Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005158
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
30 April 2015 09:00	30 April 2015 17:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This report sets out the findings of an unannounced monitoring inspection of Group J St. Anne's Residential Services to monitor compliance against the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The designated centre comprises two residential houses in a community setting. During the inspection, inspectors met with residents, staff members, the person in charge, house managers and the provider nominee.

The provider was required to take immediate action to address two significant non-compliances in relation to fire safety and safeguarding. First, inspectors found that adequate arrangements were not in place for containing the spread of fire as a number of fire doors were wedged open in one house. Second, senior staff failed to articulate that they would follow the organisation's policy in dealing with any allegation, suspicion or disclosure of abuse in the event of an allegation, suspicion or disclosure of abuse. An immediate action letter was issued to the provider nominee following the inspection. The provider responded appropriately to the immediate action letter within the required timeframe.

Staff demonstrated that they knew the residents well. Residents told inspectors that

they were happy and that staff were kind to them. Inspectors found that residents were supported to pursue educational, training and employment opportunities that were appropriate and meaningful to them.

Other non-compliances were identified in relation to personal planning, measures to ensure privacy and dignity, mandatory staff training, medication management and the arrangements in place to meet all residents' healthcare needs. Non-compliances are discussed in the body of the report and outlined in the action plan at the end of this report.

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

Outcome 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):
This was the centre's first inspection by the Authority.

Findings:
The inspector found that residents were consulted with and participated in decisions about their care. Improvements relating to ensuring access to independent advocacy for all residents and to the recording of complaints were required. In addition, improvement was required in relation to maintaining privacy in residents' bedrooms in one house.

In one house, inspectors observed that there was a glass rectangular panel on each bedroom door. Four of five bedroom doors were uncovered and could be seen through from the main hallway. This compromised residents' right to privacy and dignity while in their bedrooms. This was raised with the person in charge on the day of inspection. Assessments had not been completed that considered individual residents' choice or need for differing levels of night-time supervision or how privacy during the day might be maintained. In the second house, residents privacy was fully protected and residents who chose to lock their bedroom door had their own key to facilitate this choice.

Residents meetings were held and minutes were maintained. Residents were consulted as to how the centre was run and minutes of monthly resident house meetings were available to inspectors. Minutes documented that residents were happy in the centre and demonstrated that each resident had an opportunity to contribute to the meeting.

A small number of residents had completed a certificate in leadership and advocacy in a local institute of technology and told inspectors that they were very proud of this achievement. There was an internal advocacy committee in the service and a number of residents participated in this committee. While independent advocates had been sought for some residents; an independent advocate had not been sought for all residents who

may need one. Documentation from 2008 identified that one resident may need an independent advocate but this had not been pursued.

Residents were facilitated in exercising their religious rights. A charter of rights was displayed in the centre in an easy-to-read version.

There were policies and procedures in place for the management of complaints and these were also available in an easy-to-read version. Inspectors spoke with residents who said that they knew how to make a complaint. There was evidence that residents had been supported to make a complaint, where they chose to do so. The inspector reviewed the complaints log and found that the recording of complaints did not meet the requirements of the Regulations. A complaint from January 2015 contained insufficient detail as it did not record the details of the complaint, how it was resolved, or whether the complainant was satisfied with the outcome.

Residents were supported to use and retain control over his or her own clothes and to manage their own laundry.

Overall, residents had opportunities to participate in meaningful activities. Residents said that they enjoyed going bowling, shopping, to the cinema, to the library or going out for a meal. Some residents enjoyed going swimming, to the gym or for a walk. Special events were marked, including birthdays and residents in one house were due to attend a birthday party that weekend.

Judgment:
Non Compliant - Moderate

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Inspectors found that quality of care delivered to residents' was of an acceptable standard. Significant improvements were required to personal planning.

A specific tool was used to document each residents' assessment of their health, personal and social care needs, abilities and wishes. Information in the assessment tool was individual and detailed in places, including for example how to support a resident to take their own medication, to keep active or to maintain relationships. However, where needs, supports or risks were identified, other specific plans, had not always been completed. For example, while individual risk assessments and behaviour management plans had been completed, this was not always the case for health plans.

