Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002634
Centre county:	Wexford
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mary Gorman Coogan
Lead inspector:	Ide Batan
Support inspector(s):	Noelene Dowling;Shane Grogan
Type of inspection	Announced
Number of residents on the date of inspection:	7
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
28 July 2015 10:00	28 July 2015 19:30
29 July 2015 08:45	29 July 2015 14:00

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

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

Summary of findings from this inspection

This was the second inspection of this centre by the Health Information and Quality Authority (the Authority). The centre consists of a large detached house in a remote location in the community. The residents are provided with access to day services at the day centre which is approximately 17km away. The majority of residents had significant severe to profound intellectual disabilities. Governance arrangements in place required improvement. Good practice in health care and access to allied health care services was evident.

During this inspection inspectors met with some of the residents and staff members. They reviewed the premises, observed practices and reviewed documentation related

to risk management, residents' records, accident and incident reports, medication management, staff supervision records , policies and procedures and a sample of staff files. There was evidence that residents had access to members of a multidisciplinary health care team and it was obvious to inspectors during inspection that staff knew the residents and their individual preferences well. Many of the residents required a high level of assistance and monitoring due to the complexity of their individual needs.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. These areas include:

Risk management
staffing levels were not satisfactory.
management of complaints required review
access to meaningful activities, day care and recreation.

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

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

Theme:
Individualised Supports and Care

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

Findings:
The inspectors found that, for the most part, the rights, privacy and dignity of residents were promoted and residents' choice encouraged and respected, however improvements were required to ensure compliance with the Regulations.

Inspectors saw that residents were well cared for and staff looked after them well. The inspector observed respectful interactions between staff and residents and saw staff knock on doors and engaged positively with residents. Residents had space to be by themselves internally and externally and staff told the inspector when visitors arrived to the centre residents were afforded the opportunity to spend time with them in private.

Inspectors noted that where possible residents retained control over their own possessions and that there was adequate space provided for storage of personal possessions. All of the bedrooms were single rooms with the exception of two shared rooms. There were adequate screening arrangements in place to safeguard the privacy of residents who were sharing these bedrooms. There was adequate space for clothes and personal possessions in all the bedrooms. There were adequate laundry facilities in the house.

The financial affairs of residents were being centrally managed by the organisation head office. Checks and auditing at local level of these accounts were being undertaken as confirmed by the clinical nurse manager to inspectors. Inspectors were satisfied that the process around the management of residents' finances was robust and transparent.

However, there was insufficient evidence to determine that the programme of activities was developed following consultation with residents to ensure activities available were in

accordance with their interests, capacities and developmental needs. Some residents attended day services. Inspectors found that staff provided activities in house in addition to their other duties. There was a well equipped multisensory room in the house. In addition the inspectors also found that outings were often group based activities; one to one activities and outings were infrequent due to staffing levels. Overall, inspectors observed that activities were led by routine and resources not the resident and their support needs and wishes.

The inspector reviewed the complaints log. There were no complaints logged. However, inspectors were informed of an issue during the inspection which had not been logged as a complaint. There was a complaints policy. However, it was not on display in a prominent position and it was not available in a format accessible to residents and their representatives. It was unclear how residents were assisted to understand the complaints procedure. The service required a review of how complainants are responded to ensuring the response is robust and appropriate to the type of complaint received.

There was evidence that staff maintained resident's dignity and privacy when carrying out personal care. Residents religious and spiritual needs were facilitated in so far as possible. Staff told inspectors that residents attend mass once per month in the day centre. However, staff also said that it was not possible to take some residents out to mass on Sundays due to insufficient staffing levels.

Judgment:
Non Compliant - Moderate

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

Theme:
Individualised Supports and Care

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

Findings:
Overall the inspectors found communication systems in place to facilitate resident's communication needs. Staff outlined to inspectors that all residents had deficits in communication and that all residents were supported to communicate. A communication plan was in place for each resident and resident's communication difficulties were assessed and guided practice. Staff presented detailed knowledge of each individual's communication needs, and the inspectors observed this in interactions between residents and staff. The inspectors found residents had access to speech and language therapy (SALT) and found evidence of assessment led practice in the area of communication.

There was a folder available with accessible relevant information. There was also pictorial representation of pertinent information for some residents, for example, pictures of staff on duty, the food menu and areas of interest. There were very comprehensive communication passports available in the event of a resident requiring care in another service. It was apparent to the inspectors that by virtue of long standing relationships staff were very familiar with the resident's communication and what it meant. Inspectors observed that staff responded to resident's communication as outlined in the personal plans. For example, they recognised the signs of pain and took the appropriate action in response to this. Residents had access to televisions and staff were aware of their favourite television programs and music.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Residents were supported to attend a day service owned and managed by Wexford Residential Intellectual Disability Services. Activities available included swimming, bowling, art therapy and music sessions. Staff outlined and inspectors observed that transport was available to bring residents to activities.

