# Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002459</td>
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<tr>
<td>Centre county:</td>
<td>Cork</td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Suzanne Moloney</td>
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<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
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<tr>
<td>Support inspector(s):</td>
<td>Vincent Kearns</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>21</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
• to monitor compliance with regulations and standards
• following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
• arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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**

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<th>From:</th>
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<tr>
<td>14 October 2014 08:00</td>
<td>14 October 2014 16:50</td>
</tr>
<tr>
<td>15 October 2014 07:30</td>
<td>15 October 2014 18:20</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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**Summary of findings from this inspection**

This was a registration inspection of a HSE centre for adults with disabilities and was the second inspection of this centre. The first inspection was a monitoring inspection carried out 19 and 20 March 2014. As part of the inspection process, inspectors met with residents, relatives and staff. Inspectors reviewed records such as residents' personal plans, medical records, policies and procedures, records of accidents and incidents, complaints log and personnel records.

Overall, the findings of this inspection demonstrated an inadequate level of compliance with the Health Act 2007 (Care and Support of Residents in Designated
Centre’s for Persons (Children and Adults) with Disabilities) Regulations 2013 and a significant number of improvements were required.

There were some recent changes to the governance and management structure with the appointment of a new provider nominee and the recruitment of a new person in charge. While there was a clearly defined management structure at senior level, improvements were required in relation to the daily supervision of care, in particular at weekends in the absence of the person in charge. Following discussions by inspectors with the provider nominee in relation to the findings of this inspection and in conjunction with the findings of the previous inspection, it was agreed that the person in charge would assume responsibility for this centre only, as the role had previously involved managing a number of centres.

Since the last inspection in March 2014 there were some improvements made to the centre such as upgrading the fire safety system and painting and decorating. However, due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents. Many areas on the centre were unclean, paintwork was damaged and surfaces of some equipment were damaged making them difficult to clean. Fire exits remained locked and not all were accessible with the same key, some fire exits opened inwards which was not in compliance with best practice and not all staff had adequate knowledge of fire safety practices.

Due to institutional practices, residents were not adequately supported to develop skills to enable them live as independently as possible and personal plans did not adequately identify how residents would be supported to achieve personal goals. There was no structured induction process to support new members of staff provide evidence-based care for the residents living in the centre and even though there were improvements in the staff training since the last inspection, improvements were still required such as the provision of training for communicating with residents with communication difficulties.

A number of additional improvements were required, including in areas such as:
- residents rights, dignity and consultation
- links with the community
- contract of care
- personal plans
- the centre was not suitably clean
- risk management practices
- fire safety arrangements
- safeguarding and safety
- notification of incidents
- provision of education and training to residents
- mealtimes and nutrition
- medication management
- statement of purpose
- governance and management arrangements
- records management
The action plan at the end of the report identifies additional improvements required 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 and the National Standards for Residential Services for Children and Adults with Disabilities 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:
Overall inspectors were not satisfied that issues identified for improvement in relation to residents' rights, dignity and consultation following the last inspection in March 2014 were satisfactorily addressed.

There was no evidence of a structured process of ongoing consultation with residents, relatives or advocates in relation to how the centre was planned and run. The action plan following the last inspection identified plans for a service user forum, however, this had not yet been implemented. A number of residents had access to an advocate and information was available on how to contact the advocacy service. However, a number of residents had moderate to severe intellectual disability and some residents had significant communication needs and would require assistance to access advocacy services. Inspectors were not satisfied that all residents that would benefit from the support of an advocate had the support of an advocate to speak on their behalf. For example, a small number of residents expressed to inspectors their desire for alternative accommodation and even though this was recorded in the complaints log, there was no documented plan in place identifying how these wishes would be addressed.

There was a policy on the management of complaints and the process for managing complaints was on public display in the centre. Inspectors viewed the complaints log that contained two complaints, both of which related to residents requesting alternative accommodation. Inspectors were not satisfied that complaints log contained a record of whether or not the residents was satisfied with the outcome of the complaint as required by the regulations.
The design and layout of the centre and care practices did not support the privacy and dignity of residents or support residents to make choices about their lives in a manner that reflected their individual preferences and diverse needs. For example, on the days on the inspection there were 21 residents living in the centre, 10 male and 11 female, only one of whom routinely participated in activities external to the centre each day. The provision of care to residents with an intellectual disability in an institutional type setting such as this was not in compliance with evidence-based practice and did not support residents to make choices about how they lived. In addition to the institutional nature of the centre there were other issues that compromised the privacy and dignity of residents. For example, the locking mechanism on the doors of bathrooms and toilets were broken and therefore none of the toilet doors could be locked to maintain the privacy of residents during personal hygiene. As will be discussed in more detail under Outcome 11, the presentation of food at mealtimes did not support the dignity of residents through practices such as adding milk to tea when it was still in large pots prior to serving residents.

The programme of activities included aromatherapy, literacy, music, art, baking, horticulture and outings to local parks and amenities. Other than outings, most activities were facilitated on site either in the vegetable garden and polytunnel (greenhouse) or in the prefabricated building located in the garden at the rear of the centre. Inspectors were informed that many residents enjoyed assisting with growing and harvesting vegetables and salads, which were mostly sold and any profits were reinvested in the garden. However, as identified at the last inspection, there was no evidence that the programme of activities was developed or adapted following consultation with residents to ensure they were in accordance with residents' interests, capacities and developmental needs.

Judgment:
Non Compliant - Major

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:
There was a communication policy, dated May 2014 and due for review in May 2015.

A significant number of residents had moderate to severe intellectual disabilities and some had significant communication needs to the extent that they were non-verbal.
Staff were seen to interact with residents and were aware of the communication needs of residents, however, they were not equipped to always meet those needs. For example, the record of one resident that was non-verbal indicated that he used LAMH (a standardised, manual sign system for those with intellectual disabilities and communication needs) as a means of communication. However, none of the staff had training in LAMH and were unable to communicate using this sign system. This resident occasionally presented with challenging behaviour, which, according to the resident’s records, was often precipitated by anxiety and frustration at the inability of staff to understand him. A speech and language therapy assessment, dated 15 October 2013, recommended a total communication approach (the use of a number of modes of communication such as signed, oral, auditory, written and visual aids), however, this was not referenced in the resident’s personal plan and there was no evidence that it was used in practice.

There was no evidence of the use of visual aids, such as pictorial menus, to communicate with residents. There was no evidence of the use of assistive technology or other aids and appliances to promote residents’ full capabilities in relation to communication. Residents had access to television and some residents had televisions and radios in their bedrooms. There was minimal evidence that residents were supported to develop and maintain links with the community.

**Judgment:**
Non Compliant - Major

**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:**
Residents were supported to maintain links with family members and inspectors noted visitors coming and going on both days of the inspection. There were adequate facilities for residents to meet with visitors in private. However, there was no structured process for relatives to be involved or kept informed of the wellbeing of residents. For example, not all families were kept informed of progress in relation to the transition of their relative to a community setting.

There was no evidence the residents were actively supported to develop and maintain links with the wider community through participation in community based activities.
**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There was an admissions policy. Inspectors were informed by the provider that the centre no longer accepted new admissions. Due to the institutional design and layout of the centre and some institutional practices, inspectors were not satisfied that the service was suitable for all residents living in the centre and did not have the capacity to meet their needs. For example, as has already been described in Outcome 2, staff were not adequately equipped to communicate with residents with communication difficulties. Additionally, and this is discussed in more detail in Outcome 5, residents were not adequately supported to develop life-skills to support them to live as independently as possible or to achieve goals set out in personal plans.

Since the last inspection a contract of care had been developed, which was sent to relatives for signing to indicate agreement, however, not all relatives agreed to sign the contracts. The contract set out the services to be provided and the fees to be charged, however, additional fees for services such as chiropody and hairdressing were not included.

