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. For example, although some information was available pertaining to a resident with behaviour that challenges, staff had difficulty locating this information and a behaviour plan was produced for that resident. Also, information pertaining to restrictive practices was not current, for example, a resident's file referenced a restrictive practice that was no longer in use. In addition, risk assessments in relation to aggression and violence and self-injurious behaviour were not current. Gaps relating to the completion of risk assessments were previously discussed under Outcome 7: Health and Safety and Risk Management and in the associated action. Inspectors spoke with staff who were able to articulate what constitutes abuse and the steps to take in the event of a suspicion, allegation or incident of abuse. However, according to training records, the majority of staff did not have up-to-date training either in relation to managing behaviour that challenges or the protection of vulnerable adults. This gap is noteworthy as it was a finding in the previous monitoring inspection of this centre in May 2014. This is further discussed in the wider context of mandatory training for staff under Outcome 17: Workforce.

There was a system in place to manage residents' monies on a day to day basis. All staff interviewed were able to describe a clear local system in place that was subject to checks, countersigning and audit in a consistent way. Information from the provider in relation to the management and allocation of residents' money at service-level was requested at a meeting following the inspection.

The organisational policies in place for the protection of vulnerable adults, behaviour that challenges, restrictive practices and intimate care were within their review date.

The inspector reviewed restrictive practices in the centre and found that the required documentation and checks had been completed.

Judgment:
Non Compliant - Major

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Overall, the healthcare needs of residents were met through access to health care services and appropriate treatment and therapies. However, gaps were identified in relation to the documentation of residents' allergies.

Residents had access to medical care and a general practitioner (GP) visited the centre on a weekly basis.There was evidence in the plans of access to MDT, including input from psychology, speech and language therapy, orthotics, social workers, occupational therapy, dental services and dietetic services. Physiotherapy was provided for residents at their day service.

There was evidence of communication between the centre and the acute sector in relation to residents' health status and any specific areas of need. Residents' health was monitored and managed on an on-going basis. Daily and other reports were maintained as necessary. Monitoring of residents was completed where indicated e.g. following a head injury or to monitor seizure activity. Staff confirmed that all residents had received the influenza vaccine prior to the winter period.

However, gaps were identified in relation to the documentation of residents' allergies. Inspectors found significant deficiencies in relation to allergy documentation that may

have posed a risk to residents. The health plans of two residents indicated that they may be allergic to a specific antibiotic. The house manager confirmed that this information was not accurate for one resident. Allergy documentation pertaining to the second resident was unclear. Staff were not clear in relation to whether the second resident was allergic to the antibiotic. The relevance of this failing is that systems were not in place to protect residents against adverse drug reactions.

Inspectors found that the food on offer in the centre was generally nutritious and varied. Meals were planned on a weekly basis. Staff were satisfied that the residents enjoyed the food and that there was always a choice on offer. A number of staff spoke to inspectors about the meals which the residents particularly enjoyed i.e. fish, pasta and roast dinners. Staff had received training in relation to the assessment of malnutrition of residents'. Residents' weights were monitored by the dietician and oversight of residents' weight and health status was by the clinical nurse manager. Advice relating to dietary needs was available for each resident from the dietician and speech and language therapist. Advice was documented in the residents' healthcare folders and relevant information contained in a folder in the kitchen. Some residents could eat independently and where residents needed support, this was offered discreetly.

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):
No actions were required from the previous inspection.

Findings:
There were polices and procedures in place for medication management. Inspectors found that all staff were not aware of the polices and procedures in place.

The centre had a specific policy for medication management which was last updated in May 2014. Inspectors also found that there were centre-specific procedures for the prescription, administration, recording, safekeeping and disposal of medications. Medicines were supplied to the centre by a local pharmacy on a monthly basis. Used and out-of-date medication was also returned to the same pharmacy. Documentation was maintained in relation to medication returns.