There was a policy on visiting and staff told inspectors that families were welcome and were free to visit. A log was maintained of all visitors. There was adequate communal space in the house to receive visitors with a kitchen/dining room and a separate living room. The inspectors saw in daily notes and in personal plans evidence of relatives visiting but also residents going home to see family at weekends.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The inspector saw that there was a system in place regarding planned admission to the centre. There were policies and procedures in place to guide the admissions process. The admissions policy did not take into account of the need to protect residents from abuse by their peers as required by the Regulations. Written agreements were in place outlining the support, care and welfare of the residents and details of the services.

However, any additional cost that may be incurred as part of their service was not outlined. To comply with the Fire Regulations it is necessary that residents will relocate to a temporary location for a period of time. There were detailed transitional plans available for inspection. This included that all residents were to have an individual relocation plan with input from the family. There was to be a phased introduction for the residents to the new temporary accommodation with day trips being organised, meals in the temporary house and residents being shown their new bedrooms.

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):
No actions were required from the previous inspection.

Findings:

Inspectors reviewed a sample of the personal plans and saw there were inconsistencies in the completion and review of the plans. Personal plans were disjointed and inspectors found plans difficult to navigate due to the amount of unnecessary or duplicated information held in each one. The inspectors also saw where detailed assessments had been carried out by allied health professionals, reviews had not taken place and it was unclear if the recommendations had been adhered to.

The person in charge said that reviews had taken place but there was no documentary evidence available to support this. It was unclear whether or not agreed time-frames in relation to achieving identified goals and objectives with named staff members responsible for pursuing objectives with residents had been met. There was not clear recording of whether the goals and objectives in the person centred plans were being met. There was limited evidence of consultation and participation of residents or their family members in the development or reviews of care plans.

There was an activities of daily living and recreational, diversional and creativity activity assessments completed in relation to each resident. There were also proactive risk assessments and health screening tools had been completed. There was evidence of interdisciplinary team involvement in residents' care including nursing, dietician, psychiatric and General Practitioner (GP), dentist and chiropody services. There were residents' daily reports that had been completed by staff and there was also an activity profile/activity record that included details of daily activities. In particular, there was a "client profile/key things you need to know about me" was written from the residents' point of view and gave inspectors a picture of each resident.

If a resident had to attend hospital either as an emergency or as part of a planned treatment each person-centred planning folder had a form, "hospital admission pack", available which was given to the receiving hospital. There was also a protocol available for staff to follow in relation to hospital admissions. The director of nursing told inspectors that it had been agreed that staff would stay with residents should they require hospitalization.

Overall, inspectors were not assured that the personal plans did not set out in a formal manner the services and supports required to enhance the quality of life of residents, to promote their independence and to realise their goals and aspirations. The plans did not adequately address:

• education, lifelong learning and employment support services, where appropriate
• development, where appropriate, of a network of personal support
• transport services
the resident's wishes in relation to where he/she want to live and with whom
• the resident's wishes or aspirations around friendships, belonging and inclusion in the community
• the involvement of family or advocate.

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):
No actions were required from the previous inspection.

Findings:
The centre provided accommodation for eight residents in a purpose built bungalow on a large private site located approximately 17 km from Enniscorthy. All residents had a single bedroom with the exception of two shared bedrooms. The bedrooms were viewed by the inspectors and found to be fully furnished to a good standard and provided ample storage for clothing and personal belongings. There were a sufficient number of suitably adapted bathrooms, showers and toilets for residents use in the centre.

The person in charge said residents were welcome to bring in articles of furnishings in order to personalise their rooms if they wished and most had personalised their rooms with photographs of family and friends, artwork, soft furnishings and personal memorabilia. There was ample communal accommodation which included a sitting room, kitchen and dining room. There was a large fully equipped multisensory room also which many residents liked to use as observed by inspectors.

Overall the premises were clean and well maintained with flooring, lighting and heating systems satisfactory. Apart from light meals, snacks and breakfast all catering is done in a central location but the kitchens are equipped with sufficient equipment for storage and preparation of food. Food safety procedures were implemented in the unit in regard to the food which is transported from the central location. Laundry facilities were provided and were adequate.

Staff said laundry is generally completed by staff but residents are encouraged to be involved in doing their own laundry. The house was set on large grounds with car parking facilities to the front and the gardens to the rear contained suitable garden seating and tables provided for residents use. Inspectors observed that the bathroom with the bath had multisensory equipment for relaxation. Assistive equipment was required for a number of residents including hoists and specialised chairs. Records demonstrated that such equipment was serviced regularly and overhead hoists had been installed. A maintenance log was available and issues were identified and managed promptly. Vehicles used to transport residents had evidence of road worthiness and insurance. There were satisfactory arrangements for the management of clinical and other waste.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
Inspectors reviewed the risk management policy that was currently in use. It set out the procedure for risk assessment. It did not comply with article 26 (1) as it did not include:

•Hazard identification
•measures to control identified risks
•measures to control specified risks including unexpected absence of a resident, accidental injury, aggression and self harm,
•arrangements for incident reporting and learning from incidents
•arrangements to ensure risk control measures are proportional.

