<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
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<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0002456</td>
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<td><strong>Centre county:</strong></td>
<td>Monaghan</td>
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<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
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<td><strong>Registered provider:</strong></td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Kevin Carragher</td>
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<tr>
<td><strong>Lead inspector:</strong></td>
<td>Catherine Rose Connolly Gargan</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Siobhan Kennedy</td>
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<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>12</td>
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<td><strong>Number of vacancies on the date of inspection:</strong></td>
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About monitoring of compliance

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

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

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

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

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

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

**The inspection took place over the following dates and times**

<table>
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<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>22 June 2015 10:30</td>
<td>22 June 2015 18:30</td>
</tr>
<tr>
<td>23 June 2015 10:30</td>
<td>23 June 2015 18:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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**Summary of findings from this inspection**

This was an announced inspection completed in response to an application by the provider for registration of the designated centre as required by the Health Act 2007. The designated centre consists of two community houses located in Co. Monaghan and is operated by the Health Service Executive. This was the second inspection of the centre by the Authority. The inspectors found that the provider had demonstrated a responsive approach to regulation. Satisfactory actions were taken by the provider to address and complete areas of non-compliance identified, however further improvements are required in some areas of the service as discussed in the body of this report and associated action plan to bring the designated centre into compliance with the regulations.
This inspection was facilitated by the person in charge who was present at the opening and closing meeting. As part of the inspection process, inspectors met with residents and staff, reviewed documentation and observed practice. Completed pre-inspection questionnaires issued by the Authority were also reviewed. Feedback was generally complimentary of staff within the centre and the quality of service provided to residents. Inspectors found that staff engaged with residents in a dignified and respectful manner and residents spoken with confirmed their satisfaction and happiness with living in the designated centre.

The inspectors found that service improvements had been implemented that positively impacted on the quality of life of residents since the last inspection in June 2014. Inspectors found that 66% of residents in the centre were aged from 66 to 79 years and had retired from attendance at day services. Due to the ageing profile of many residents in the designated centre and increased dependency needs and support a review of staffing levels and skill mix was required to ensure their more complex needs are met. There was an absence of a activation programme to meet the specific needs of retired and elderly residents.

Non-compliances were identified with twenty two regulations on this inspection, seventeen of which is the responsibility of the provider and five is the responsibility of the person in charge. Compliance was found in six outcomes. Substantial compliance requiring minor improvement was required in a further four outcomes as follows Outcome 2: Communication, Outcome 3: Family and personal relationships, Outcome 12: Medication Management and Outcome 14: Governance and Management.

Moderate non - compliance was identified in the following Outcomes:
Outcome 1: Residents' Rights and Consultation,
Outcome 5: Social Care Needs,
Outcome 6: Safe and Suitable Premises and
Outcome 7: Health and Safety and Risk Management
Outcome 11: Healthcare Needs
Outcome 16: Use of Resources
Outcome 18: Records and documentation
Outcome 17: Workforce.

The action plan at the end of this report identifies the required actions the provider/person in charge is required to take to ensure the designated centre is in compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
On the last inspection of the centre on 24 June 2014, the privacy and dignity needs of residents were found to be compromised by the layout and design of a double room in one of the community houses.

On this inspection, inspectors reviewed the actions taken to address these findings and found that the layout of the twin room had been reviewed to include installation of an additional wardrobe providing each resident with their personal wardrobe space which they could access freely if they wished. A room was refurbished to provide a second comfortable communal area for residents’ use including meeting visitors in private.

Inspectors found that a record of complaints was maintained. A review of same referenced appropriate investigation and the complainant's satisfaction with the outcome was also recorded. An accessible format copy of the policy was displayed.

All residents had private accommodation in the form of their own bedroom with the exception of two residents who shared a twin bedroom. On this inspection, inspectors found that some residents entered other residents’ bedrooms without permission. While one resident was provided with a key to lock their door while they were out of the centre, other residents who expressed dissatisfaction with others entering their bedrooms at will were not provided with the means to safely lock their bedroom doors for their privacy if they wished. Inspectors also found that residents could not lock some showers/toilets while using same in the designated centre.

Arrangements for ensuring residents' finances were appropriately managed and safeguarded were in place and informed by policy and procedural documentation. Each
A resident had an assessment completed to assess level of support required by staff with managing their personal finances. All transactions were recorded and supported by signatory evidence to support transparency.