Each resident had a written personal plan. Resident and family involvement in personal planning was documented. However, significant improvement was required in relation to the personal plans. Of the three personal plans reviewed in one house, none were complete. In some files, information was missing, such as who the key staff were involved in the residents' care. Where complete, the information was individual and person-centred and in an accessible format, including pictorial format.

There was no evidence that all personal plans had been reviewed annually (or more frequently if necessary), as required by the Regulations. Inspectors were unable to ascertain the effectiveness or otherwise of the personal plan or whether the review of personal plans were multi-disciplinary; three of five files reviewed in one house did not contain a review of the personal plan.

Each resident had a timetable that outlined what he or she did on a daily and weekly basis. Activity logs were maintained and included activities both internal and external to the centre. Residents described to inspectors a wide range of activities in the community, based on individual residents' choices and interests.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
While arrangements were in place in relation to health and safety and risk management, a number of improvements were required. A major non-compliance was identified in relation to fire safety.

Inspectors found that adequate arrangements were not in place for containing fires. Inspectors observed that a number of fire doors were wedged open in one house. These included doors to the office, the kitchen and the living/TV room. This was brought to the

attention of the person in charge on the morning of the inspection. Inspectors re-visited the house in the late afternoon and found that the same fire doors were still wedged open. An immediate action plan was issued to the provider nominee following the inspection.

There was a risk management policy which set out the procedure for identifying hazards including checklist, judgement based on experience, flow charts, brain storming and systems analysis. However it did not include incident reporting which was used as the main tool to identify hazards.

A safety statement was in place and was up to date. Risk assessments had been completed within the previous months. However, the risk assessment system was not sufficiently robust as a number of risk assessments were too broad in content. The inspector reviewed a sample of risk assessments for hot water, manual handling and lone workers in detail and found that they provided insufficient guidance for staff. The provider nominee told the inspector that the system in place for lone workers required review at service level to ensure that adequate arrangements and safeguards were in place for residents and staff.

Records were maintained in relation to incidents and there was evidence of learning and follow up of incidents. The inspector reviewed the incident book and found that incidents dating from 16.12.2014 identified the need for an additional staff member in the mornings to manage behaviours that challenge. A review of incidents from that date (16.12.2014) to the day of inspection revealed five incidents of behaviour that challenges during the morning period. The inspector spoke with staff, the person in charge and the provider nominee who confirmed that an additional staff member was required during the busy morning period. The provider nominee outlined steps in place to address this need. This will be addressed under Outcome 17: Workforce and in the associated action.

While the organisation had was using guidelines in relation to infection control, there was no infection control policy in place. Arrangements were in place in relation to infection control. The centre was clean and tidy. Infection control audits were being completed on an annual basis. Appropriate facilities for hand hygiene were provided. Systems were in place in relation to cleaning, including colour-coded mops and cloths. Cleaning schedules were in place and were maintained.

The inspector saw evidence that suitable fire prevention equipment was provided throughout the centre. Servicing records for the fire alarm and emergency lighting were up-to-date. Daily and weekly checks were completed as required. Staff demonstrated an awareness of procedures to follow in the event of a fire. Records of practice fire drills were maintained and any issues arising during such practice drills were recorded. While the person in charge told the inspector that all resident could evacuate without assistance during a practice fire drill, staff said that some residents required assistance to do so. In addition, the evacuation procedure did not adequately account for the mobility and cognitive needs for residents in the event of an emergency.

Inspectors saw evidence that the vehicles owned by the centre, and used to transport residents, were roadworthy, regularly serviced and insured.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Policies and procedures were in place in relation to the protection of vulnerable adults, behaviour that challenges and intimate care. However, the system in place for protecting residents from all forms of abuse was not sufficiently robust and a major non-compliance was identified in this area.

While training in relation to the protection of vulnerable adults had recently taken place; senior staff failed to articulate that they would follow the organisation's policy in dealing with any allegation, suspicion or disclosure of abuse. The organisation's policy directs staff to report any allegation, suspicion or disclosure of abuse to their line manager/person on call/service manager. A senior staff told the inspector that they would deal with it locally instead on the first occassion. This failing was at the level of major non-compliance. The provider nominee was required to take immediate action to address this issue.