There was a signed and current health and safety statement available. A number of safety audits of the premises and work practices had been undertaken by the person in charge on a regular basis by the person in charge. There were relevant policies in place including an emergency plan which contained all of the required information including arrangements for the interim accommodation of residents should this be required. Emergency phone numbers were readily available to staff. Emergency alarms were placed in a strategic location should they be required. There was a policy on residents' absconding and a risk assessment and management plan for each individual resident available.

These were found to be pertinent to the residents assessed needs including manual handling and falls risks, and/or epilepsy. Appropriate systems to manage the risk were also evident. The policy on infection control was detailed and staff articulated good practice in relation to this. Staff were observed taking appropriate precautions and using protective equipment including gloves, aprons and sanitizers. Some improvements were required in the development and on going monitoring of a centre specific risk register. Risks identified in the organisational register included environmental, clinical and corporate risks with controls identified to manage them. The local risk register contained information on identified risks such as fire, lone working, and choking episodes, resident absconding and the risks were rated in order of priority. However the register did not contain other pertinent information such as clinical risks pertinent to the resident population including the development of pressure ulcers or nutritional deficits.

Inspectors reviewed the fire safety register and saw that fire drills had been carried out

at a minimum twice yearly. There were ski sheets on all residents' beds for use in the event of emergency. The records maintained of the drills demonstrated that they were primarily talks to staff on evacuation procedures and did not actually take account of the resident's dependency levels of staffing levels at night. Staff were able to articulate the procedures to undertake in the event of fire. Fire safety management equipment including the emergency lighting and extinguishers had been serviced quarterly and annually as required. Ten of the eleven staff were overdue for fire training although this was scheduled for August 2015.The HSE fire service had identified upgrading works which were required in the centre. The provider had engaged the services of an external consultant to review the premises. A number of remedial actions were identified in this centre. These included items such as additional fire doors, smoke alarms in the attic, a revised alarm system and more effective compartmentalising of the premises including the ground floor where the residents live. The provider stated that there were no time scales as to when the work for this centre would be undertaken or its status in terms of risk identified by the fire safety report.

Personal evacuation plans had been compiled for each resident. These were very detailed. However, there were only two staff present in the centre from 18:00hrs most evenings and overnight. Given the number of residents who require full assistance if they are in bed inspectors were not satisfied that that there was an adequate plan to either evacuate residents or move them to a safe location internally given that there was only one fire compartment in the premises. Details on accidents and incidents were maintained. A review of the accident and incident log indicated that such incidents did not occur regularly. Appropriate medical attention and remedial and preventative actions were taken.

However, while there was an auditing system undertaken inspectors found that these were generic in nature, not open to seeking information and were not focused on quality and safety of care as relevant to this resident group. The audits covered a wide range of issues including medication personal planning, health and safety and fire safety. There was no evidence of accidents/ incidents, falls or challenging behaviour being reviewed. There was no system for the identification of risks to prevent accidents/ incidents. There was no evidence of trends being identified. The audits did not provide an effective system for on going and review. For example, trends or time frames were not identified which would inform changes to practices. The hazard identification and assessment of risks throughout the centre was not adequate as the following risks had not been assessed.This included:

• lack of an adequate emergency plan for the evacuation of residents at night.
• locked exit doors which had had unsecured keys on rings next to them posing a risk of residents not been able to exit if the keys were missing
• bedrails which were very loose posing a risk of entrapment to residents.

The person in charge was required to address the latter matter and did so during the inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
The inspectors reviewed the policies and procedures for the prevention, detection and response to allegations of adult abuse which is currently the HSE Trust in Care policy. The provider stated that it was intended to adopt the revised policy for the protection of vulnerable adults with a disability issued in 2014 by the HSE. Training for staff and the person in charge was being arranged prior to the implementation of this policy. The director of nursing/director of service was the designated person responsible for managing and initiating nay screening or investigation .The role had had been discussed with this person at previous inspections and she was found to be knowledgeable on how such as process would be managed. Records demonstrated that all current staff in the centre had received initial and up to date training in the prevention of and response to abuse.

Staff were able to articulate their understanding and responsibilities in relation to this and there was a designated line of accountability identified. Inspectors were informed by the person in charge that there were no allegations of this nature made or being investigated at this time. A review of a sample of the records pertaining to resident's monies being withdrawn from the personal property accounts for specific purchases or as weekly pocket money indicated that the systems for recording this money and its usage were transparent. All monies given for residents use were dated and the expenditure was recorded and receipted for the finance office.