There were no residents in receipt of an antibiotic or injections on the day of inspection. Staff informed inspectors that medicine charts and administration charts were taken to the respective resident's day service. Each unit in the centre had a locked cabinet for

medications. A medicine fridge was available in one unit and shared with the other units.

Not all staff were aware of the medication management policies in place in the centre. An inspector spoke with a staff nurse who said that she was not aware of what was contained in the medication management policy, despite having signed the policy as read. This will be further discussed under Outcome 18:Records and documentation and in the associated action.

Inspectors found deficiencies in relation to allergy documentation that may have posed a risk to residents. This was previously discussed under Outcome 11: Healthcare Needs and in the associated action.

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

Findings:
Arrangements were in place to review the quality of the service, including unannounced visits to the designated centre and an annual review. Inspectors found that improvements were required to the governance and management of the designated centre and that this failing was at the level of major non-compliance.

The person in charge was the person in charge for two designated centres. There were four units or bungalows in this designated centre. The person in charge had the required experience and qualifications for the post and staff to whom inspectors spoke said that the person in charge was supportive.

At the close of inspection, a preliminary feedback meeting was held with the provider nominee. The Assistant Chief Executive Officer (A/CEO) attended the Authority's Head Office on 22.1.2015 to receive formal feedback and areas that required improvement were discussed at that meeting. These included issues as discussed in this report and in particular, major non-compliances as identified under Outcomes 1: Residents' Rights, Dignity and Consultation; 5: Social Care Needs; 6: Safe and Suitable Premises; 8:

Safeguarding and Safety and; 14: Governance and Management.

However, the provider had failed to provide evidence that effective management systems were in place to ensure that the service provided is safe, appropriate to the resident's needs and consistent and effectively monitored. As previously discussed under Outcome 8: Safeguarding and Safety, some staff reported that they did not feel safe to raise concerns within the service. This was also a finding in a single-issue inspection in December 2014 in the remaining two units that make up the designated centre. As previously discussed under Outcome 5: Social Care Needs, the centre did not adequately meet the needs of all residents. As indicated by the poor standard of hygiene and state of repair in some parts of the centre and as previously discussed in Outcomes 6: Safe and Suitable Premises and 7: Health Safety and Risk Management, the day to day oversight and supervision of the centre was neither consistent nor adequate.

In addition, a number of failings identified in the previous monitoring inspection in May 2014 had not been satisfactorily addressed. For example and as previously discussed under Outcomes 6: Safe and Suitable Premises and 17: Workforce, the design and layout of the centre was not suitable for its' stated purpose as it did not meet residents' individual or collective needs in an acceptable way and; not all staff had received mandatory training relating to the management of behaviour that challenges and the protection of vulnerable adults. Also, staff reported that staffing levels at times were insufficient and provided clear and consistent examples of negative impacts on residents as a result.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
Inspectors found that although a training programme was in place, not all staff had received the mandatory training required by the Regulations and other relevant legislation. Not all staff had received mandatory training relating to the management of behaviour that challenges and the protection of vulnerable adults and this gap was also

a finding in the previous monitoring inspection in May 2014. Staff indicated that staffing levels at times were insufficient and cited examples of negative impacts on residents as a result. Inspectors found that these failings were at the level of major non-compliance.

An accurate staffing roster was maintained, as required. However, a number of staff of different grades said that staffing levels at time were insufficient and that that this had a negative impact on residents. Specific examples were provided to inspectors: One staff said that there were times when it was difficult to take residents out; this was previously discussed under Outcome 5: Social Care Needs. Another staff said that the number of house managers had been reduced from four to two; the staff member explained that as a result the remaining staff team lost an important 'back-up' system as house managers would have filled in where needed. Another staff said described that this meant it could be difficult to adhere to a cleaning schedule and that as a result, laundry and cleaning were completed either on a 'clean as you go' basis or whenever staff got the chance. This was further discussed under Outcome 7: Health Safety and Risk Management. These challenges were also relayed to inspectors at two previous inspections in May and December 2014.