**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:
Each resident received a comprehensive nursing assessment and each resident had a personal plan. Consistent with the findings of the last inspection, the plans predominantly focused on health issues, were not person-centred and did not have the maximum participation of the resident. For example, the personal plan for one resident indicated that her number one goal was to move from the centre to alternative accommodation. However, the plan did not identify who was responsible for assisting the resident to achieve this goal and did not identify anticipated timelines for when this would be achieved. Another resident asked inspectors if they could tell her when she was leaving the centre, as the uncertainty was causing her some anxiety. Even though a move to alternative accommodation was imminent for this resident, this was not reflected in the resident’s care plan and staff members were not aware when the move would take place.

While some plans indicated they had been reviewed, this was not the case for all plans and where reviews took place, the review did not always include an assessment of the effectiveness of the plan. Additionally, reviews were not always multidisciplinary. Based on a sample of personal plans, some were signed by residents, however, it was not clear what level of involvement residents had in developing plans based on their lack of knowledge and levels of anxiety in relation to their living arrangements. There was minimal evidence of the involvement of relatives in the development of plans. Relatives informed inspectors that they had discussions with staff in relation to residents' likes and dislikes, however, there was no ongoing discussion in relation to identifying and supporting residents achieve their goals. This was supported by discussions with relatives indicating they were not aware of residents' personal plans and were unaware of the imminent move of residents to alternative accommodation. Personal plans were stored in residents records, which were stored in the nurses' office making them inaccessible to residents and they were not written in an accessible format based on the needs of each resident.

Care practices were institutional in nature and staff members confirmed to inspectors that at least one resident's potential for independence had diminished due to living in the centre. While inspectors were informed that there would be a transition process to support residents move to alternative accommodation, this was not documented and staff members were not familiar with the planned process. There was minimal evidence that there was a programme in place to support residents develop life-skills to enable them to live as independently as possible. Institutional practice was reinforced by the segregation of residents and staff on the basis of gender. There was minimal integration of either female and male residents or staff, for instance at mealtimes, as there were separate dining rooms for female and male residents and separate arrangements for managing female and male residents' finances.
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:  
This was a two-storey premises that comprised a male and female wing, and on the days of the inspection residents were free to move between both wings. Resident accommodation comprised 30 single bedrooms, nine of which were unoccupied and unfurnished. Inspectors were informed that there would be no further admissions to the centre and these rooms would remain unoccupied. There were wash-hand basins in some, but not all, of the bedrooms. On the days of the inspection five female and eight male residents' bedrooms were on the ground floor and all other residents bedrooms were on the first floor.

Sanitary facilities comprised cubicle style toilets with wash-hand basins, assisted shower rooms and assisted bathrooms. Improvements were noted in the toilets and bathrooms since the last inspection, however, additional improvements were required. In particular the absence of a functioning locking mechanism on the doors of bathrooms and toilets needed to be addressed to support the provision of privacy and dignity for residents during personal hygiene activities.

There were two prefabricated buildings at the rear of the centre, one of which was used for activities and the other contained offices for medical, nursing and administrative staff.

Due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents. This was partly due to the large number of residents being accommodated in the centre, which did not support privacy and dignity and contributed to a noisy environment. This in turn posed challenges for staff to provide person-centred care and contributed to episodes of challenging behaviour by residents. Some improvements had taken place since the last inspection, which included fire safety improvement works, the centre had been painted internally and washable surfaces had been installed on the walls of bathrooms and toilets. However, despite these improvements, the centre was not suitably clean and decorated. For example:
• there was ingrained dirt in the corners of work surfaces, rust and stains on electrical appliances in the kitchenette, such as the cooker, dishwasher
• a number of bathrooms did not have extractor fans and there was evidence of mould on walls and ceilings
• there were no suitable sluicing facilities, resulting in commode pans being cleaned in the shower room, which potentially compromised the prevention of cross contamination
• there was dust, dirt and cobwebs behind a wire mesh in the treatment room
• there were no signs on bathroom and toilet doors
• cobwebs were visible on walls and ceilings
• excessive dust was noted on extractor fans, fire extinguishers and in the "soft play area"
• a coffee table was damaged leaving a sharp edged corner on the table
• walls and chairs were stained
• the fabric on a number of chairs was damaged
• paintwork was chipped in many areas
• the floor surface was torn and stained in one of the sunrooms.

Records were available demonstrating the preventive maintenance of equipment such as hoists, beds and baths.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
There was a corporate safety statement dated 2014 and a departmental safety statement dated January 2014. The centre had a risk register that addressed risks such as fire, accidents, violence in the workplace, service user absconding, and accidents, however, it did not address self-harm. There was no overall risk management policy outlining the arrangements in place for identifying, recording, investigating and learning from serious incidents. The inspector reviewed the record of accidents and incidents. Following an accident or incident an incident form was completed by a member of staff, which was usually reviewed by the consultant psychiatrist and/or the general practitioner (GP), who made recommendations for actions in response to some of the incidents. There was also a clinical risk management form associated with each incident for making recommendations in response to the incident but this was not completed for all incidents. There was, however, no evidence of an overall review of accidents and
incidents to identify trends to support learning and minimise the re-occurrence of such events.

Staff carried personal alarms to alert other staff when assistance was urgently required. However, the panel identifying the location of the staff member requiring assistance was located in a locked nurses' office and did not support staff to come to the aid of their colleague in a timely manner.

Each resident had a number of risk assessments completed and stored in their care plan, which included a risk assessment of residents that smoked. Some of these risk assessments did not adequately identify the controls in place or additional measures required to minimise the risks identified. Inspectors observed a number of risks that were not addressed in the risk register or individually for residents, such as access to the kitchen where sharp utensils and hot water boilers were readily accessible. Inspectors were not satisfied that there was an adequate system in place for monitoring risk to promote the health and safety of residents in the centre.

Inspectors noted that unlabelled cleaning chemicals, used for cleaning baths and wash-hand basins, were stored in toilets and bathrooms but there was no risk assessment to identify the risk of ingestion by residents or whether they should be stored securely and inaccessible to residents. Inspectors also noted personal hygiene items, such as skin barrier creams, that were available in communal bathrooms and were not labelled for individual use. Inspectors noted that one of these creams had been opened and was visibly unclean and posed a risk of cross contamination.

There was an emergency plan that addressed emergencies such as fire, electrical disruption, loss of water, loss of heating and the safe placement of residents in the event of a prolonged evacuation. Records indicated that most, but not all, staff had received up-to-date training in fire safety.

As part of the application process, confirmation of compliance with statutory requirements relating to fire safety and building control was signed by a suitably qualified person and submitted to the Authority. Inspectors viewed the fire safety register that indicated the preventive maintenance of the fire alarm system and the annual servicing of fire safety equipment. There were, however, no records available of testing emergency lighting and staff were unable to confirm that suitable emergency lighting was available. The fire alarm panel, used to identify the location of a fire, was located in the nurses' office, which was usually locked and not easily accessible by staff and inaccessible by residents or visitors in the event of a fire. Records indicated that most but not all staff, had received up-to-date training on fire safety. Not all staff members spoken with were knowledgeable of the evacuation process in the event of a fire, including the assembly point, and not all staff were familiar with the location of the fire alarm panel. Fire exits were locked and could only be opened with keys. Inspectors were informed that plans were in place to enable all doors to be opened with a master key and each member of staff would have a key. However, on the days of inspection some final fire exits locked with a different key. Inspectors observed a number of fire safety hazards, including door ledges on fire doors that were potential trip hazards and one of the fire doors opened inwards. Records indicated that fire drills were held frequently and each record outlined the number of staff and residents involved and time
it took for evacuation. One these records indicated that one of the final fire exits was unsuitable for use in the event of a fire and suggested that an alternative exit be used, this exit, however, continued to be identified as a fire exit. There were arrangements for reviewing fire precautions including the inspection of fire doors and ensuring fire exits were unobstructed. Each resident had a personal emergency evacuation plan outlining what to do in the event of a fire, however, these plans were identical for most residents and did not address each individual residents requirements in relation to evacuation, such as level of mobility and planned mode of evacuation.