Money paid in on behalf of residents in fee payments were recorded in the resident's name. The provider was acting as agent for a significant number of residents. The records, including savings on behalf of residents were transparent and available for the resident or their representative to review if this was required. Inspectors reviewed the details and arrangements in relation to a resident who was the subject of a protective court order. The details of the order were available and records showed that the provider complied with the order in relation to the resident's finances and care

Inspectors were satisfied that the system's for the support of behaviour that challenges and the use of restrictive practices supported residents in the least restrictive and most

beneficial manner. There was an up-to-date policy on the management of behaviour that is challenging and on the use of restrictive procedures which was in line with national policy and both policies were comprehensive in detail and guidance for staff. The policy on the use of restrictive practices clearly defined the exceptional circumstances in which such procedures should be used system for monitoring and reviewing them.

Records demonstrated that residents had regular access to psychiatric service. Inspectors observed that behavioural psychological support was not easily available but the director of nursing stated that this was currently being reviewed. A behavioural support specialist nurse was also available. However, due to staff shortages the latter was working full-time in another centre therefore the availability to offer assessment; training and on going support for staff is limited. Staff had received training in an approved method of managing behaviour but a small number of staff were overdue for refresher training.

Behaviours that challenged were not a significant feature of this service. A review of behaviour management plans demonstrated an understanding of meaning of the behaviour for the resident, potential triggers which included breaks in routine or noise levels and the most supportive strategies prevent to manage the behaviour if it occurred. The plans had been devised with the support of the behaviour psychologist and there was evidence of consultation with relatives in relation to this. There was no evidence that pro-re nata (as required) medication was used to manage behaviours. Records indicated that a reduction in the incidents of self harming behaviour had reduced. Strategies included access to the multisensory room, preferred music, and therapeutic blankets. Staff were able to articulate these to inspectors and they were also observed being used.

The use of restrictive practices was minimal and was assessed as being necessary and the least restrictive with alternatives considered. This included the locking of the external doors to prevent a resident leaving in an unsafe manner, but this did not impact negatively on any other residents. A number of residents were using bedrails.

These were implemented for safety reasons following assessment. There were regular and documented checks undertaken on the resident during the night or the day of they were in bed. Where seat belts were used on specialised chairs they were integral to the chairs and prescribed by the occupational therapist. There was no evidence that such practices were overused or implemented randomly without due process and assessment. There was evidence that families had been consulted in relation to the methods used. However, some risks were noted by inspectors in the systems themselves and these are detailed and actioned in outcome 7.

Judgment:
Compliant

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 review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated the provider's compliance with the obligation to forward the required notifications to the Authority.

Judgment:
Compliant

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

Theme:
Health and Development

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

Findings:
Where appropriate to the residents' capacity and needs there was evidence of life skill development. Basic self-care skills and social skill development was supported by staff where the residents capacity allowed this. For example, staff told inspectors that a resident undertook small household tasks with staff support. However, there was no evidence of any recommendations following these assessments. This is actioned under Outcome 5 'Social Care Needs'. Most residents attended day care services.

Personal plans provided detail as to the level of personal care support and also details as to personal tasks residents could support themselves with. Staff could be seen to make efforts to ensure there was social participation for residents, for example going to shopping centres or for meals out when staffing levels permitted this.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Inspectors noted that there was timely access to medical services and appropriate treatment and therapies. There were regular General Practitioner (GP) visits, annual medical reviews and staff confirmed that the GP service was timely and responsive. Residents had access to a consultant psychiatrist who attended the centre frequently. Referrals were made to specialist neurological services as required. Where treatment was recommended or prescribed by a medical practitioner, inspectors saw that this treatment was facilitated in a timely manner.

Staff informed inspectors that the level of support which individual residents required varied and was documented as part of the resident personal plan. From reviewing residents personal plans inspectors noted that residents were provided with support in relation to areas of daily living including eating and drinking, personal cleansing and dressing, toileting and oral care. There was evidence of a range of health assessments being used within the framework of the holistic assessment including physical well-being assessments, epilepsy nursing assessment, falls assessments, people related hazard assessment, eating and drinking assessment.

Inspectors noted that there was evidence of multidisciplinary involvement in residents care and welfare including dietician, speech and language therapy, dental and occupational therapist involvement. Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. There were a number of short and medium health support plans to address identified healthcare needs and records of support interventions provided by the interdisciplinary team members.

The level of support which individual residents required varied as observed by inspectors. However, there were deficiencies in the management of aspects of residents' health care. There were menus in the centre which offered choice There were individualised place mats designed for each resident. These mats contained residents' name/photograph and gave an outline of their food preferences/assistance that they may require. Inspectors were informed that residents' meals were prepared off site and delivered in thermally insulated food trolleys. However, on the days of inspection, inspectors saw that the choices provided were limited in relation to modified diets particularly in the evenings. There was documentary evidence of advice from dieticians and speech and language therapist available and staff ere knowledgeable on the

residents' dietary needs, likes and dislikes. Although access to dietetic services was limited there was evidence that the GP monitored dietary requirements.