The provider nominee acknowledged in the feedback meeting difficulties that the service had experienced due to a number of staff retiring and recruitment challenges and specifically, that this presented challenges in relation to cleaning. The provider nominee outlined steps that the organisation had taken to increase staffing levels since the most recent inspection in December 2014 including an additional staff nurse on night duty and additional supernumerary hours for house managers, which will be reviewed at the end of February 2015.

The inspector spoke with staff who confirmed what training they had received and viewed staff training records that were held in the centre. Internal memos relating to scheduled training for 2015 were viewed. Training records reviewed for both bungalows indicated that although a training programme was in place, not all staff had received the mandatory training required by the Regulations and other relevant legislation.

Not all staff had received up-to-date mandatory fire safety training, as required by the Regulations. Not all staff had received up-to-date mandatory training in relation to the protection of vulnerable adults or the management of behaviour that challenges, as also required by the Regulations. This gap in mandatory training relating to fire safety, the management of behaviour that challenges and the protection of vulnerable adults was also a finding in the previous monitoring inspection in May 2014.

Training records indicated that manual handling training was up-to-date. The majority of staff had received combined hand hygiene and infection control training, although a small number of staff had not received this training within the required two year timeframe as determined by the Service. One staff member had never received this training. Not all staff had received training in relation to food safety, which is required for all food handlers under relevant food safety legislation.

Some staff had completed other recent training relevant to their roles and responsibilities including in relation to stoma care, assessment of residents with malnutrition and care of persons living with dementia. A number of care staff had

completed FETAC modules relating to care of the older person and occupational first aid. A staff nurse had completed a diploma in first line management.

Inspectors found that there was an accurate staffing roster showing staff on duty, which included the times that all staff were on duty.

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):
No actions were required from the previous inspection.

Findings:
One aspect of this outcome was included as part of this inspection.

As previously mentioned under Outcome 12: Medication Management; not all staff were aware of the medication management policies in place in the centre. An inspector spoke with a staff nurse who said that she was not aware of what was contained in the medication management policy, despite having signed the policy as read.

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

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 Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0003944
Date of Inspection:	13 January 2015
Date of response:	18 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:
Opportunities available to residents to participate in meaningful activities were limited, particularly in the evening and at weekends. Activities were not based on an assessment of residents' interests, capacities and preferences. Available activities were limited in range and scope.

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

Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
All care plans are currently under review; there is a specific focus included on the area of activation for service users in the centre, this will incorporate an assessment and review of individualised activities for each resident. Activities are currently tracked and documented on individualised activity planners. A schedule of activities that the service user likes will be detailed in the care plan for each individual and the individual can decide what they wish to participate in on a given evening and at weekends. Rosters will be reviewed by the house manager and PIC to support activation for service users in the evenings and at weekends. There is in house support from a CNM3 from another part of the organisation, provided to staff in the centre on 17/02/2015 and 18/02/2015 specifically focusing on providing meaningful activities for service users in the centre. The house manager and PIC will report weekly to the nominee provider on the activities engaged in by service users in the evenings and at weekends.

Proposed Timescale: 27/02/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The information in the complaints procedure did not reflect local practices.

Action Required:
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

Please state the actions you have taken or are planning to take:
• The Home Manager has addressed with staff at house meetings the correct complaints procedure and outlined the contents of the service policy on complaints.
• The home managers in this centre have arranged meetings with the service users for week ending the 20/02/2015 to explain the complaints procedure in a service user friendly manner. The easy read complaints procedure is accessible and available to service users in all houses in the centre.
• Standardised reporting format is currently being piloted across other centres in the organisation. This will be a final and circulated reporting system by 13/04/2015. The Quality and Risk Officer and the nominee provider will provide training to all staff in the centre on complaints, receiving complaints, addressing complaints, reporting complaints, recording complaints, closure of complaints and satisfaction of complainant with outcome, access to advocacy services for service users and their families. This training is scheduled for 23/02/2015 and 02/03/2015.