There was evidence that residents were consulted about how the centre was planned and run. The inspectors saw where residents were involved and encouraged to make choices about their lives in the centre that reflected their individual preferences. For example, residents were facilitated and encouraged to personalise their bedrooms to reflect their individuality and interests. There was a residents' forum conducted weekly with staff and which were minuted.

While an advocacy service was available to residents to support their choice and decision making, arrangements were not in place to ensure advocates who would support residents were known to them.

**Judgment:**
Non Compliant - Moderate

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### 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:**
Inspectors were informed that work was in progress on developing accessible format personal planning templates and resident guides for each community house. Inspectors observed that some documents were provided to residents in accessible format such as complaints procedure. Staff photographs were displayed to reflect the duty rota and the pharmacist’s name and photograph was displayed for residents’ information. The menu of the day available to residents was also presented in pictorial format to facilitate their informed choice. There were some residents with hearing difficulties and were assessed and provided with assistive equipment to meet their needs in this area. Fire alert was in a pictorial format to assist residents with hearing deficits in the event of an emergency. Lámh language methods were used with some residents to assist their vocabulary and language skills. There was evidence that residents with speech deficits were appropriately referred for assessment for use of assistive technology to support their needs.

While staff demonstrated a comprehensive understanding of the meaning of some residents' communication methodologies, personalised documentation was not developed referencing each resident’s communication gestures and sounds to assist...
their communication with those less familiar with them. Inspectors reviewed the policy informing management of residents' communication and found that it did not adequately inform the needs of residents in the centre. This finding is discussed further in outcome 18. Residents had access to television, radios and telephones.

**Judgment:**
Substantially Compliant

**Outcome 03: Family and personal relationships and links with the community**

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
There was a policy in place which advised on appropriate procedures to support visiting of residents in the designated centre. Residents were supported and empowered with staff assistance to maintain family contacts which included visiting and for some residents staying overnight. Residents were also observed by inspectors to be encouraged by staff to maintain family contact by telephone. However, not all residents in the centre had family contacts and inspectors found that no appropriate alternative contacts outside of the designated centre, in the absence of family was explored for these residents.

Each house had a visitors' book which was up to date with a record of visitors who attended the centre on the days of inspection. There were no restrictions to visitors in the centre unless requested by the resident or supported by their risk assessment. Inspectors found clear evidence from review of the personal records of residents, feedback from the Authority's pre-inspection questionnaires and from speaking to residents and staff that where available, family members were actively encouraged and involved in the lives of residents. From a sample of records reviewed, there was evidence that where possible, family members had been involved in the personal plan meetings of residents and were consulted regarding any change in the residents' health or well-being.

A room in one of the community houses was refurbished since the last inspection to provide an additional area where residents could meet their visitors in private if they wished.

**Judgment:**
Substantially 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 organisation had an admissions policy in place which included the procedures to be followed for transfers, discharge and temporary absence of a resident. This policy document was reviewed on inspection and while no deficits were found in respect of resident care on the days of this inspection, the policy did not adequately inform all aspects of these procedures. The policy did not adequately inform the procedures to take should an emergency occur or temporary absence in respect of a holiday, visiting family or an admission to hospital. The policy did not inform the procedure to be taken if a resident was admitted to hospital including the information to be communicated to the acute setting and the support, if any, the resident would receive from the designated centre whilst temporarily absent from same. The admission procedure did not adequately inform residents' choice or transition needs when moving into the centre from care in the family home or another service. This finding is addressed in outcome 18. There were no new residents in transition on the day of inspection in the designated centre.

Inspectors found that each resident had a contract detailing terms of residency, aspects of care covered as distinct from services not covered by the fee to the resident. Some contracts were countersigned in agreement by residents.

**Judgment:**
Compliant

**Outcome 05: Social Care Needs**

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

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

Findings:
Inspectors reviewed a sample of residents' personal files and found that each resident had an assessment completed which identified their health, personal and social care needs. This document was not in accessible format on the days of inspection but was being developed at a regional level. On the last inspection of the centre in June 2014, inspectors found inconsistencies in the robustness and/or the meaningfulness of goals set with residents. For example, some goals were already part of the residents’ daily routine and some others had not been reviewed in response to deterioration in health.