Care practice as described by staff and documented in care plans conveyed that at end of life, the dignity of residents was respected, that their comfort and well being was a priority and that whoever wished to be with them were facilitated to remain as long as they wished. The person in charge told the inspector that residents had good access to the specialist palliative care services. This was a nurse led service which provided onsite visits to residents and also advice via telephone. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans and medication charts indicated that symptom control was effective for residents to ensure adequate pain relief and comfort as evidenced in a file reviewed by the inspector.

However, there was no policy for end of life to guide practice that linked the current procedures in place and provided guidance for staff on care planning for end of life. An end of life policy should include and support factors such as advance health care directives, consent, refusal of treatment and how to provide support to other residents and relatives. There was evidence in medical records that end-of life care and decisions regarding resuscitation were discussed by the general practitioner (GP) in a timely manner with families.

The decisions reached were recorded in the medical records. However, there was no evidence of discussion or input from residents or relatives on the record or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated. Staff who spoke to the inspector demonstrated knowledge of how to provide end of life care. However, as the centre provides care to residents at the end of their lives there were no staff trained in end of life care which would assist in ensuring palliative care was being provided in accordance with contemporary evidenced based practice.

The inspector saw that the personal plans did not address the topic of spirituality and dying in line with residents' emotional, psychological and physical needs. All of the documentation and care planning in relation to end of life care requires review as plans of care were seen not to coordinate and direct the care to be delivered and to ensure that the autonomy of the resident is upheld at all times. While care needs were identified on admission and documented accordingly there was no evidence of any advance care planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

Judgment:
Non Compliant - Moderate

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

Theme:
Health and Development

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

Findings:
Medications for residents were supplied by a hospital pharmacy department. 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' medicines were stored securely. Staff confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection. Inspectors noted that there was evidence of good practice when administering medications such as the use of "Do Not Disturb" tabards and availability of reference resources such as the Bord Altranais agus Cnáimhseachais na hÉireann medication guidelines.

A sample of medication prescription and administration records (MPARs) 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. 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.

There was a protocol for the use of emergency medication for the management of seizures and staff were familiar with this. A number of medication audits had been completed and there was evidence that all medication was reviewed and any impact on the residents monitored.

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose was sent to the Authority prior to the inspection as part of the application to register as a designated centre. The statement of purpose required amendments to ensure that it was specific to the centre and not the entire service. For example the staff listing in the statement of purpose was for the entire service and was not specific to the centre. In addition, the details for the person in charge were for the Director of Services and not for the person in charge of the centre.

A day service was provided in another location however it was indicated to inspectors on the day of the inspection that not all residents could attend this service on a daily basis due to a deficiency in staffing levels. It was also found that the statement of purpose was not available in a format that is accessible to residents.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The inspectors found that there was an organisational structure in place. However some improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs

The inspector found the person in charge while very experienced in intellectual disability nursing and familiar with the organisation was new to the role of person in charge of this designated centre. This had an impact of the effectiveness of governance and management arrangements within the designated centre. This became apparent when

inspecting the auditing documentation of the designated centre. For example care planning and risk assessment/management were not sufficient. While the person in charge had some good auditing in place further improvement was required in this area. This is discussed in Outcome 7.

The person in charge stated structured management meetings occurred with her line manager. The person in charge stated she had daily contact with her own manager and said she had good support systems in place. The inspector was satisfied that good lines of communication and support existed between the person in charge and the provider's management structure. However, there were no definitive deputising arrangements in place in the absence of the person in charge.

As part of the registration process the person in charge demonstrated her knowledge of her regulatory responsibilities and overseeing the delivery of care and knowledgeable on the residents needs. There was an appropriate day and night time on-call system in place with a nurse at CNM11 available to each of the centres in the region at weekends to support staff. Inspectors saw that reports were compiled by the CNM'S following their weekend on duty. Staff to whom inspectors spoke were clear about who to report to within the organisational line management structures in the centre. Staff also confirmed that person in charge and her team were committed and supportive managers. There was no annual review for the quality and safety of care provided to residents as required by legislation.

There are no other mechanisms currently for reviewing the quality and safety of care as required by the Regulations. The systems in place regarding the effective monitoring of services provided was inconsistent as evidenced in the variance in care planning, risk management and documentation in this centre. Inspectors saw there were formal support and supervision arrangements in place for staff which identified goals and objectives, any issues in relation to performance and training needs that staff may require. Inspectors saw that nurse manager meetings were held on a monthly basis. Inspectors saw that copies of the Regulations and Standards were available to staff. Staff confirmed to inspectors that there were regular team meetings.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
Adequate deputising arrangements were not in place. The person in charge of another service within the organisation would deputise for the person in charge. This is actioned under Outcome 14 'Governance and Management'.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Resources

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

Findings:
The inspectors examined staff rosters, reviewed residents physical care and psychosocial needs in care files and met with residents and discussed with staff their roles, responsibilities and working arrangements.