**Judgment:**
Non Compliant - Moderate

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**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

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

**Findings:**
There was a policy and procedure in place, dated June 2013, identifying what to do in the event of suspicions or allegations of abuse. The policy was due for review in September 2014, however, this had not been completed on the days of inspection. There was an adult protection information booklet in easy read format. There was a policy on challenging behaviour dated September 2013 and a policy on the management of restraint, including physical, mechanical and the use of medication for restraint purposes. This policy was also due for review in September 2014, but the review had not taken place.

There were no reported incidents or allegations of abuse. There were adequate systems in place for the management of residents' finances. Most, but not all, staff had received training on recognising abuse and staff members spoken with by inspectors were knowledgeable of what to do in the event of suspicions or allegations of abuse. However, two members of staff were overheard speaking to residents in a disrespectful/inappropriate manner; one staff member was heard repeatedly telling a resident to leave a room in a non-respectful and forceful tone of voice and a second staff member talked about a resident as though the resident was not present in the room at the time of the conversation.
A number of residents presented with challenging behaviour and based on a sample of records viewed, personal plans described the specific nature of the behaviour, possible causes or triggers, warning signs and risks associated with the behaviour. There were behavioural support plans outlining the reactive strategy for managing the behaviour. Restrictive measures in use in the centre included the use of medication for incidents of extreme challenging behaviour when positive behaviour strategies were ineffective. There was a "physical intervention prescription form" for recording the use of medication as a form of restraint, which was signed by a consultant psychiatrist. All doors in the centre were locked and access and egress to the centre was through a keypad controlled main door: all other doors, including emergency exits, had manual locks and could only be opened with keys held by staff. There was no policy or procedure available for the management of these locked/secured doors or residents' access or egress from the centre

There was a room for use by residents, the walls of which were covered with thick, soft material, as were the floors. There was a significant amount of dust/stains on a number of the surfaces in the room and there was a strong unpleasant odour. This room was initially described to inspectors as a "soft play area", however, other staff members described it as a "time out" room that was used for some residents during incidents of challenging behaviour. There was no policy governing the use of the room to identify when it could be used, for what type of behaviour, the length of time that residents should spend there and the level of supervision required when residents were in the room. The room was isolated from the main part of the centre and did not facilitate the close supervision of residents while they were in the room. There was no reference in residents' care plans to indicate that therapeutic use of the room or the benefits to be obtained by residents spending time in the room.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
A record was maintained of incidents occurring in the centre. Based on records reviewed by inspectors, the Authority had been notified of relevant adverse incidents within three days, however, incidents required to be notified at the end of each quarter were not submitted.
Judgment:
Non Compliant - Moderate

### Outcome 10. General Welfare and Development
*Residents' 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:**
There was a policy on lifelong learning dated May 2014. Based on a sample of records reviewed, personal care plans identified goals of developing budgeting and money management skills, and reading and writing skills. Even though there was evidence that some residents were facilitated with literacy classes as a component of the activities programme, there was insufficient evidence to identify how residents would be supported in achieving many of the goals identified. As already stated in Outcome 1, there was no evidence that the programme of activities was developed based on an assessment of residents in order to provide activities to support residents achieve their potential.

Judgment:
Non Compliant - Moderate

### 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:**
Each resident had a nursing assessment recorded on an "initial assessment" form, however, based on a sample of records viewed, all sections of the document were not
completed for each resident. For example, for one resident known to have diabetes, the section of the form for recording blood pressure, pulse, fasting blood sugar, and urinalysis was not completed. Some elements of the nursing assessment for a number of residents, such as manual handling assessment and oral health check, were not dated and it was therefore not possible to determine if all assessments were reviewed as appropriate and up-to-date.

Records indicated that residents had access to the services of a GP and there was evidence of regular assessment and review, however, there were no records available to indicate that residents were consulted in relation to whether or not the GP was acceptable to them. Residents had access to out-of-hours GP and urgent care services. The service provided in the centre was led by a consultant psychiatrist and there was evidence of regular review. Even though inspectors were informed of limited access to allied health services, records indicated referral and review by dietetics, speech and language therapy, chiropody and physiotherapy.

Most of the residents living in the centre on the days of inspection had a comprehensive assessment in 2013 by an external organisation involving a review by a multidisciplinary (MDT) team comprising a psychologist, a social worker, a speech and language therapist (SALT), an occupational therapist and nursing/behavioural support. Following the review, a report was written for each resident that contained a number of recommendations to enhance the health status of residents and to promote their independence. For example, recommendations included onward referral for assessment by other specialist/allied health services. While records indicated that many of these recommendations were implemented, there was no systematic process to ensure that all of these recommendations were addressed.

One resident had a wound and there was evidence of regular review by a wound management specialist. Wound assessment charts, including the use of photographs, were used to support the ongoing assessment and management of the wound. There was, however, no policy available to guide wound management.

Residents’ food was prepared in a kitchen based within the same campus as the centre and was delivered in heated food trolleys. Records indicated that residents had a nutritional assessment, including monthly weights. Food appeared to be nutritious, available in sufficient quantities and residents were offered a choice of food at mealtimes. A number of improvements, however, were required. For example, there was no evidence of consultation with residents in relation to the menu options available. However, residents on modified diets were not offered a choice of food at mealtimes, as there was only one option of modified texture food available for each meal. In addition and as already discussed in Outcome 2, there were no pictorial aids available to support communication with residents with communication difficulties in relation to menu options. Improvements were also required in relation to the presentation of food. For example, inspectors observed residents that were prescribed a modified diet having their food served with the potato, vegetable, meat and gravy/sauce all mashed together by staff before being served. As already discussed in Outcome 1, tea was served from large pots with milk already added. The records of one resident indicated that the resident had been given free fluids when the resident had been prescribed thickened fluids. Even though a subsequent assessment of the resident recommended that the resident could
have free fluids, this was being done in the absence of an updated review by a SALT. The personal plan of this resident did not accurately reflect the resident’s current nutritional needs, as it had not been updated following the most recent review by a SALT.

**Judgment:**
Non Compliant - Moderate

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**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:**
There was a policy on medication management dated September 2013 and due for review in September 2014, but this had not taken place. The policy was not centre-specific as it made reference to another designated centre and practices not relevant to this centre. There was no process in place to ascertain if the available pharmacist was acceptable to the residents.

Based on a review of a sample of prescription and medication administration records, all appropriate information was available on the records to support the safe administration of medicines. Residents’ prescriptions were regularly reviewed. An audit of medication management had taken place in October 2014 and deficits were identified.

There was a large quantity of "stock" medications, however, there was no stock control system in place. There was a system in place for returning unused/out-of-date medications to the pharmacist, however, improvements were required. For example, some medicines were disposed of in sharps boxes, which was not in compliance with best practice.

There were no controlled drugs in the centre on the days of inspection.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
There was a written statement of purpose, however, it did not accurately describe the services provided in the centre and did not contain all of the information required in Schedule 1 of the regulations. It did not adequately address the details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision or the arrangements made for respecting the privacy and dignity of residents. For example, it did not make reference to:
- the locked doors
- the time out room
- the segregation of residents and staff based on gender.

The statement of purpose was not available in a format accessible to the residents.