Personal plan documentation referenced assessments of residents' emotional well-being, numeracy and literacy skills, concept of time, spiritual needs, nutritional needs, independence, personal grooming and sharing their environment. Additional assessments of need were completed for some residents with other vulnerabilities informed by use of accredited assessment tools to inform their manual handling and nutrition needs implemented since the last inspection.

Each resident had a care plan developed to meet their assessed needs regarding their health care. Risk assessments were completed to inform social care needs such as visiting family/friends and accessing the community. While there was evidence that each resident's full participation was encouraged in the annual review of their personal plans, these reviews were not multidisciplinary as all healthcare professionals involved in residents' care were not involved in annual reviews. Each resident had identified their short and long term goals with support by staff and where possible, their family, details of which were documented in their personal plan information. Since the last inspection, residents’ spiritual needs were assessed in greater detail and residents who wished to practice their faith were assisted to attend religious services.

Inspectors found on this inspection that further improvement was required to ensure residents social care needs were comprehensively assessed and that they were facilitated and assisted to engage in a meaningful, individual activation plan to meet their needs, preferences, capability and interests. For example, there were six residents living in the designated centre who had retired from attendance at their day service programme as aged greater than 65years. There was no tailored activation plan in place to meet the specific occupational needs of these residents. In addition, monthly reviews did not always inform improvement in some residents' social activity. For example, a sample of monthly review documentation reviewed by inspectors referenced that one retired resident did not have reference made to their social participation activity for nineteen out of thirty one days in May 2015. There was an absence of substantial action taken to address this finding.
Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
As stated previously, the designated centre consists of two bungalow structures located in a rural setting. Inspectors observed both houses to be homely and reflective of the individuals who reside there. There were ten single bedrooms and one double room in the designated centre. Bedrooms were of varying sizes and their size and layout met the needs of the residents who currently reside in the designated centre. Some residents who required the assistance of equipment to support their mobility needs were accommodated in rooms with greater floor space. On the last inspection in June 2014, inspectors determined that the double room did not promote the privacy and dignity of the residents residing there. As discussed in outcomes 1 and 3, this non-compliance with the regulations was satisfactorily addressed on this inspection. Each designated centre had a kitchen/dining area, sitting room and a laundry area.

Storage facilities in one community house required review as inspectors found that the second sitting area also used as an area for residents to meet their visitors was used as a storage area for residents' wheelchairs. The floor space in one of the laundry rooms was reduced due to use for storage. Some of the items stored were not appropriately stored in this area and included cleaning equipment and residents' toiletries and equipment.

A hoist was available for use by one resident but has not been required to-date, all staff were trained on its safe use and servicing was up to date. This hoist was stored in a corridor area and as such posed risks to unobstructed evacuation in the event of fire. This finding is discussed in outcome 7. The layout of furniture in one sitting room did not ensure residents’ comfort and partially obstructed an access door from the kitchen to this sitting room. One assistive chair designed for a resident with mobility needs was not stationary and moved on sitting into it. The person in charge addressed this finding immediately and also requested an occupational therapy assessment to assess safety of same.

A toilet area used by a resident with mobility needs had a raised seat on it but did not
have grab rails fitted or assessment of need documented. In addition there was an absence of assessment of need for handrail supports for residents with mobility support needs on some corridor areas to promote their safe independence.

Each residence had an external area which residents could access. However, as the majority of the external space was located to the front of one community house, this area required risk assessment to ensure residents were not at risk from vehicles entering the site. This finding is discussed in outcome 7. This area also needed review in terms of provision of sufficient seating for residents as inspectors found that a single bench was located in this area which did not meet the comfort needs of all residents. The person in charge advised inspectors on the second day of inspection that additional seating had been purchased.

Inspectors observed that a resident's bedroom in one community house was accessed from the utility area which contained laundry equipment. This arrangement required review and is discussed further in outcome 7.

Some furniture and fittings were found to be in need of repair. For example, a bed headboard, a wardrobe door and some door handles. There was also evidence of damp in corridor floor in one community house which was being addressed at the time of inspection.

There was adequate numbers of showers and toilets to meet the needs of residents residing in the designated centre. Inspectors observed a persistent malodour in one resident's en-suite which staff had made ongoing efforts to disperse by cleaning and leaving the extractor fan in operation.