Overall, inspectors found evidence of a positive approach to behaviour that challenges with supports provided to manage these behaviours. Supports included behaviour management plans, supervision guidelines, risk assessments, restrictive practice guidelines and guidance on PRN ("as required") medication. Behaviour management plans demonstrated an emphasis on proactive strategies.

There were a number of restrictive practices in the centre and these were documented. Any practices in place were found recorded. However, improvement was required to the documentation, monitoring and review of approved practices. For a keypad lock on a door; it was not clear how the conclusion that it was not restrictive had been reached. While consent and guidelines were in place for a physical hold; the MDT document had not been completed in full. The review plan and reporting arrangements to the governance committee for these two practices had not been specified. The input from

the resident or their representative was not documented on the form. The document had also not been signed by all of the MDT members.

Inspectors spoke with residents who confirmed that they were happy and felt safe in the centre.

All staff, including agency staff, had received training in relation to the protection of vulnerable adults and relevant organisational policies. Staff had not received up to date training in relation to the management of behaviour that challenges, including de-escalation and intervention techniques.

There was a policy on residents' personal possessions and a log of monthly household accounts. Records of residents' valuables and property were maintained in their files and were current. Daily 'purse checks' were completed. However, this system involved the checking of residents' money twice daily and for two signatures to be documented for each check. The inspector found that the organisation's system was not being implemented in full as some checks occurred once a day only and a number of entries had only one signature.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Residents' overall healthcare needs, including nutritional needs, were met and residents had access to appropriate medical and allied healthcare services. However, some residents had significant medical needs and the time taken to meet this needs by staff impacted on other residents.

Inspectors reviewed a sample of residents' files and there was evidence of timely and frequent access to their GP of choice. Staff confirmed that an out of hours GP service was also available. In line with their needs, residents had ongoing access to allied healthcare professionals including speech and language, dietitics and dental. There was also evidence of specialist imput for the neurology and diabetic specialist services. Records of referrals and reports were maintained in residents' files.

There was clear evidence that there treatment was recommended and agreed by

residents, this treatment was facilitated. Residents' right to refuse medical treatment was respected.

Some residents had significant medical needs which required constant monitoring and intervention several times a day. Staff with whom inspectors spoke detailed that results from the monitoring were transmitted via fax to the specialist services for interpretation. Staff reported that this greatly reduced the time available to meet the needs of residents; this is covered in outcome 17.

The inspector observed that residents were encouraged and enabled to make healthy living choices in relation to exercise, weight control, healthy eating and smoking cessation. Residents were supported to attend a healthy eating course.

Inspectors observed that there were adequate quantities of food and drink; that was properly and safely prepared, cooked and served. Staff with whom inspectors spoke confirmed that a choice was provided to residents for all meals, mealtimes were flexible and snacks were available at all times. Residents were encouraged to participate in the shopping on a weekly basis. A number of residents were supported in preparing and cooking their own food and that there was adequate provision for residents to store food in hygienic conditions.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Medications for residents were supplied by local community pharmacies. Staff confirmed that there was appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Staff demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents' medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. Staff confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection.

An inspector observed that compliance aids were used by staff to administer medications to residents. Compliance aids were clearly labelled to allow staff to identify individual medicines.

A sample of medication prescription and administration records was reviewed by an inspector. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications.

The inspector saw that the practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais. Medication prescription records did not contain the signature of the nurse who transcribed the record. Transcribed medication prescription records did not clearly outline the dose to be administered. For example, some paracetamol prescriptions indicated that one or two tablets were to be administered but did not identify the dose of these tablets.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines. Staff with whom inspectors spoke confirmed that no residents were self-administering medication at the time of inspection.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

Training had been provided to staff on medication management and the administration of buccal midazolam.

An inspector reviewed a sample of medication incident forms and saw that errors were identified, reported on an incident form and there were arrangements in place for investigating incidents.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found that there was a clearly defined management structure in place in the designated centre.

While the management structure in place was clearly defined, the provider had recognised the need to strengthen the governance and management arrangements at organisational level. As a result, three new clinical nurse managers (CNMs) were in the process of being recruited.

A small number of audits took place were available for review with the centre and these related to medication management and infection control; this system required improvement to ensure oversight of the quality and safety of care in the centre. An unannounced inspection of the centre had not taken place within the previous six months.