**Judgment:**
Non Compliant - Moderate

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**Outcome 14: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The centre was operated by the health service executive (HSE) and was one of five designated centres for adults with a disability operated by the HSE in the Cork region. A new provider nominee had recently been appointed with responsibility for all of the HSE
disability centres in Cork. A new person in charge (PIC) had recently been recruited by the service, and following interview, inspectors were satisfied that she had the required qualifications, experience, and demonstrated sufficient knowledge of legislation and of her statutory responsibilities.

While there was a clearly defined management structure, with clear lines of authority, accountability and responsibility at senior management level, improvements were required in relation to the supervision of care delivery on a day to day basis within the centre. The PIC reported to the provider nominee. The PIC was supported in her role by a clinical nurse manager 3 (CNM 3) who worked four days each week, from Monday to Thursday, and was based in an office to the rear of the centre. In the absence of the PIC, an assistant director of nursing (ADON) was available but was based in another centre approximately 50 kilometres away. Based on a review of the roster and discussions with staff, clarity was required in relation to who was in charge and supervised care delivery from Friday to Sunday and at evenings and weekends. In order to maintain staffing levels the centre relied on staff to work overtime and on agency staff. If a clinical nurse manager or a senior staff nurse was scheduled to work overtime on a particular shift they would be deemed to be in charge. However, if they decided not to work the overtime shift at short notice, which frequently occurred, then a nurse from the agency could be in charge. Inspectors were not satisfied that this provided adequate oversight of the centre to support the consistent delivery of safe, effective care.

The findings of the previous inspection, in March 2014, identified unsatisfactory governance and management arrangements in the centre. The findings of this inspection identified that no significant improvements had taken place and many of the issues identified on the previous inspection were not satisfactorily addressed. The provider agreed that the recently appointed PIC would assume responsibility for this centre alone, rather than the previous arrangement whereby the PIC was responsible for a number of centres.

A number of audits had been completed by the PIC in the weeks prior to the inspection, however, there was minimal evidence of a systematic process to review the quality and safety of care prior to these audits. The audits included medication management, complaints management, wound management, restraint management, and an audit of personal finances. The audits identified a number of required improvements, however, as the audits had only recently been completed there was minimal evidence of improvements in response to the audits. An infection prevention and control audit completed by an infection control nurse in July 2014 identified a number of issues for improvement, however, the findings of this inspection indicate that many of the issues identified were not satisfactorily addressed. These included the inappropriate storage and communal use of personal hygiene items and deficits in environmental cleaning. The process of audit did not incorporate consultation with residents and/or their representative/relatives.

**Judgment:**
Non Compliant - Major
**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:**
The person in charge was absent for a period in excess of 28 days and the required notification was submitted to the Authority.

**Judgment:**
Compliant

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**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:**
While there was evidence to support the provision of resources, for example, by the improvements made to the centre since the last inspection in areas such as fire safety works and redecoration, improvements were required. The facilities and services available did not reflect the statement of purpose or support residents to achieve maximum independence and quality of life.

**Judgment:**
Non Compliant - Minor

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**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:**
The centre provides a consultant psychiatrist led service and all of the residents had an intellectual disability. The centre was predominantly staffed by psychiatric nurses and only a small number have a qualification in intellectual disability. There was insufficient whole time equivalent staff for the number of staff rostered on duty each day. The staffing shortfall was filled by staff working overtime and by agency staff. As already discussed in Outcome 14, there were inadequate arrangements in place for the supervision of care delivery at all times. For example, a number of newly qualified registered psychiatric nurses had started working in the centre approximately one year prior to this inspection. Prior to commencing work in the centre, these nurses had visited the centre for approximately one hour to get information about the centre, such as duty rosters, however, there was not an adequate programme of induction particularly in relation to the specific profile of residents living in the centre.

Training records viewed by inspectors indicated a programme of education to address the shortcomings identified at the last inspection. A significant number of staff had attended fire safety training, manual handling training and recognition and response to abuse, however, as identified in the relevant outcomes of this report, not all staff had received up-to-date training on these subjects. Additional training provided and attended by a significant number of staff included the management of aggression and violence, care planning, the management of challenging behaviour, hand hygiene, children first and cardiopulmonary resuscitation. Additional training, however, was required to support staff care for residents, particularly in relation to communicating with residents with communication difficulties.

Of a sample of personnel files viewed by inspectors, most contained all the requirements of the regulations such as photographic identification, Garda vetting, current registration with relevant professional body, however, a number of files did not containing a full employment history with a satisfactory explanation for any gaps or two written references, including a reference from their most recent employer.

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

**Findings:**
Records in relation to Schedule 2, 3, and 4 were available in the centre and made available to inspectors. Records were kept secure but easily retrievable. However, records such as personal care plans were not in an accessible format or accessible to residents.

There was a residents’ guide in an accessible format, however, it did not include all of the information required by the regulations, such as the terms and conditions relating to residency, arrangements for resident involvement in the running of the centre, how to access any inspection reports on the centre or sufficient detail of the complaints process.

Most of the policies and procedures outlined in Schedule 5 of the regulations were available, however, some were not centre-specific, such as the medication management policy and others were not available, such as provision of behavioural support; creation, access and destruction of records; and access to education training and development.

There was no directory of residents containing all of the information specified in paragraph 3 of Schedule 3 of the regulations.

As part of the application process the provider had submitted proof of insurance and injury to residents and damage to property.

**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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Health Information and Quality Authority**

**Regulation Directorate**

**Action Plan**

**Provider’s response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002459</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>14 October 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>18 February 2015</td>
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</tbody>
</table>

**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 design and layout of the centre and care practices did not support the privacy and dignity of residents or support residents to make choices about their lives in a manner that reflected their individual preferences and diverse needs. For example:

- the provision of care to residents with an intellectual disability in an institutional type setting such as this, is not in compliance with evidence-based practice and does not

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
support residents make choices about how they live
• the locking mechanism on the doors of bathrooms and toilets were broken and therefore could not be locked to maintain the privacy of residents during personal hygiene
• the presentation of food at mealtimes did not support the dignity of residents through practices such as adding milk to tea when it was still in large pots prior to serving residents.

**Action Required:**
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:**
The nursing team will work with the multidisciplinary team and relatives to support the resident in a social model of care in making choices, recognising their individual preferences while meeting their diverse needs. As part of this review to date the Service level plan and the Service placement plan is actively progressed at management meetings.

A further two A/CNM2 posts have been appointed to strengthen the supervision bringing the number of CNM2 posts to four. Two/three CNM2 will be scheduled on the day duty roster with at least one CNM2 to provide governance at weekends.

A new locking system and signage has been sourced for all bathrooms and toilet facilities to support the resident with privacy dignity and intimate care needs is presently in progress.

The practice of adding milk to the tea in tea pots has been discontinued following a meeting with staff after the inspection (6th October 2014). The nutritional policy will be reviewed and a protective meal time committee to be set up, with service users, relatives and staff.

**Proposed Timescale:** 14/02/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of a structured process of ongoing consultation with residents, relatives or advocates in relation to how the centre was planned and run.

**Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
Residents & relatives attended a gathering celebration on the 30th November 2014. This provided an opportunity to share information about the planned closure, the plans to identify appropriate alternative placements for residents and the supports that will be provided during the transition process. There is a planned schedule of reviews and residents/relatives are actively involved in same. Negotiation is on-going with Advocacy Services to build on and strengthen advocacy support. The advocates are to begin a process of getting to know all service users in accordance with individual wishes. Where appropriate key workers will assist the individual, in particular to support those residents with communication difficulties. As this develops there will be planned group meetings for residents.
Aug 2015(to provide support following Discharge)

**Proposed Timescale:** 31/08/2015  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
A number of residents had moderate to severe intellectual disability and some residents had significant communication needs and would require assistance to access advocacy services. Inspectors were not satisfied that all residents that would benefit from the support of an advocate had the support of an advocate to speak on their behalf.