**Judgment:**
Non Compliant - Moderate

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### Outcome 07: Health and Safety and Risk Management

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

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

**Findings:**
A Regional safety statement was available and was updated for 2015. The health and safety of residents, staff and visitors was found to be generally promoted in the designated centre on the days of inspection. A review of documentation evidenced that the centre had the requisite risk management policy and documentation and that this documentation was centre-specific. There was a risk register that reflected risks present
in the centre, demonstrated that risk assessments were being conducted on an ongoing basis and that control measures were being implemented to address these risks. However, not all potential risks were identified and assessed with concomitant controls stated to mitigate level of risks found. The following areas of risk were not referenced in the risk register;
- risk to residents from vehicular access within the area used as their outdoor space in one community house.
- risk to residents with reduced mobility by absence of handrails on corridors
- risk posed by a bathroom window opening outwards into a footpath.
- risk of trip posed by a fire hearth jutting into a narrowed access pathway for residents entering a sitting room from a kitchen.
- risk posed by a hoist stored in a corridor.
- risk posed by use of keys to lock bedroom doors was not assessed to ensure unrestricted access by staff to residents in the event of an emergency when keys were left in engaged locks inside the doors
- residents who smoked, although always supervised by staff did not have smoking risk assessments completed. Some residents kept lighters and cigarettes on their person. There was no smoking policy available in the centre on the days of inspection. This finding is addressed in outcome 18

Inspectors found that the centre was visibly clean and hand hygiene was carried out by staff in facilities provided as appropriate. However, cleaning equipment was inappropriately stored on the sink in the laundry. A bedroom was accessed through a utility room where residents' laundry was managed. There was a potential risk of infection from contaminated linen. As discussed there was a malodour present in an ensuite. There was an infection control policy in place in the centre to inform practice in this area.

Inspectors found that the necessary fire safety procedures were in place to safeguard residents and others against the risk of fire. There was a fire procedure in place for both houses. There was evidence of regular checks and good housekeeping practice with respect to fire safety.

Inspectors reviewed the documentation relating to the maintenance and servicing of fire equipment and were satisfied that the appropriate maintenance and checks were occurring at regular intervals. Residents also had personal evacuation plans in place and there was evidence that regular fire drills took place. Fire drills were conducted to reflect the conditions that would be present both at day and night including the number of staff on duty and the location of residents at various times. However, there was evidence that a resident in one community house refused to leave. There was no reference to how this would be managed in the event of a fire occurring at night when one staff member was on duty. There was also evidence that symbols were utilised to demonstrate to residents with a hearing impairment of what to do in the event of a fire.

The community houses were each fitted with a fire alarm system and emergency lighting throughout. The layout of both houses ensured there were adequate escape routes from the building in the event of fire.

However a door designated as a fire exit between the kitchen and sitting room was semi obstructed by the positioning of a chair in the sitting room of one community house. Fire doors were provided where necessary to contain fire and smoke in the event of same
occurring in the designated centre. However a perspex panel was located in an area over a door from a kitchen to a utility room containing a washing machine/dryer and resident’s bedroom. This finding had not been addressed in the documentation reviewed. A number of fire exit doors were locked with a key, particularly at night. Inspectors found that where this was the case, a key was provided directly adjacent to the door in a break glass unit and that this arrangement had been risk assessed and recorded.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Safeguarding and Safety**

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

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**Theme:**
Safe Services

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

**Findings:**
The designated centre has a policy in place titled 'Guidelines on the Protection from Abuse of Vulnerable Adults with a Disability' advising on prevention, detection and response to abuse. As discussed in outcome 2, advocacy services for residents required improvement. Inspectors confirmed that all staff had received training in prevention, detection and response to abuse. Staff spoken with confirmed to inspectors that they were aware of the appropriate action to be taken in the event of an allegation or suspicion of abuse. All members of a regional safe-guarding team had not been established to support the HSE National Safeguarding policy requirements and as such implementation of the policy into practice was hindered in the absence of clear referral and support pathways.

Inspectors reviewed the management of an allegation of abuse and found it to be satisfactory and reflective of the policy in place. Inspectors found that there were arrangements in place for managing unexplained bruising. No incidents of unexplained bruising were recorded. A tracking record was introduced to inform monitoring and investigation procedures for residents presenting with repeated unexplained bruising to their skin. Staff-resident interactions were observed on the days of inspection and inspectors observed staff to be supportive and caring towards residents during the days of inspection. Residents confirmed they felt safe and relatives responded in the Authority’s pre-inspection questionnaires that they felt their relative was safe and well
The designated centre has a policy in place informing management of residents’ personal property and possessions. On review of practice inspectors found that all transactions were transparent and supported by signatory records. Arrangements were in place for secure storage of residents’ money. A personal property record was maintained for each resident, but required improvement to include a record date and clarity in the detail of property listed.