Staff were clear in relation to lines of authority and were able to identify the person in charge.

The person in charge was full-time and was the person in charge for three designated centres. The person in charge was a qualified general nurse and had completed a certificate in first line management.

There were systems in place to support the person in charge, including a house manager in each of the two houses that comprise the designated centre. Inspectors spoke with staff who confirmed that the house managers and person in charge were supportive and approachable.

Regular house meetings took place and minutes were kept of such meetings. Inspectors viewed such minutes and found that included discussion of issues relevant to the quality and safety of care provided to residents. House meetings were generally attended by the person in charge. The house manger and person in charge met on a 1:1 basis on a monthly basis. Monthly managers meetings were also held that included the person in charge, provider nominee and which were attended by other persons depending on specific topics under discussion. A structure was not in place however for regular meetings attended by all house managers as is the case in other parts of the organisation.

There was a system in place for the completion of annual staff appraisals. Inspectors spoke with staff who confirmed that such appraisals took place.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:
The inspector found that overall, the skill mix of staff was appropriate to the number and assessed needs of the residents on the day of inspection and that the staff rota was properly maintained. However, it had not been demonstrated that the number of staff during key hours in the morning was appropriate to meet the needs of residents and ensure safe delivery of service during that specific time-period. Mandatory training for all staff in relation to the management of behaviour that challenges was outstanding.

As previously mentioned under Outcome 7: Health and Safety and Risk Management, incident records identified the need for an additional staff member in the mornings to manage behaviours that challenge. As previously mentioned in outcome 11, the time taken to monitor and transmit test results impacted on the time available to meet the needs of other residents in the morning where only one non-clinical staff member was available. The inspector spoke with staff, the person in charge and the provider nominee who confirmed that an additional staff member was required during the busy morning period.

There was a training plan in place and the annual staff appraisal system facilitated the identification of staff training needs. The inspector reviewed staff training records for regular and rostered agency staff. Most, but not all, mandatory training was up to date. Mandatory training in relation to the protection of vulnerable adults and fire safety was up to date. Mandatory training in relation to the management of behaviour that challenges was not up to date for all staff. This was previously addressed under Outcome 8: Safeguarding and Safety.

A previously identified area for development at service level, and in this centre, related to the finding that a number of care staff did not possess a formal recognised qualification relevant to the role of care assistant, such as the FETAC Level 5 Healthcare Assistant course or equivalent. A funded plan is in place to address this gap. Staff had completed other training or instruction relevant to their roles and responsibilities including in relation to hand hygiene, safe moving and handling and food safety.

A clear system in place for new staff was described to the inspector. Supervision arrangements were in place. The inspector reviewed an induction log that had been completed for all new staff members. This included centre policies, observation skills, incident reporting and the management of behaviours that challenge.

Staff appraisals were completed on an annual basis and staff confirmed that such appraisals took place. House meetings were held every four to six weeks and minutes were maintained of such meetings.

Staff files were held centrally and reviewed by an inspector who found that they met the requirements of Schedule 2 of the Regulations.

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:

Julie Hennessy
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[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005158
Date of Inspection:	30 April 2015
Date of response:	05/06/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' right to privacy and dignity was not protected. In one house, inspectors observed that there was a glass rectangular panel on each bedroom door in one house. Four of five bedroom doors were uncovered and could be seen through from the main hallway.

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

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:
All residents will be afforded privacy at all times when in their bedrooms. The person in charge will ensure that all glass panels will be covered with an obscure panel to ensure they are not transparent.

Proposed Timescale: 05/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An independent advocate had not been sought for all residents who may need one.

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:
All service users requiring the supports of an independent advocate will be supported by the person in charge to access this service. At a house meeting the person in charge and staff will share information with all service users around advocacy and their right to independent advocates. All staff in the centre will attend advocacy training.

Proposed Timescale: 30/06/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The recording of complaints did not meet the requirements of 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 system for recording complaints is being reviewed at service level. This recording log will now be in place in the centre for the recording of complaints. This recording log

indicates what actions were taken e.g. if investigation took place, how the complaint was dealt with, record any recommendations made and will also note the complainants satisfaction with the outcome. Training on the management of complaints has been delivered to all staff.