Sufficient resources for fundamental care such as food, health care, equipment maintenance and upkeep of the premises and vehicles used are available and utilised. However, there was evidence of insufficient staff to ensure that resident's wellbeing and access to activities could be maintained on a consistent basis in accordance with the statement of purpose. This is actioned under outcome 17 Workforce.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
The inspectors found that improvements were required regarding the workforce to comply with the Health Act 2007 (care and support of residents in designated centres for persons (children and adults) with Disabilities) Regulations 2013. There was a centre-specific policy on recruitment and selection of staff and the person in charge was familiar with the recruitment process.

There was insufficient provision of staff to meet the needs of the residents. There was no recognised dependency tool in use to determine the dependency levels of residents. Inspectors were not assured that the staffing levels were adequate to meet the activation needs and goals of residents as observed by inspectors during inspection and in personal plans of residents. Staffing levels were low at weekends and in the evening times as observed by inspectors. The person in charge said that she would often work on the floor if staff were on leave and not replaced. This had an impact on effective managements systems as the person in charge is unable to fulfil her role and meet regulatory requirements as discussed under outcome 14.

During the inspection inspectors observed the person in charge and staff interacting and speaking to residents in a friendly, respectful and sensitive way. Based on talking to staff and observations by inspectors staff members were knowledgeable of residents individual needs. The inspectors spoke to staff on duty during the inspection; all staff appeared to be competent and were aware of their roles and responsibilities.

The management team demonstrated commitment to providing on going education and training to staff relevant to their roles and responsibilities. There was a training plan in place for 2015. However, there were gaps in mandatory training such as challenging behaviour, manual handling and fire safety as observed by inspectors.

As outlined under outcome 11 there was a deficit in some training needs required to provide a contemporary evidence base to aspects of clinical care. The staff training and development programme should maintain the skills of the workforce therefore ensuring staff are up skilled to meet the changing needs of residents.

A random sample of staff files were checked during the inspection. There was one deficit with the requirements of Schedule 2 of the Regulations. For example :

No UK police check for the PIC while she was resident in the UK from 1999-2003.

There were no volunteers working in the centre at the time of inspection.

Judgment:
Non Compliant - Moderate

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
The inspectors found that most of the records required for compliance with the regulations were up to date and comprehensive. The risk management policy was not comprehensive and was in the process of being reviewed. The service is in transition with regard to the policy on safeguarding residents against abuse. These issues are dealt with in more detail under Outcome 7.

It was also found that the documents were numerous with much duplication. It was difficult to find the required information from the range of available documents. Inspectors were informed that there is a pilot programme being trialled in relation to personal plans and once this was complete, a new process would be rolled out to the entire service. This process will enable a more succinct collation and recording of information.

Adequate insurance cover was in place. The inspectors found that systems were in place to ensure that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002634
Date of Inspection:	28 July 2015
Date of response:	17 September 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate evidence of consultation with residents or their relatives in relation to the organisation of the centre.

1. 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.

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

Please state the actions you have taken or are planning to take:
1.Multidisciplinary review meetings have now been scheduled of being arranged. Families and residents will be invited to attend , also proposed to be in attendance will be the Consultant Psychiatrist, Clinical Psychologist, SLT,OT CNM2 and Staff nurse.

2. Annual review meetings are scheduled and will be held on a unit level between the resident, their family representative, key worker and CNM2.

3.Weekly schedule review meetings are commencing between each Service User and their keyworker or representative

Proposed Timescale: 15/12/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Access to day care and individual recreational opportunities were restricted due to staffing levels.

2. 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:
1.Adjustments to the rosters have been made which increase staffing between the hours of 18.00 and 20.30 and extra staffing has been provided at the weekends. An additional multitask worker every second Saturday to support personal plans.This will enable the residents to avail of extra activation opportunities and outings and also enable them to meet their goals.

2.Ongoing recruitment initiatives are progressing and are expected to fill current staff vacancies on the roster. With a full staff compliment the staffing levels will be adequate to enhance the services users recreational opportunities.

Proposed Timescale: 31/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no easy read or suitable version of the complaint procedure available for the residents

3. Action Required:

Under Regulation 34 (1) (a) you are required to: Ensure that the complaints procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
1.A revised format for making a complaint has been developed and is prominently displayed on the unit.

2.Each keyworker is responsible for meeting with the service user and for reviewing this process and documenting same.

3.The National advocacy supports have been communicated to the Service Users and their family members.

Proposed Timescale: 15/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were informed of an issue during the inspection which had not been logged as a complaint

4. 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:
1.The PIC will ensure all complaints are logged, outcomes documented and whether the complainant is satisfied.
2.The issue identified has been logged and outcome to date documented. Further meeting scheduled with parent.