**Action Required:**  
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

**Please state the actions you have taken or are planning to take:**  
Meetings have commenced for the PIC with the service users’ key workers to meet with the service users/relatives to identify and alleviate any anxiety or concerns around the service and plans for the immediate future.

Person in Charge to meet with the National Advocacy and Cork Advocacy services to identify current available support and to develop additional supports. Initial meetings held on 10/11/2014 and 17/11/2014. Following further discussions there will be an advocacy forum and individual advocacy service for residents and relatives to support them in the transition and in the settling phase in the new service

Through the PCP process, service users with their families will be met on an individual basis and supports will be provided in partnership with all the stakeholders.

A referral has been made for Speech and Language Therapy for all of the individuals who have communication deficits and to support staff in utilizing alternative and augmentative communication systems. One staff has attended training on augmentative communication. A Speech and Language Therapist has provided material on picture communication systems.
**Proposed Timescale:** 31/01/2015  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The programme of activities was not developed or adapted following consultation with residents to ensure they were in accordance with residents' interests, capacities and developmental needs.

**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:**  
The Day Service has begun a one to one programme with each resident to explore their choices and agree activities based on their needs/preferences. This information will be readily available in an easy read format incorporating pictures/photographs.

A Psychologist, Occupational Therapist and Speech and Language Therapist have been sourced to support the residents with behaviours of concern, sensory needs and communication needs to access activities and new experiences based on their individual needs.

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**Proposed Timescale:** 30/04/2015  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The complaints log did not contain a record of whether or not residents were satisfied with the outcome of complaints as required by the regulations.

**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:**  
The Complaints Officer and the CNM2s' will ensure the complaints procedure is adhered to. Any complaints logged will have documented the investigations and outcomes in line with policy. The person in charge will audit the complaints log and prepare reports for the management team meeting.

Staff will be supported to understand behaviours that may indicate a concern or
complaint that a service user with an intellectual disability cannot communicate by other means.

**Proposed Timescale:** 15/12/2014

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents with communication difficulties were not adequately supported to communicate, for example:
- there was no evidence of the use of visual aids, such as pictorial menus, to communicate with residents
- staff were seen to interact with residents and were aware of the communication needs of residents, however, they were not equipped to always meet those needs, such as the ability to communicate with residents through sign.

**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:**
A Speech and Language Therapist is being sourced to support staff to communicate appropriately and effectively with service users.

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

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of the use of assistive technology or other aids and appliances to promote residents' full capabilities in relation to communication.

**Action Required:**
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

**Please state the actions you have taken or are planning to take:**
A Speech and Language Therapist is being sourced to identify alternative and augmentative communication systems for service users as appropriate. This information will be included in all service users PCPs.
### Outcome 03: Family and personal relationships and links with the community

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence the residents were actively supported to develop and maintain links with the wider community.

**Action Required:**
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

**Please state the actions you have taken or are planning to take:**
Service users/relatives survey to be completed to determine each service users wishes and interests for participation in the wider community.

The Person Centred Plan for each individual will be reviewed to support individuals to develop links with the wider community in accordance with their wishes or known wishes represented on their behalf by their relative /advocate.

This will all be part of each resident’s transitional plan which will have the overall support of a Multidisciplinary Management Team. Key Performance Indicators to be set with each resident, for example including a choice of two community based activities weekly.

### 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:**
The contract of care set out the services to be provided and the fees to be charged, however, additional fees for services such as chiropody and hairdressing was not included.

**Action Required:**
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

**Please state the actions you have taken or are planning to take:**
The current contract of care will be reviewed to include details of any additional fees and to include an easy read format to support the individual.

**Proposed Timescale:** 31/12/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Due to the institutional design and layout of the centre and some institutional practices, inspectors were not satisfied that the service was suitable for all residents living in the centre and did not have the capacity to meet their needs.

**Action Required:**  
Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**  
There will be no further admissions to the service. A new Discharge Policy will focus on the transition of service users to a community setting meeting their needs in terms of choice, level of ability and supporting any complex needs.

The statement of purpose is to be reviewed and updated to provide for the changing profile of the service.

**Proposed Timescale:** 18/12/2015

**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:**  
Personal plans did not address all needs identified on assessment, such as the total communication approach recommended for one resident.

**Action Required:**  
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

**Please state the actions you have taken or are planning to take:**  
All PCPs are currently being reviewed to take cognisance of deficits identified as part of the HIQA inspection.
Proposed Timescale: 31/01/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre was not suitable for all residents living in the centre and did not have the capacity to meet their needs, for example:
• the institutional design and layout of the centre did not support the privacy and dignity of residents
• the noisy environment contributed to episodes of challenging behaviour
• institutional practices contributed to the diminution of residents' potential for independence.

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:
No further admissions. It is intended for the service to close on 30th June 2015.

The is a placement group that have monthly meetings for sourcing placements for each service user based on their person-centred care plan.

A Resident/Relatives gathering was held on the 30th November 2014 and this allowed for the opportunity to discuss the shortcomings of the service and the need to progress the closure plan. The value of establishing a resident/relative committee was discussed and it was agreed that this would be to be set up. It was also explained that each individual would have a transition plan, suitable service providers would be identified and advocacy support would be provided.

As the number of service users gradually reduce this should alleviate the negative impact on service users due to the design of the present facility. Since the inspection four residents have been supported in a transition to a community setting with another service.

To strengthen the governance and leadership there are now two additional CNM2s appointed and are working over the seven day week.

Each resident’s transition plan will take into consideration their requests of geographical preference/choice, behaviour of concern and supports required, complex needs, level of intellectual disability, age and known interests. The new service provider has been requested to engage with service users and their families in relation to the location on the new service so as to ensure that visiting arrangements and integration with the local community are made as easily as possible. It has been agreed that the needs of the service users and their preferred choices are met as far as possible. In advance of the new service provider being identified staff in the centre have already engaged with service users and their families in relation to their preferred location and need.

The centre has the support of a consultant Psychiatrist and a General Practitioner.

To strengthen the Multidisciplinary support a Speech and Language Therapist and
Dietician have been sourced and have completed swallow and dietician assessments. A number of staff has received training on EDS (Eating Drinking & Swallowing Disorders) and modified diets. A Psychologist is currently completing assessments for three Residents and a referral has been made to support residents with behaviour management. An Occupational Therapist with sensory integration training will complete assessments for three residents on the 20th February and a referral has been made to support some residents with sensory needs. The Resident/Relative committee, the National Advocacy and the Cork Advocacy Service will provide strong guidance in meeting the rights of the residents in the transition plans. A referral was made for a resident to elderly care services in the preferred geographical area. An assessment has been undertaken and the outcome of same is awaited. One resident has an identified residential place pending finalization of costs.

Service development plans and costing have been received from two service providers with proposals to develop new services for the residents by purchasing suitable accommodation and it is intended a decision will be made during February 2015. Two service providers are in discussions on possible placements for two to three residents. To date there is no service plans or no community facility assigned.

It is planned that the service providers for each resident will be agreed in February to facilitate the involvement of the residents/relatives with progressing transition plans. It is recognised that the due to the urgency in responding to the unsuitable building and institutional setting that the initial changes may have major impacts for the residents due to their behaviour and complex needs and the number of residents experiencing change at the same time. To alleviate any negative impacts and to assist in analysing their needs in a community setting a team member from an alternative service provider will provide support in the centre over the day and night. This will also give an opportunity for the service users to develop relationships with staff from the new providers.

Further discussions will need to be held following contract of services for each resident, with resident/relative and other relevant stakeholders to agree a closure plan in June 2015 that is in line with Regulations and standards and best meets the needs of each resident in their move to a community setting.