Some residents in the designated centre had a history of presenting with behaviours that challenge. Inspectors reviewed the positive behaviour support plans and were satisfied that the appropriate assessments had occurred and that the appropriate proactive and reactive strategies were in place. Staff spoken with were also aware of the appropriate strategies. The organisation had a policy in place to inform support procedures for residents who exhibited behaviours that challenged and the use of restrictive practices. Staff in both community houses had attended PMAV (Professional Management of Aggression and Violence) training and training on positive behavioural support which included de-escalation procedures.

The inspectors observed from review of accident and incident records and notifications forwarded to the Authority that some residents engaged in behaviours that challenge including destruction of property. Each resident who presented with challenging behaviour had a positive behavioural support plan developed to inform individual triggers and de-escalation procedures. Protective equipment in use to prevent injury during epileptic seizures was assessed however, assessment documentation required improvement to ensure it did not pose restrictions to those using this equipment. Some environmental restrictions following risk assessment were in place to prevent adverse outcomes for vulnerable residents. A restraint log was maintained referencing all restrictive incidents.

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:
Inspectors reviewed the accident/incident log and confirmed that all incidents as required by Regulation 31 had been notified to the Chief Inspector. All restrictive
practices were notified appropriately. The person in charge demonstrated the appropriate knowledge of their statutory obligation to notify the Chief Inspector.

**Judgment:**
Compliant

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**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:**
There was no policy available to staff to advise on procedures to ensure residents’ access to education, training and development in the designated centre. While seven residents had retired from attendance at a structured day programme, the other five residents attended a day service programme five days per week.

As discussed in outcome 6, residents who had retired did not have an activation plan in place to meet their needs, capabilities and interests. However, personal plan documentation reviewed referenced meaningful goal setting for each resident and there was evidence that residents were supported in achieving these personal goals. There was also evidence that residents were supported to supported to attend training programmes for which they were awarded certificates of completion.

**Judgment:**
Compliant

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

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
Inspectors reviewed a sample of residents' personal plans and were assured that residents' needs were reviewed on an annual basis. Health care needs were identified in this annual assessment. Inspectors found on the last inspection in June 2014 that:
- appropriate plans of care were not always developed as a result of assessment,
- there was also an absence of evidence based tools being utilised to assist with the development of a plan of care.
- appropriate referral to the dietician/speech and speech and language therapy specialists were not done
- staff involved in the preparation of food and had not received training in food preparation and hygiene.

Inspectors found on this inspection that although improved with implementation of accredited assessment tools to identify resident needs, care plans and staff training in food preparation and hygiene, the care of residents with complex nutritional needs were not adequately addressed. While there was evidence of referral for dietetic review, consultation was subject to waiting list arrangements. In the absence of action to expedite consultation, some residents with complex nutritional needs were at risk of deteriorating health.

Residents spoken with stated that they liked the food and that there was a choice available to them. Inspectors confirmed this by a review of the daily menus. Menus were in accessible format. Inspectors observed that residents were provided with opportunity to have snacks and drinks throughout the day outside of their main meals.

Staff preparing meals demonstrated that they were informed and knowledgeable regarding the dietary needs of residents including those with assessed swallowing difficulties. Residents' body weights were monitored with increased frequency for those at risk of weight loss/gain. However the nutrition policy available to advise staff dated 13 November 2013 was not adequate as it did not advise on some specialised diets for residents in the centre with complex needs and did not adequately advise on all aspects of nutritional assessment. This finding is addressed in outcome 18.

Some residents had a diagnosis of epilepsy. Protocols were in place to advise staff on medication administration in the event of prolonged seizure activity including transfer to hospital. All staff had attended training on Epilepsy Awareness to inform their practice. From review of residents' documentation, inspectors observed that residents were appropriately referred to and reviewed by relevant medical specialists and allied health professionals including occupational therapy and physiotherapy as required. While dietetic specialists reviewed residents with evidence of positive outcomes for them, this service was not always timely as subject to waiting list arrangements. Records of referrals, clinical interventions and treatments were maintained in each resident's documentation.