3.Comments, suggestion and complaints has been reviewed and updated and is in situ.

Proposed Timescale:
1.Completed
2.23/10/2015
3.Completed

Proposed Timescale: 23/10/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Details of potential additional costs were not clearly outlined in the contract

5. 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 "Terms of Residency" have been amended to reflect any additional costs.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admissions policy did not take into account of the need to protect residents from abuse by their peers as required by the Regulations

6. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
1.The admission policy will be amended to reflect the need to protect residents from abuse by their peers.

Proposed Timescale: 15/10/2015

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 fully reflect residents' individual needs, choices and aspirations.

7. 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:
1.New holistic plans are currently being piloted in other units within the service and will be rolled in this centre

2.CNM2 has met with keyworkers and discussed the need to improve reviewing of all documentation.

3.Annual multidisciplinary review meetings have been scheduled.

4.CNM2 to meet with keyworkers and service users monthly to discuss progress in meeting goals, setting targets and time frames and updating of holistic life plans.

5.Weekly service user reviews to commence highlighting weekly activities, meal choices and complaints/areas of concern.

Proposed Timescale:
1.31/12/2015
2.Completed
3.10/11/2015
4.31/09/2015
5.21/09/2015

Proposed Timescale: 31/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents annual reviews were not comprehensive and multidisciplinary.

8. 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:
Dates have been set for annual multidisciplinary reviews for all the service users.

Proposed Timescale: 21/09/2015

Theme: Effective Services

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

Annual reviews were not multidisciplinary.

9. 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:
Dates have been scheduled for multidisciplinary reviews for all of the service users. Invited to the multi disciplinary meeting will be the Consultant psychiatrist, Clinical psychologist, SLT, OT, CNM2 and staff nurse aswell as the service user and a family representative.

Proposed Timescale: 10/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The effectiveness of the residents personal plans were not reviewed annually or more often as required.

10. 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:
1.Annual multidisciplinary review dates have been set.
2.Annual review meetings are scheduled and will be held on a unit level between the resident, their family representative, key worker and CNM2.
3.CNM2 will meet with keyworkers and service users monthly to discuss progress in meeting goals, setting targets and time frames and updating of holistic life plans.

Proposed Timescale:
1.10/11/2015
2.15/12/2015
3.31/09/2015

Proposed Timescale: 15/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessed needs of the residents for access to day care, activation and social care were not satisfactorily met.

11. 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:
1.Adjustments to the rosters have been made which increase staffing between the hours of 18.00 and 20.30 and extra staffing has been provided at the weekends. This will enable the residents to avail of extra activation opportunities and outings and also enable them to meet their goals.

2.A dependency tool is currently sought suitable to assess the needs of the service users. A multidisciplinary meeting to review skill mix and possibilities of staff to reflect Service Users needs

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff told inspectors that a resident undertook small household tasks with staff support. However, there was no evidence of any recommendations following these assessments.

12. 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:
1.Skills maintenance programmes are in place which are under review by the key worker. It is the responsibility of the key worker to develop these programmes and to ensure the service users is provided with the opportunity to develop their skills.

2.The CNM2 will meet with the key workers' and service users monthly to discuss progress in meeting goals, progress made with skills programmes, setting targets and time frames and updating of holistic life plans.

Proposed Timescale:
1.Completed
2.31/09/2015

Proposed Timescale: 30/09/2015

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 hazard identification and assessment of risks throughout the centre was not adequate as the following risks had not been assessed. This included:
lack of an adequate emergency plan for the evacuation of residents at night.
locked exit doors which had had unsecured keys on rings next to them posing a risk of residents not been able to exit if the keys were missing
bedrails which were very loose posing a risk of entrapment to residents.

13. 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:
1.Bed rails have been attended to in order to meet Regulations. Risk assessment in place.
2.Door key's available for each staff member on duty to carry on their person for the duration of their shift. Risk assessment in place.
3.Break glass units containing a key already in situ at each exit.
4.Unsecured keys removed from doors.
5.Risk assessment in place for development of pressure ulcers and nutritional deficits.
6.Fire drills carried out simulating staffing levels at night time. Fire officer has attended the unit and carried out fire training with staff.
7.Dependency tool currently being sourced to identify the service users dependency levels.
8.Date to be identified for upgrading works to begin.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for learning and review from accidents and incidents required improvements.

14. 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:
1.Two weekly nurse manager review meetings scheduled with agenda to include Incident reflection and learning
2. New national incident management forms commenced

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a risk management policy which set out the procedure for risk assessment. It did not comply with article 26 (1) as it did not include hazard identification.

15. 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:
1.The Risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.

2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not include the measures and actions in place to prevent accidental injury to residents, staff and visitors.

16. Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
1.The risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.
2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not include the measures or actions in place to control prevent self harm.

17. Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
1.The risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.