Proposed Timescale: 05/06/2015

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:
There was no evidence that all personal plans had been reviewed annually (or more frequently if necessary), as required by the Regulations.

Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
All person centred plans will be reviewed in the centre and will have review dates set in advance of the actual review date so as to ensure the plans are always in date. These will be planned by the person in charge and the house managers in the centre houses. There will be an audit completed by the person in charge of personal plans quarterly, with detailed action plans and people responsible following each audit. The person in charge is responsible to ensure that all plans are reviewed 12 monthly or more frequently as required.

There will be training delivered to the staff in house from a CNM3 from another part of the organisation in the area of care planning and documentation of changes to care needs, this will take place week commencing 22/06/2015. The person in charge will ensure that all personal plans for all service users will be completed by 10/07/2015

Proposed Timescale: 30/08/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Significant improvement was required in relation to the personal plans to meet the requirements of the Regulations. Files were incomplete with key information missing.

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:
There will be an audit completed by the person in charge of personal plans immediately and quarterly thereafter, with detailed action plans and people responsible following each audit. The person in charge is responsible to ensure that all plans are reviewed 12 monthly or more frequently as required.

There will be training delivered to the staff in house from a CNM3 from another part of the organisation in the area of care planning and documentation of changes to care needs, this will take place week commencing 22/06/2015. The person in charge will ensure that all personal plans for all service users will be completed by 10/07/2015, and that all information relating to the service user and their care is available in the plan.

The person in charge with the support of the newly appointed clinical nurse manager 3 will ensure that all care plans have a detailed assessment of service users needs, and a clear plan of care for the individual relating to each area of assessment. Where multi disciplinary team support is needed for assessments this support will be provided, by existing team members or contracted in to meet service user need.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Where needs, supports or risks were identified, other specific plans, had not always been completed.

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:
All service users care plans will be reviewed by the person in charge and the house manager. Following completion of assessments in each aspect of the service users care plan, changes and risks that may be highlighted or already identified will have plans of care with appropriate action set out. There will be staff named as responsible for these actions, with a review date documented. The person in charge will monitor and the CNM3 audit the effectiveness and ensure the completion of these actions.

Proposed Timescale: 30/07/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management system was not sufficiently robust in that a number of risk assessments did not provide adequate guidance for staff. In addition, the arrangements in place for lone workers required review.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The Service Human Resources Director, Nominee Provider, Person in Charge and Clinical Nurse Manager 3 are reviewing staffing in the centre service users support needs will be the basis of this review to ensure that appropriate skill mix and safe practices are in place, this process commenced on 20/06/2015. The occasions in the centre when there are lone working practices will be reviewed during the review, and where service users needs determines that additional staff support is needed at key time this will be put in place in the centre, through redeployment of hours to centre and also through reviewing the existing roster and ensuring that staff hours are rostered in the most effective manner possible to meet the service user needs.
Rostering of staff will be reviewed, to ensure that both service users and staff are safe in the centre at all times. Where there are occasions of staff working in isolation, risk assessments will be completed by the person in charge, with support of the health and safety officer.

The service has an incident reporting policy, with clear guidelines for staff on the recording and reporting of incidents. This policy includes instruction for staff on developing an action plan and identification of additional control measures to reduce the risk of reoccurrence of the particular incident, and valuable learning for staff through this process. This policy is read and implemented in conjunction with the risk management policy.

A CNM3 from another part of the Service will support staff in the centre with onsite training in relation to the identification of hazards and risks and control measures. This CNM3 will also support the staff in the completion of centre specific, and service user specific, risk assessments.

The Person In Charge and House Manager will also receive refresher supports, from the CNM3, on the weekly walkabout hazard inspection checklist. This input will be delivered to staff in the centre by the middle of July.

Proposed Timescale: 30/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The organisation did not have an infection control policy in place.

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:
The centre has an infection control folder in place and training on same has been delivered to all staff. As referenced in the Infection Control Folder, the guidance document in use in the centre is the HSE community infection prevention and control manual 2011, and all staff are trained on this policy.

The Authority did not agree this action plan response to with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 15/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The evacuation procedure did not adequately account for the cognitive understanding of all residents.