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

Findings:
On the last inspection of the centre in June 2014, the designated centre did not have a current policy in place regarding medication management. A draft policy which was under review as a result of findings of inspectors at an organisational level and was found to be satisfactorily implemented on this inspection. However, review of this policy on inspection evidenced improvement required in the information to inform appropriate secure storage and disposal of unused or out of date medications. This finding is addressed in outcome 18. The medication policy was centre-specific to inform practice in respect of staffing arrangements. Separate policy documents were in place to inform medication procedures by nurses and care staff as medications were administered by care staff in one of the two community houses. Only Nursing Staff administer medication in both community homes. The inspector observed medication administration and found it to be safe and in line with best practice procedures.

A pain assessment tool was in use to assess residents’ pain. Medication prescription and administration documentation was revised since the last inspection to include provision of adequate space for insertion of comments. Inspectors observed that medication was stored appropriately and stock was checked weekly.

Auditing procedures were completed by the person in charge since the last inspection. However the centre's pharmacist did not adequately complete their obligations including quarterly audits of medications in the community houses. The person in charge told inspectors that residents had access to the pharmacist if they wished, however no one availed of this facility. There was evidence that residents had received assessments to ascertain if they were in a position to self medicate.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

**Findings:**
As part of the application to register the designated centre under the Health Act 2007, the provider was required to submit a Statement of Purpose to the Chief Inspector. Inspectors reviewed the Statement of Purpose dated 11 May 2015 and found that it accurately described the service provided and contained the information as required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013,

**Judgment:**
Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a clear management structure in place. The provider nominee was the regional manager for the service. The provider nominee is supported by a director of nursing and an assistant director of nursing. The person in charge is employed as a Clinical Nurse Manager Grade 2 and has responsibility for the two community houses which form the designated centre. The person in charge reports directly to the director of nursing. The person in charge met with the Director of Nursing formally on a monthly basis at a forum for all persons in charge in the region. The person in charge met with the director of nursing approximately every 8 weeks. Both these meeting forums were informed by an agenda and minuted. There was also evidence that the staff employed to work directly in the community houses met regularly as a group with the person in charge.

The person in charge was available throughout the two days to facilitate the inspection. The person in charge has the necessary qualifications and experience to ensure
compliance with the legislation and demonstrated adequate knowledge of the operation of the designated centre. The evidence supported her involvement in the governance, operational management and administration of the centre. The person in charge was knowledgeable regarding residents and their assessed needs. Through observation and speaking to residents, inspectors confirmed that residents were familiar with the person in charge.

Although at an early stage, there was evidence of a system in place to monitor the quality and safety of care and quality of life of residents. There was evidence of audits of medication management practices, infection prevention and control and health and safety. Some actions were taken to address deficits identified but it was not clear if all deficits were addressed as action plans were not developed clearly identifying the action to be taken and to enable tracking to satisfactory completion.

There was evidence that the provider or the director of nursing nominated on behalf of the provider had visited the designated centre regularly in the previous six months and the provider produced a report on the quality and safety of care and support provided in the centre as required by Regulation 23.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There were suitable deputising arrangements in place should the person in charge be absent and the Provider was aware of his responsibility to notify the Chief Inspector of the absence. To date the person in charge had not been absent for a period of more than 28 days.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in

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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 found that the designated centre was in general, adequately resourced to ensure the effective delivery of care and support in accordance with the centre's Statement of Purpose. The layout and design of the centre premises consisting of two community houses, one of which required review in relation to access to a bedroom from the utility room/back hall as discussed in outcome 6. The layout of a sitting room in the designated centre also required review to ensure residents' comfort and safety needs were met as a door from the kitchen to the sitting room which was designated as a fire exit was partially obstructed by furniture as discussed in outcome 7.

Staffing arrangements did not ensure adequate support was available to the one staff on night duty to ensure the needs of residents could be met in the event of residents with health conditions requiring emergency care as discussed in outcome 11 and 17. Fire evacuation drills did not clearly demonstrate that one staff member could safely evacuate residents to a place of safety. Although all residents were mobile on the days of inspection, there was evidence of issues that may compromise safe evacuation which were not addressed such as elderly residents with reduced mobility and residents who refused to leave on fire drills completed to date.

Inspectors also found that improvements were required to ensure timely access to dietetic and speech and language services for residents with complex needs.