Proposed Timescale: 27/02/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not aware of independent advocacy services available to assist residents if they wished to make a complaint.

Action Required:
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:
• The regional advocacy committee has been tasked to prioritise the development of advocacy services to commence in the Villa's.
• Service users with no family members will be referred to an independent advocacy service. Meeting will take place with the independent advocate on 06.02.2015, in relation to one particular service user.
• Advocacy training for staff scheduled for 04.02.2015.

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:
The designated centre failed to meet the needs of all residents; the mix of residents within the centre was not suitable for one resident and two other residents had been identified as being ready to move to a community-based house.

Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
• In relation to one resident, it was highlighted to the HSE at a management meeting on the 28.01.2015. Full case conference to incorporate representation from the HSE, as significant funding may be required, will be organised by the 10/03/2015.
• This individual has been referred to an independent advocate adult services, and the advocate has been appointed.
• Recommendations from MDT members involved in service users care will be reviewed by the key worker and PIC for all residents, and action plans will be developed around these recommendations to ensure their achievement. Where recommendations are out of date that were not acted upon, the PIC will arrange a follow up MDT for the service users in question.

• The PIC and nominee provider will arrange a full review of all service users residing in the houses in this centre with the focus specifically on their living arrangements and their wishes and the wishes of their families for the service user's future living arrangements.

Proposed Timescale: 30/04/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Current personal plans did not meet the requirements of the Regulations.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
Staff are currently receiving support in the centre to develop their skills in the completion of appropriate and effective care plans to meet the needs of all the service users. This support is being delivered by a CNM3 in the areas of assessment, quality of life, measuring outcomes, activation and meaningful activities for service users. The house manages and PIC will then continuously audit and review the quality and effectiveness of the care plans.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
MDT recommendations made during the personal planning review process had not been implemented for a resident.

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:
• Recommendations from MDT members involved in service users care will be reviewed by the key worker and PIC for all residents, and action plans will be developed around these recommendations to ensure their achievement. Where recommendations are out of date that were not acted upon, the PIC will arrange a follow up MDT for the service users in question.
• The nominee provider has met with all area managers and house managers on

11/02/2015 and outlined the failures regarding the follow up and action of MDT recommendations. Going forward there will be a named key staff involved in the direct care of a service user identified as being responsible for following up on each identified action or goal for the service user. This staff may not necessarily be in a position to complete the actual recommendation but will be the responsible person for linking with other supports needed to ensure recommendation is achieved or reviewed as necessary. This key staff will update PIC regarding achievement of recommendations, or of any obstacles to achievement. The PIC, key worker and nominee provider as necessary will address individual teams and team members where recommendations are not adhered to.
• In relation to one resident, it was highlighted to the HSE at a management meeting on the 28.01.2015.
• This individual has been referred to an independent advocate, adult services.
• Full case conference to incorporate representation from the HSE, will be organised by the 27.02.2015.
• All MDT recommendations for this service user will be reviewed by the house manager, Key worker and PIC and all recommendations will have action plans and review dates set, to support the achievement of the goals and recommendations.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The review process was not adequate. For example, supports required for residents to meet personal goals were not specified.

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 current review of the care plans onto the new format will identify the supports required by the residents to meet personal goals.
• The nominee provider has met with all area managers and house managers on 11/02/2015 and outlined the failures regarding the follow up and action of MDT recommendations. Going forward there will be a named key staff involved in the direct care of a service user identified as being responsible for following up on each identified action or goal for the service user. This staff may not necessarily be in a position to complete the actual recommendation but will be the responsible person for linking with other supports needed to ensure recommendation is achieved or reviewed as necessary. This key staff will update PIC regarding achievement of recommendations, or of any obstacles to achievement. The PIC, key worker and nominee provider as necessary will address individual teams and team members where recommendations are not adhered to.
• To support the service users achievement of goals and recommendations, the team

on making recommendations with identify the necessary supports required for their achievement, these supports will be documented. This will also support staff to have the knowledge necessary to involve all necessary team members, families, and advocates etc to ensure goal and recommendations achievement. All PICs have been informed of this by the nominee provider and will liaise with house managers and ensure same is implemented.