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:

Personal plan reviews did not include an assessment of the effectiveness of the plan.

Action Required:

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

**Please state the actions you have taken or are planning to take:**
An audit of care plans to be completed by the PIC which will evaluate the effectiveness of the progress for the individual.

Individual care plans will be held for all service users in supporting their social model of care.

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

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not adequately involved in developing their personal plans and there was minimal evidence of the involvement of relatives, where appropriate. Relatives were not always kept informed of progress in relation to personal plans, for example in relation to progress with transitioning to the community.

**Action Required:**
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident’s wishes, age and the nature of his or her disability.

**Please state the actions you have taken or are planning to take:**
All relatives will be invited to an event on the 30/11/2014 to facilitate a consultation and information sharing session.

The team will work with the multidisciplinary team and relatives and the new service teams to support the service user in a social model of care.

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

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were stored in residents’ records, which were stored in the nurses’ office making them inaccessible to residents and they were not written in a format accessible to each resident.

**Action Required:**
Under Regulation 05 (5) you are required to: Ensure that residents’ personal plans are made available in an accessible format to the residents and, where appropriate, their
representatives.

**Please state the actions you have taken or are planning to take:**
A person centred care plan will be made available in easy accessible and readable format for each service user. The key worker will support the service user in developing the personal plan so that they will have a greater input into the aims and objectives of the plan.

| **Proposed Timescale:** 31/01/2015 |
| Theme: Effective Services |

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plan reviews were not always multidisciplinary.

**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:**
Reviews are held involving the resident/relative, psychiatrist, GP, building on the multidisciplinary support the service has support of a speech and Language Therapist, Dietician. A Psychologist is currently completing assessments for three residents and an Occupation Therapist is to do assessments on the 20th February.

The personal plans will be reviewed with the service user, the relative and the MDT team.

| **Proposed Timescale:** 14/02/2015 |
| Theme: Effective Services |

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in relation to ongoing nursing assessment and review:

- all sections of the nursing assessment were not completed for each resident
- some elements of the nursing assessment for a number of residents, such as manual handling assessment and oral health check, were not dated and it was therefore not possible to determine if all assessments were reviewed as appropriate and up-to-date
- the personal plan of one resident did not accurately reflect the resident's current nutritional needs, as it had not been updated following the most recent review by a SALT.

**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:**
An audit of care plans to be completed by the PIC which will assess the effectiveness of the progress for the individual.

Feedback of the audit outcomes and the education of staff on the learning outcomes on the requirements for documentation to be given at staff meetings and guiding staff at individual meetings.

**Proposed Timescale:** 31/01/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While records indicated that many recommendations of a MDT assessment were implemented, there was no systematic process to ensure that all of these recommendations were addressed.

**Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
An audit of care plans to be completed by the PIC which will assess the effectiveness of the progress for the individual.

Individual care plan reviews to be held for all residents in supporting their social model of care.

The personal plans will be reviewed with the resident, the relative and the MDT team.

The assessments will be updated based on the changing needs and choices of the residents.

**Proposed Timescale:** 31/01/2015
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While inspectors were informed that there would be a transition process to support residents move to alternative accommodation, this was not documented and staff members were not familiar with the planned process. There was minimal evidence that there was a programme in place to support residents develop life-skills to enable them
to live as independently as possible.

**Action Required:**
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

**Please state the actions you have taken or are planning to take:**
All relatives will be invited to an event on the 30/11/2014 to facilitate a consultation and information sharing session.

Service user/relatives committee to be set up.

The nursing team will work with the multidisciplinary team and relatives to support the resident in a social model of care in making choices, recognising their individual preferences while meeting their diverse needs. There will be ongoing person centred support in building on the resident’s independence in preparation for community living.

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

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents.

**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:**
Due to the building not being in compliance with regulation and standards as a home for a person with a disability there will be no further admissions to the service. Alternative service providers and service type will be agreed for all residents in February. Further discussions will need to be held following contract of services for each resident, with resident/relative and other relevant stakeholders to agree a closure plan in June 2015 that is in line with regulations and standards and best meets the needs of each resident in their move to a community setting.

**Proposed Timescale:** 30/11/2014

**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The premises was not in a good state of repair, for example:

- there was ingrained dirt in the corners of work surfaces, rust and stains on electrical appliances in the kitchenette, such as the cooker, dishwasher
- a number of bathrooms did not have extractor fans and there was evidence of mould on walls and ceilings
- there were no suitable sluicing facilities resulting in commode pans being cleaned in the shower room, which was not good infection prevention and control practice and could contribute to cross contamination
- many bathrooms and toilets did not have a functioning locking mechanism
- a coffee table was damaged leaving a sharp edged corner on the table

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:
As the service is supporting the service users to transitional to community facilities minimum structural work is planned to take place between now and the closure date.

The damaged coffee table has been removed.

A new locking system and signage for all bathrooms and toilet facilities to support the residents with privacy, dignity and intimate care needs is presently in progress.

The infection control nurse has been to the service and is due to return again on Dec 5th in supporting a review of the cleaning schedules and audits.

This includes a review of the current schedule of household staff which is being undertaken to give greater continuity to meet cleaning requirements pending the planned closure. There are a number of service users with complex dependency needs being discharged from the service.

Proposed Timescale: 15/12/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre was not suitably clean and decorated, for example:

- there was dust, dirt and cobwebs behind a wire mesh in the treatment room
- there were no signs on bathroom and toilet doors
- cobwebs were visible on walls and ceilings
- excessive dust was noted on extractor fans, fire extinguishers and in the "soft play area"
• walls and chairs were stained
• the fabric on a number of chairs was damaged
• paintwork was chipped in many areas
• the floor surface was torn and stained in one of the sunrooms

**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:**
A new locking system and signage for all bathrooms and toilet facilities to support the resident with privacy, dignity and intimate care needs is presently in progress.

The padding was removed from the soft play area on the 16th October and the room is no longer in use.

The infection control nurse has been to the service and is due to return again on Dec 5th in supporting a review of cleaning schedules and audits. This review includes the current schedule of household staff to give greater continuity to meet cleaning requirements pending the planned closure.

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**Proposed Timescale:** 15/12/2014

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**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:**
There was no overall risk management policy outlining the arrangements in place for identifying, recording, investigating and learning from serious incidents.

**Action Required:**
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review. The risk management policy will be developed by this committee which will include a system for identifying and recording and the investigation of any risks or near misses and learning from the serious incidents or adverse events involving residents.

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**Proposed Timescale:** 18/01/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of improvements were required in relation to the management of risk:
• there was no evidence of an overall review of accidents and incidents to identify trends to support learning and minimise the reoccurrence of such events
• some risk assessments did not adequately identify the controls in place or additional measures required to minimise the risks identified
• a number of risks that were not addressed in the risk register or individually for residents, such as access to the kitchen where sharp utensils and hot water boilers were readily accessible
• unlabelled cleaning chemicals, used for cleaning baths and wash-hand basins, were stored in toilets and bathrooms but there was no risk assessment to identify the risk of ingestion by residents or whether they should be stored securely and inaccessible to residents
• the personal alarm panel identifying the location of the staff member requiring assistance was located in a locked nurses office and did not support staff to come to the aid of their colleague in a timely manner.

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:
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review. The risk management policy will be developed by this committee which will include a system for identifying and recording and the investigation of any risks or near misses and learning from the serious incidents or adverse events involving residents including responding to an emergency.

The cleaning chemicals are no longer stored in the bathroom or toilet areas. They are now in a secure locked press which is inaccessible to residents.

All accidents and incidents will be audited and trends identified. Feedback to be given to staff at team meetings’ to support the learning and any changes that need to be made to minimise a recurrence.