2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy did not include the arrangements in place for identification, recording and investigation of and learning from serious incidents or adverse events involving residents.

18. 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:
1.The risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.

2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not include the arrangements in place to control violence and aggression.

19. Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
1.The risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.

2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not comply with article 26 (1) entirely as it did not satisfactorily identify the procedures for the risk of residents absconding.

20. Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
1.The risk management policy has been reviewed to incorporate the above components of assessment, management and ongoing review of risk.

2.The standing agenda for our service management team meeting will include risk management.

Proposed Timescale: 21/09/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of staff had not had updated fire training.

21. 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:
Fire training is ongoing. Ten staff member have received training.

Proposed Timescale: 31/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that that there was an adequate plan in place to either evacuate residents or move them to a safe location internally given that there was only one fire compartment in the premises.

22. 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:
1.Schedule of Fire Upgrading works has commenced in the Service A date planned for upgrading works to begin in this centre in March 2016

2.Following fire training a schedule was devised to incorporate simulation of night time evacuation.

3.Fire officer has attended the unit and carried out fire training with staff.
4.Personal evacuation plans are in place and reviewed as required.

Proposed Timescale:
1.31/03/2016
2.Completed
3.Completed
4.Completed

Proposed Timescale: 31/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had received training in an approved method of managing behaviour but a small number of staff were overdue for refresher training.

23. 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:
All staff currently receiving training Positive Behaviour Support training.

MAPA training is ongoing. Staff requiring training identified to the CNM3's office.

Proposed Timescale:
1.31/10/2015
2.31/10/2015

Proposed Timescale: 31/10/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The documentation and care planning in relation to end of life care requires review as plans of care were seen not to coordinate and direct the care to be delivered and to ensure that the autonomy of the resident is upheld at all times.

24. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
1.End of life policy to be put in place and end of life care plan.
2.Training requested from RCNME and NMPDU to address aspects of End of Life Care Skills.
3.A more comprehensive End of Life care section will form part of the new Personal Plans and be discussed at scheduled review meetings with Service users and their family member.

Proposed Timescale:
1.31/10/2015
2.31/03/2016
3.31/12/2015

Proposed Timescale: 31/12/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The choice of food for residents who required this in a modified form was very limited in the evening time.

25. 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:

1.PIC communicated with the Catering Manager and requested further choices of food particularly for the evening meal for those on modified diets.
2.Weekly Service User review includes weekly discussion on meal choices.

Proposed Timescale:
1.Completed
2.21/10/2015

Proposed Timescale: 21/10/2015

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 requires review to ensure it is centre-specific.

26. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
Statement of Purpose reviewed and WTE included.

Proposed Timescale: 21/09/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No annual service review has been undertaken which includes the views of resident or relatives.

27. 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:
1.Satisfaction surveys have been sent out to families.
2.Review being completed

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that management systems were in place to ensure that the service provided was safe appropriate to residents needs consistent and effectively monitored for example care planning and risk assessment/management were not sufficient.

28. 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 review of service auditing system to follow the completion of the annual review. PIC to improve on auditing system and follow upon reviews.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate deputising arrangements were not in place. The person in charge of another service within the organisation would deputise for the person in charge.

29. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
PPIM has now been identified for the unit.

Proposed Timescale: 21/09/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A random sample of staff files were checked during the inspection. There was one deficit with the requirements of Schedule 2 of the Regulations.

30. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
Awaiting return of police check for PIC.

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing compliment was not appropriate to the number and assessed needs of the residents

31. 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:
1.Adjustments to the rosters have been made which increase staffing between the hours of 18.00 and 20.30 and extra staffing has been provided at the weekends. An additional MTW every second Saturday to support personal plans.This will enable the residents to avail of extra activation opportunities and outings and also enable them to meet their goals.

2.Ongoing recruitment initiatives are progressing and are expected to fill current staff vacancies on the roster. With a full staff compliment the staffing levels will be adequate to enhance the services users recreational opportunities.

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff had not had updated mandatory training in fire safety, challenging behaviour and manual handling.

32. 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:

1.Ten staff have received fire training.
2. All staff are currently receiving positive behaviour support training.
3. MAPA training is ongoing.
4.Ten staff have received manual handling training. Training is on going.

Proposed Timescale: 31/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received other appropriate training in end of life care to enable them to deliver care in accordance with contemporary evidence based practice.

33. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Training requested from RCNME and NMPDU to address aspects of end of life care skills.

A more comprehensive End of Life care section will form part of the new personal plans and be discussed at scheduled review meetings with Service users and their family member.

Proposed Timescale: 31/10/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not meet the requirements of regulations. It did not adequately cover the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

34. 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:
1.The risk management policy has been reviewed to incorporate the above components

of assessment, management and ongoing review of risk. 2.The standing agenda for our service management team meeting will include risk management.
Proposed Timescale: 21/09/2015