Proposed Timescale: 27/03/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the premises could no longer be effectively cleaned, in particular in and around the bath, shower and sinks.

Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
• Deep cleaning as required has commenced 02.02.2015.
• Upgrade of shower rooms in the four centres to be designed / costed and to commence by the 27.02.2015.The areas were reviewed by the Director of Logistics on 12/02/2015.
• Work to make the bathrooms and shower areas more accessible to service users, and more accessible for cleaning purposes is scheduled to commence week beginning 16/02/2015.

Proposed Timescale: 30/05/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The designated centre did not meet the requirements of Schedule 6 of the Regulations. For example: rooms were not of a suitable size and layout to meet the needs of residents; private accommodation was not adequate; communal accommodation was not adequate and; the bath, showers and toilets were not of a sufficient standard to meet the needs of all residents.

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:
• The HSE have been made aware in 2014 and again on the 28.01.2015 of the unsuitability of the premises
• The ACEO and the Director of Logistics met on the 29.01.2015 to determine a phased cost plan in order to meet the requirements under schedule 6 and submit costings to the HSE for additional funding.
• The Director of Logistics will audit and access maintenance requirements in all the houses in the centre by the 27.02.2015.
• An application for Capital Assistance with the Offaly County Council was successful (for a new facility). Number and identification of service users appropriate for this new facility to be determined by 20.03.2015.
• Currently areas linked to the centre provides office space to employees, these areas will be redirected back to the centre for service user use, the large reception are will be refurbished to create an additional shared living area for service users and their visitors, with open and safe access out onto the garden area.
• The plan for the future is that 6 service users will be the maximum number of residents accommodated in each of these centres. The service user review group will identify service users to move from the centre. The organisation will actively seek funding for staffing resources and houses within the community to accommodate these individuals and the proposed timeframe for this transition is May 2016.

Proposed Timescale: 20/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the premises were in a poor state of repair.

Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
• The HSE have been made aware in 2014 and again on the 28.01.2015 of the unsuitability of the premises
• The ACEO and the Director of Logistics met on the 29.01.2015 to determine a phased cost plan in order to meet the requirements under schedule 6 and submit costings to the HSE for additional funding.
• The Director of Logistics will audit and access maintenance requirements in the centre by the 27.02.2015.
• An application for Capital Assistance with the Offaly County Council was successful. Alteration works and refurbishment will be complete by the end of 2015. The house will accommodate 4/5 individuals, Residents from group A and one other designate centre, will be prioritised to determine who will reside in the new centre. The number of residents in Group A will decrease, the service users who will move from Group A will be determined through a service user review group which will include participation from the service users and families.

• Where areas within the centre are in a poor state of repair, painting and decorating will be attended to and the services of external contractors will be sought by the PIC.
• Additional living space will be provided to the service users in the centre, through the relocation of office staff away from the centre. Currently areas linked to the centre provides office space to employees, these areas will be redirected back to the centre for service user use, a larger bedroom can be provided from this area for one service user and a quite place for service users who wish to spend time alone away from others. There is a large reception area to the centre which will be refurbished to create an additional shared living area for service users and their visitors, with open and safe access out onto the garden area.
• A large additional living room with garden access will be provided to all residents in the centre. This will be facilitated by refurbishing an existing large reception area.

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The physical design of the centre was poor. For example, a number of the bedrooms were significantly limited in size. Given the level of physical needs of the residents in one unit, the bedroom sizes presented significant challenges in terms ensuring the safe moving and handling of residents by staff in such confined spaces.