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:
The evacuation procedures for all service users will be reviewed by the person in charge, house manager and the service fire manager. The designate centre has a trained fire marshall who will be part of the team reviewing the evacuation procedures. For service users with mobility and cognitive difficulties additional support in developing the evacuation plan will be sought from occupational therapist and psychologist, to support individuals to evacuate as efficiently as is possible during an evacuation. The person in charge in the designate centre will ensure that all service users are included in fire evacuation drills, and the person in charge and house manager will facilitate a service user meeting to explain the purpose and plan in place for evacuation of the house in the event of a fire.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place for containing fires. A number of fire doors were wedged open in one house, including doors to the office, the kitchen and the living/TV room.

Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Following the immediate action plan, door holding and release devices have been fitted to the doors in the centre and will be fitted and linked to the fire system. These devices ensure that doors close automatically in the event of a fire. These were fitted on 07/05/2015.

All wedges removed from doors and the house on 01/05/2015. The PIC and nominee provider has met with all staff re the ceasing of the practice of use of wedging devices to hold doors open.

Proposed Timescale: 07/05/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
However, improvement was required to the documentation, monitoring and review of approved practices.

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:
All restrictive practices in place in the centre will be reviewed by the restrictive practices committee, whose membership includes members of the multi disciplinary team, the Person in charge and the house manager. All restrictions will be documented as restrictive, and all documentation and evidence of restrictions in place will be reviewed to ensure that they are the least restrictive means possible. Where there is no evidence of other less restrictive means being sampled, existing restrictions will be reviewed to establish if a lesser restriction can be used.

All restrictive practices will be monitored by the house manager and person in charge, and audits will be completed by the person in charge, 3 monthly or more frequently as necessary. These audit findings will be reported on to the restrictive practices

committee and the nominee provider by the person in charge.

Proposed Timescale: 30/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received up to date training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
The person in charge will ensure that all staff will attend receive training in the management of behaviour that is challenging; the service training includes training on techniques for de-escalation and intervention techniques. The person in charge will maintain a log of all staff training and ensure refresher dates are scheduled and attended by staff. Staff in the centre will receive support from a nurse from another part of the service, who is an instructor in the Therapeutic Management of Aggression and Violence, this support will be delivered to the staff in the area and will include reviewing each service users behaviour support plan and needs around same.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Senior staff failed to articulate that they would follow the organisation's policy in dealing with any allegation, suspicion or disclosure of abuse in the event of an allegation, suspicion or disclosure of abuse.

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:
The senior staff member has attended refresher training in service user protection and welfare, and management of allegations of abuse.

The staff in the designate centre and the person in charge have been supported by the nominee provider to gain the necessary understanding of the process for the protection and welfare of service users, this was done through an in-house information sharing session to all staff facilitated by the Nominee provider.

Proposed Timescale: 25/05/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
• The practice of transcription was not in line with guidance issued by An Bord Altranais agus Cnáimhseachais
• Transcribed medication prescription records did not clearly outline the dose to be administered.

Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The medication management documentation with regards to transcribing will be reviewed by the person in charge, medication management co coordinator, the director of nursing and a pharmacist to bring the practice in line with An Bord Altranais agus Cnaimhseachais na hEireann.

The document will be brought to the service Drugs and Therapeutics committee, where changes will be agreed , signed off and it will be included in the service policy on medication management.

Proposed Timescale: 30/06/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It had not been demonstrated that the number of staff during key hours in the morning was appropriate to meet the needs of residents and ensure safe delivery of service during that specific time-period.

A number of care staff did not possess a formal recognised qualification relevant to the role of care assistant, such as the FETAC Level 5 Healthcare Assistant course or equivalent.

Action Required:

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

Please state the actions you have taken or are planning to take:
The Service Human Resources Director, Nominee Provider, Person in Charge and Clinical Nurse Manager 3 are reviewing staffing in the centre. Service users' support needs will be the basis of this review to ensure that appropriate skill mix and safe practices are in place, this process commenced on 20/06/2015. The occasions in the centre when there are lone working practices will be reviewed during the review, and where service users needs determines that additional staff support is needed at key time this will be put in place in the centre, through redeployment of hours to centre and also through reviewing the existing roster and ensuring that staff hours are rostered in the most effective manner possible to meet the service user needs.

Proposed Timescale: 30/08/2015