All risk assessments will be updated in line with risk management policy to identify controls in place or additional measures required to minimise the risks identified.

The locked nurse’s office which houses the personal alarm panel will cease to be locked from the 08th Dec 2014 as new arrangements have been made for the use of this office.

Proposed Timescale: 18/02/2015
**Theme: Effective Services**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted personal hygiene items, such as skin barrier creams, that were available in communal bathrooms and were not labelled for individual use. One of these creams had been opened and was visibly unclean and posed a risk of cross contamination.

**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:**
Personal toiletries are no longer left in the bathroom areas and service users are encouraged to keep their belongings in their labelled toilet bags / storage boxes in their own room.

**Proposed Timescale:** 20/10/2015

**Theme: Effective Services**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no suitable sluicing facilities, resulting in commode pans being cleaned in the shower room, which potentially compromised the prevention of cross contamination.

**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:**
As the service is supporting the service users in a transitional plan to move to community facilities minimum structural work is planned to take place between now and the closure date.

The infection control nurse has been to the service and is due to return again on Dec 5th in supporting a review of cleaning schedules and audits.

The residents with complex dependency needs have been transitioned to alternative placements since the inspection.
**Proposed Timescale:** 20/12/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Each resident had a personal emergency evacuation plan outlining what to do in the event of a fire, however, these plans were identical for most residents and did not address each residents requirements in relation to evacuation, such as level of mobility and planned mode of evacuation.

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

**Please state the actions you have taken or are planning to take:**  
Each service user’s emergency evacuation plan will be reviewed simultaneously with the development of the risk management policy and procedures.

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**Proposed Timescale:** 18/02/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There were arrangements for reviewing fire precautions including the inspection of fire doors and ensuring fire exits were unobstructed, however this was not always completed.

**Action Required:**  
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**  
A further two A/CNM2 posts have been appointed to strengthen the supervision bringing the number of CNM2 posts to four. This will allow for two/three CNM2s to be scheduled on the Day Duty Roster with one CNM2 on to address governance issues at weekends. These posts will allow the introduction of a supervision system for auditing fire precautions and ensuring updated documentation is kept, audited and the outcomes brought to team meeting for planned actions.

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**Proposed Timescale:** 15/12/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Inspectors observed a number of fire safety hazards, including;
• there were door ledges on fire doors that were potential trip hazards
• one of the fire doors opened inwards
• there were no records available of testing emergency lighting and staff were unable to confirm that suitable emergency lighting was available.
• fire exits could only be opened with a key
• the fire and safety officer indicated that one of the identified fire exits was unsuitable.

**Action Required:**
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
As the service is supporting the service users in a transitional plan to move to community facilities minimum structural work is planned to take place between now and the closure date.

A new key system has been put in place which minimises the number of keys required for external doors. Each member of staff on duty holds a set of these keys.

The fire officer has been contacted to review the fire system in place and incorporate the records of testing emergency lighting.

**Proposed Timescale:** 15/12/2014

**Theme:** Effective Services

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The fire alarm panel, used to identify the location of a fire, was located in the nurses office, which was usually locked and not easily accessible by staff and inaccessible by residents and visitors in the event of a fire.

**Action Required:**
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

**Please state the actions you have taken or are planning to take:**
The locked nurse’s office which houses the fire alarm panel will cease to be locked from the 8th Dec 2014 as new arrangements have been made for the use of this office.

**Proposed Timescale:** 08/12/2014

**Theme:** Effective Services

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff members spoken with were knowledgeable of the evacuation process in the
event of a fire, including the assembly point, and not all staff were familiar with the location of the fire alarm panel.

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

**Please state the actions you have taken or are planning to take:**
A further two A/CNM2 posts are now appointed to strengthen the supervision bringing the number of CNM2 posts to four allowing for two/three CNM 2’s to be scheduled on the Day Duty Roster with one CNM 2 on to address governance issues at weekends. These posts will allow the introduction of a supervision system for auditing fire precautions and ensuring updated documentation is kept, audited and the outcomes brought to staff meeting for planned actions.

Arrangements will be put in place for all staff to receive training to meet with fire emergency procedures and drills.

**Proposed Timescale:** 18/01/2015

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**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not satisfied that there was clarity in relation to the use of the soft play/time out room regarding:
- the evidence base to support the use of the room
- the therapeutic use of the room or the benefits to be obtained by residents spending time in the room
- when it could be used
- for what type of behaviour
- the length of time that residents should spend there
- the level of supervision required when residents were in the room

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

**Please state the actions you have taken or are planning to take:**
The padding was removed from the soft play area on the 16th October and the room is no longer in use.
Proposed Timescale: 16/10/2014

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no policy or procedure available for the management of locked/secured doors or residents access or egress from the centre

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

Please state the actions you have taken or are planning to take:
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review.

Proposed Timescale: 18/02/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two members of staff were overheard speaking to residents in a disrespectful/inappropriate manner; one staff member was heard repeatedly telling a resident to leave a room in a non-respectful and forceful tone of voice and a second staff member talked about a resident as though the resident was not present in the room at the time of the conversation.

Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
A further two A/CNM2 posts are now appointed to strengthen the supervision bringing the number of CNM2 posts to four allowing for two/three CNM 2 s’ to be scheduled on the Day Duty Roster with one CNM 2 on to address governance issues at weekends.

Staff that have not received ‘recognising and responding to abuse’ training will attend for training on the 3rd of March 2015. The new policy on safeguarding vulnerable adults has been brought to the attention of all staff, residents and relatives. A discussion regarding the implementation of this policy will be facilitated at staff meetings.

A referral for Speech and Language therapy has been made to support staff to communicate appropriately and effectively with residents. Communication picture symbols have been provided by the speech and language therapist. One staff has received training regarding alternative and augmentative communication.
**Proposed Timescale:** 31/01/2014  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Most, but not all staff, had received up-to-date training on the recognition and response to abuse.

**Action Required:**  
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**  
Staff who have not received up to date training in safeguarding, recognising and responding to abuse will be identified and training will be offered at the next available date on the 3rd of March.

Review of recognising and responding to abuse and the vulnerable adult Policy will be facilitated at team meetings to support the service user with dignity and respect at unit level.

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**Proposed Timescale:** 31/03/2015

**Outcome 09: Notification of Incidents**  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Incidents required to be notified to the Chief Inspector at the end of each quarter were not submitted.

**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:**  
Incidents have been submitted as per notification requirements when due since the inspection date.

Incidents from previous Quarters to be submitted to comply with regulations.
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Incidents required to be notified to the Chief Inspector at the end of each quarter were not submitted.

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

Please state the actions you have taken or are planning to take:
Incidents have been submitted as per notification requirements when due since the inspection date.

Incidents from previous quarters to be submitted to keep in line with regulations.

Proposed Timescale: 15/01/2015

Outcome 10. General Welfare and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence to demonstrate that residents are supported to attain educational goals outlined in personal plans.

Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
Each service user will be consulted and through this transitional phase will be facilitated to explore education and / or employment opportunities.

Proposed Timescale: 30/04/2015

Outcome 11. Healthcare Needs

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Records indicated that residents had access to the services of a GP and there was evidence of regular assessment and review, however, there were no records available to indicate that residents were consulted in relation to whether or not the GP was acceptable to them.

**Action Required:**
Under Regulation 06 (2) (a) you are required to: Ensure that a medical practitioner of the resident's choice or acceptable to the resident is made available.

**Please state the actions you have taken or are planning to take:**
The statement of purpose will be reviewed and incorporate information that should a service user or relative request a choice of G.P this will be facilitated.