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 HSE have been made aware in 2014 and again on the 28.01.2015 of the unsuitability of the premises
• The ACEO and the Director of Logistics met on the 29.01.2015 to determine a phased cost plan in order to meet the requirements under schedule 6 and submit costings to the HSE for additional funding.
• The Director of Logistics will audit and access maintenance requirements in the centre by the 27.02.2015.
• An application for Capital Assistance with the Offaly County Council was successful. Number and identification of service users appropriate for this new facility to be determined through a service user review group, with focus on reviewing the accommodation needs of service users and this review group will include participation of service users and families. The review group will commence by 20/03/2015.
• Additional space will be provided to the service users in the centre, through the relocation of office staff away from the centre, where bedrooms are small, changing to one of these additional rooms in the centre will be implemented.

Proposed Timescale: 31/12/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The organisation's risk management policy was not being implemented in full as a number of risk assessments were not current.

Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
All risk assessments in relation to the health and safety for the service users will be reviewed and updated by the 27.02.2015

Proposed Timescale: 27/02/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The physical environment, facilities and resources were not developed and managed to minimise the risk of service uses acquiring a healthcare-associated infection. For example, parts of the premises either could no longer be effectively cleaned or had not been cleaned to an acceptable standard, the overall monitoring of infection control standards was inadequate and there were gaps in the system in place for the training of staff in relation to hand hygiene and infection control.

Action Required:
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:
• Deep cleaning as required has commenced on 02.02.2015. PIC is communicating with external contractors to source costing to continue accessing deep cleaning on a monthly basis for the centre.
• The bathroom and shower areas were reviewed by the Director of Logistics on 12/02/2015. Work to make the bathrooms and shower areas more accessible to service users, and more accessible for cleaning purposes is scheduled to commence week beginning 16/02/2015.
• The house manager and PIC will review the training logs of all staff, hand hygiene training will be completed by all staff in the centre and refreshers will be scheduled for

all staff.
• The lead staff , CNM3, for another area of service in the organisation will be deployed to the centre for two days to complete a hygiene audit for the area, linking throughout the audit with the house manager and the PIC. The CNM3 will support the PIC in the development of cleaning logs and schedules for the centre.

Proposed Timescale: 30/03/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that staff had up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
• Training has commenced on Challenging Behaviour by the Clinical Psychologist and will be completed by the 16.02.2015.
• Training in protection and welfare of vulnerable adults and the management of allegations of abuse will be completed by the 16th February 2015.

Proposed Timescale: 16/02/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Allergy documentation pertaining to the two residents was either unclear or inaccurate.

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:
• Care Plan was reviewed, updated and clarified in relation to the allergies of the two residents by the Home Manager.
• Documentation stating the resident's allergies are displayed on the Drug cabinet to

alert all staff of the allergies.

Proposed Timescale: 31/03/2015

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:
The provider had failed to demonstrate that effective management systems were in place to ensure that the service provided is safe, appropriate to the resident's needs, consistent and effectively monitored. For example, some staff reported that they did not feel safe to raise concerns, the centre did not adequately meet the needs of all residents and the day to day oversight of the centre was neither consistent nor adequate.

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 is a lead person identified on each duty shift since the 20th December 2014.
• There are two home managers in place in Group A.
• Both managers have been supernumerary since Monday 19th January 2015 to ensure all recommendations are acted and issues addressed.
• On the 9th December 2014 the CEO sent a letter to staff to remind staff of the abuse policy, and their responsibilities to report any concerns.
• Standardised reporting format is currently being piloted across other centres in the organisation. This will be a final and circulated reporting system by 13/04/2015. The Quality and Risk Officer and the nominee provider will provide training to all staff in the centre on complaints, receiving complaints, addressing complaints, reporting complaints, recording complaints, closure of complaints and satisfaction of complainant with outcome, access to advocacy services for service users and their families. This training is scheduled for 23/02/2015 and 02/03/2015.
• The Quality & Risk Officer delivered training to the PIC's and Home Managers on the 19.01.2015 in relation to the regulations, the requirements of the PIC's and the outcomes of inspections.
• A/CEO and Quality & Risk Officer met with the PIC's and Home Managers on the 04.02.2015 in relation to these core policies Complaints Policy DOCS 003, Policy on the protection and Welfare of Vulnerable Adults and management of allegations of abuse DOCS 020, Intimate care guidelines DOCS 064 and incident reporting.
• Nominee Provider met with all house managers and PICs on 11/02/2015. Nominee Provider reiterated to all managers that all complaints and concerns will be dealt with as per policy and also acknowledged how difficult it is for staff to make a complaint, especially if it is about colleagues. The service will support all staff involved and also the Employee assistance programme is an additional to staff involved in the complaints

process. Highlighted at this meeting the process for making a complaint, PICs and House managers to bring this information back to staff in the centre. The Service manager and Quality and Risk officer will facilitate training dates with staff to explain and outline the process for staff making a complaint, and also the process for staff to follow when dealing with a complaint from a service user, family member etc. The first two of these dates are scheduled for 23/02/2015 and 02/03/2015.
• On 09/02/2015 adverts were posted to recruit 2 x CNM3 positions to support the residential centres in this organisation, Group A being one of these centres. These posts will be full time positions.

Proposed Timescale: 31/03/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that staffing levels at time were insufficient and that that this had a negative impact on residents.

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

Please state the actions you have taken or are planning to take:
• The Service will commence a full service user review to ensure a clear identification of their individual staff support needs.
• The Quality and Risk Officer has completed a training needs analysis of the staff in Group A and training dates will be scheduled
• A number of Staff Nurses from Group A have attended training on PEG feeding on the 06/01/2015.
• Clinical input continues from the Assistant Director of Nursing on a weekly basis.
• Funding has been secured from the HSE on 16th January 2015 to ensure that all non nursing staff have a minimum training of Fetac level 5.
• Both managers have been supernumerary since Monday 19th January 2015 to ensure all recommendations are acted and issues addressed.
• A CNM3 has transferred from the Limerick Service since the 04.02.2015 for 3 weeks with the specific function of assisting staff to update care plans and documentation as required.
• Household post has been advertised for this designated centre to relieve this duty from care staff.

Proposed Timescale: 12/02/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Mandatory training was outstanding, including in relation to responding to the protection of vulnerable adults and the management of behaviour that challenges. Also, some staff required training relevant to their role including: hand hygiene/infection control training and training in relation to food safety.

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:
• One staff had not received training in Hand Hygiene, training scheduled 25.02.2015. The house manager and PIC will review the training logs of all staff, hand hygiene training will be completed by all staff in the centre and refreshers will be scheduled for all staff.
• The nominee provider has requested the infection control committee and the training co coordinator to review the timelines between hand hygiene training sessions, to ensure that all staff are at all times up to date with training in this area, and that refreshers are in line with best practice recommendations.
• Training has commenced on Challenging Behaviour by the Clinical Psychologist and will be completed by the 16.02.2015.
• Training in protection and welfare of vulnerable adults and the management of allegations of abuse will be completed by the 16th February 2015.
• Training on the complaints process and policy will commence on 23/02/2105 and 2/03/2015.

Proposed Timescale: 31/03/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of the medication management policies in place in the centre.

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:
The PIC in the area with the medication management nurse will provide input to all staff in the centre on the medication policy for the service area. Staff will familiarise

themselves with the policy also and sign the policy to indicate they have read and understood same. The medication management nurse is on the service drugs and therapeutics committee; she will feed back from this committee to all PICs and house managers, who will in turn share this information wih staff at the centres local meetings.
Proposed Timescale: 31/03/2015