**Proposed Timescale:** 18/01/2015

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation choice of food for all residents:
- there was no evidence of consultation with residents in relation to the menu options available
- residents on modified diets were not offered a choice of food at mealtimes, as there was only one option of modified texture food available for each meal
- tea was served from large pots with milk already added.

**Action Required:**
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

**Please state the actions you have taken or are planning to take:**
A protective meal time committee has been set up with representatives of service users, and staff members. This committee is reviewing the nutritional policy.

The Catering department was contacted and attended a nutritional committee meeting in supporting more choice for all service users including those on special / modified diets.

The Service Users / Relatives committee set up to support choice on Menu options.

The practice of adding milk to the tea in tea pots has been discontinued following a meeting with staff after the inspection (6th October 2014).

**Proposed Timescale:** 18/02/2015

**Theme:** Health and Development
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records of one resident indicated that the resident had been given free fluids when the resident had been prescribed thickened fluids. Even though a subsequent assessment of the resident recommended that the resident could have free fluids, this was being done in the absence of an updated review by a SALT.

**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:**
A referral has been made for Speech and Language therapy in consultation with the Service User and his / her family. The care plan has been reviewed in accordance with the assessed needs of the Service User.

A Speech and Language therapist and Dietician have been sourced and have completed assessments and provided support to staff in training and awareness in caring for Service Users with dysphagia and modified dietary needs.

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

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed residents that were prescribed a modified diet having their food served with the potato, vegetable, meat and gravy/sauce all mashed together by staff before being served.

**Action Required:**
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

**Please state the actions you have taken or are planning to take:**
This practice was discontinued immediately after the inspection on 16th October 2014.

**Proposed Timescale:** 18/02/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to medication management practices, as:
• there was a large stack of "stock" medications, however, there was no stock control system in place
• some medicines were disposed of in sharps boxes, which is not in compliance with best practice.

**Action Required:**
Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

**Please state the actions you have taken or are planning to take:**
The practice of disposing of medication in the sharps box has been discontinued.

The PIC in consultation with the pharmacist and senior nursing staff will review the medication management policy to ensure suitable practices are in place in line with best practices.

**Proposed Timescale:** 31/03/2015

**Theme:** Health and Development

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no process in place to ascertain if the available pharmacist was acceptable to the residents.

**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:**
The Statement of Purpose will be reviewed and incorporate information that should a service user or relative request a choice, or not be satisfied with the current pharmacy service, they will be facilitated in as far as possible to avail of another pharmacy service.

**Proposed Timescale:** 18/01/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose was not available in a format accessible to the residents.

Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be reviewed and reflect the changing needs of the service users in supporting them in a transition plan to a community setting. The new revised Statement of Purpose will be adapted to an easy read format to support the service users.

Proposed Timescale: 18/01/2015
safety of care prior to these audits. As the audits had only recently been completed there was minimal evidence of improvements in response to the audits

• an infection prevention and control audit completed by an infection control nurse in July 2014 identified a number of issues for improvement, however, the findings of this inspection indicate that many of the issues identified were not satisfactorily addressed. These included the inappropriate storage and communal use of personal hygiene items and deficits in environmental cleaning.

**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:**
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review

A planned schedule of reviewing policies and practices’ will be set up (by 18th December 2014) which will incorporate audits in measuring the effectiveness of the care and practice against the regulation, standards, Health and Safety and infection control standards. The outcomes of each review will be reported on at the Management meetings.

**Proposed Timescale:** 18/12/2014

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The process of audit did not incorporate consultation with residents and/or their representative/relatives.

**Action Required:**
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

**Please state the actions you have taken or are planning to take:**
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review

A planned schedule of reviewing policies and practices’ will be set up (by 18th December 2014) which will incorporate audits in measuring the effectiveness of the care and practice against the regulation, standards, Health and Safety and infection control. The outcomes of each review will be reported at the Management meetings.

All reviews will involve the service users / relatives consultation.
**Proposed Timescale:** 18/12/2014  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Inspectors were not satisfied that the system in place for identifying the person responsible for supervising care delivery at evenings and weekends provided adequate oversight of the centre to support the consistent delivery of safe, effective care.

**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 further two A/CNM2 posts are now appointed to strengthen the supervision bringing the number of CNM2 posts to four allowing for two/three CNM 2 s’ to be scheduled on the Day Duty Roster with one CNM 2 on to address governance issues at weekends.

A planned Roster for all staff will be prepared three weeks in advance to ensure consistency and support for service users.

**Proposed Timescale:** 31/12/2014

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**Outcome 16: Use of Resources**  
**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The facilities and services available do not reflect the statement of purpose or support residents to achieve maximum independence and quality of life.

**Action Required:**  
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**  
The Statement of Purpose will be reviewed to reflect the changing needs of the service users. It will facilitate service users to work towards maximum independence and improve their quality of life.

**Proposed Timescale:** 18/01/2015
**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was an over reliance on staff working overtime and on agency staff that did not support the continuity of care.

**Action Required:**
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**
A review of the WTE posts has been completed by the PIC and the Administrator.

Overtime will be minimised by the recruitment of staff on temporary contracts to provide consistency and continuity of care.

The implementation of a planned Roster for all staff three weeks in advance will be part of this process.

**Proposed Timescale:** 31/12/2014

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have the required training to meet the needs of all residents, particularly in relation to communicating with residents with communication difficulties.

**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:**
A training and development plan to be drawn up prioritising the relevant training for staff in supporting the service users.

The HSE induction policy will be adapted to be service specific and new staff will receive a formal induction in accordance with the policy.

A speech and language therapist has been sourced and provided training to a number of staff on dysphagia.
A Dietician has provided training to a number of staff on modified diets.
A staff member has attended training on alternative and augmentative communication.
Speech and language therapist has been identified to provide support for staff to communicate appropriately and effectively with service users.

**Proposed Timescale:** 18/02/2015  
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
There were inadequate arrangements in place for the supervision of care delivery at all times.

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

Please state the actions you have taken or are planning to take:  
A further two A/CNM2 posts have been appointed to strengthen the supervision bringing the number of CNM2 posts to four allowing for two/three CNM 2 s’ to be scheduled on the Day Duty Roster with one CNM 2 on to address governance issues at weekends.

A planned Roster for all staff will be prepared three weeks in advance to ensure consistency and support for service users.

**Proposed Timescale:** 31/12/2014  
**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
There was not an adequate programme of induction for new staff, particularly in relation to the specific profile of residents living in the centre.

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

Please state the actions you have taken or are planning to take:  
The HSE induction policy will be adapted to be service specific and new staff will receive a formal induction as per the policy.

**Proposed Timescale:** 31/12/2014

**Outcome 18: Records and documentation**
Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies were not centre-specific, such as the medication management policy and others were not available, such as provision of behavioural support; creation, access and destruction of records; and access to education training and development.

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:
A committee to be established with members of the Multidisciplinary team in supporting policy and procedure development and review

A planned schedule of reviewing policies and practices’ will be set up (by 18th December 2014) which will incorporate audits in measuring the effectiveness of the care and practice against the regulation, standards, Health and Safety and infection control standards. The outcome of each review will be reported at the Management meetings.

Proposed Timescale: 18/12/2014

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no directory of residents containing all of the information specified in paragraph 3 of Schedule 3 of the regulations.

Action Required:
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

Please state the actions you have taken or are planning to take:
A Data Base will be developed to provide the information required in the Directory of 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:
There was a residents' guide in an accessible format, however, it did not include all of the information required by the regulations, such as the terms and conditions relating to residency, arrangements for resident involvement in the running of the centre, how to access any inspection reports on the centre or sufficient detail of the complaints process.

**Action Required:**
Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident.

**Please state the actions you have taken or are planning to take:**
The current guide will be discussed with service users / relatives on the 30th November 2014. A sub-group will be established to review this document.

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