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

**Findings:**
Inspectors reviewed a sample of staffing rosters and confirmed that the staffing levels on the day of inspection were reflective of the rosters. Staff spoken to on the day of inspection stated that they felt that the number of staff on duty was sufficient to meet the needs of the residents. However, a review of staffing levels and skill mix as found at night was required to ensure the needs of residents could be met with regards to safe evacuation of residents in the event of a fire and care of residents in the event of a medical emergency. The inspectors found there was adequate staff available to meet the needs of residents on both days of the inspection.

The staffing levels for one of the community houses were:

- **Staff Nurse:** 8.00 - 20.00 x 7 days per week
- **Care Assistant:** 8.00 - 20.00 x 7 days per week
- **Staff Nurse:** 20.00 - 8.00 x 7 nights per week
- **Care Assistant:** 20.00 - 8.00 x 7 nights per week

This staffing arrangement ensured residents could attend social activities in the evening. The person in charge told inspectors the staffing levels and skill mix were subject to on-going review and monitoring to ensure the needs of residents were met.

The staffing levels for the second community house were:

- **Staff Nurse:** 8.00 - 20.00 x 7 days per week
- **Care Assistant:** Mon - 12:30 - 21:30,
  - Tues 14.30 - 21.30,
  - Fri - 08:00 - 20:00,
  - Wed, Thurs, Sat and Sun 9:30-09:30
- **Care Assistant:** 20.00 - 08.00 x 7 nights per week (lone worker). There was a lone worker policy in place.

These staffing levels did not ensure the needs of residents were met at night to ensure all residents could be safely evacuated. The fire drills referenced an incident where one resident refused to leave the centre and another resident required recent hospital admission in response to an emergency arising from an ongoing healthcare condition. The person in charge advised inspectors that an additional healthcare assistant was available to provide support at night to three community houses. However, at the time of these inspections this support was not available as this additional resource was required to meet increased resident needs in another community house. This finding requires review to ensure the staffing levels and skill mix of staff in the designated centre adequately meet the assessed needs of residents at night.

Inspectors reviewed a sample of training records for staff. Of the records reviewed, staff had completed mandatory training requirements in addition to training in areas reflecting the needs of residents.

Inspectors were verbally informed that a new system was being implemented in the designated centre for the formal supervision of staff based on re-structuring within the
larger organisation. However, there was adequate evidence to support supervision and competency assessment of staff by the person in charge.

A sample of four staff employment files were reviewed on this inspection. They were found to contain the information as required by Schedule 2 of the regulations in each case. All registered nursing staff were recorded on the active register of nurses in Ireland. There were no volunteers working in the centre.

**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:**
As stated in outcome 17, inspectors reviewed a sample of staff files and confirmed that they contained all of the relevant information as required by Schedule 2.

The designated centre maintained a directory of residents which contained the pertinent information as required by Schedule 3 of the regulations and recorded temporary absences by residents as appropriate.

The records as required by Schedule 4 were maintained in the designated centre, inclusive of all accidents and incidents in the designated centre and a record of all charges to the resident.

Inspectors reviewed the policies and procedures as required by Schedule 5, and identified a number of policy documents that did not inform practice due to the absence of adequate information as discussed throughout this report.

The communication policy did not adequately inform the needs of residents in the centre.

The nutrition policy available to advise staff dated 13 November 2013 was not adequate as it did not advise on some specialised diets for residents in the centre and did not
adequately advise of all aspects of nutritional assessment.
There was no smoking policy available in the centre on the days of inspection.
A policy document advising on residents' access to education and training was not available.

As part of the application to register the designated centre under the Health Act 2007, the provider evidenced to the Chief Inspector that there was adequate insurance in place against accidents or injury to residents.

Residents personal documentation was protected and securely stored in the designed centre. Records were easily accessible. A policy document was available to inform record keeping and management.

**Judgment:**
Non Compliant - Moderate

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**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:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002456</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>22 June 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>24 September 2015</td>
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**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:

Some residents were not provided with a means of safely locking their bedroom door.

Residents could not lock bathrooms/toilet doors while using same.

1. **Action Required:**
   Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
Thumbturn locks will be provided on all bathroom and bedroom doors to ensure that all resident’s privacy and dignity is respected in relation to, but not limited to, his or her personal and living space.

<table>
<thead>
<tr>
<th>Proposed Timescale: 02/10/2015</th>
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<tbody>
<tr>
<td>Theme: Individualised Supports and Care</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements were not in place to ensure advocates who would support residents were known to them.

2. **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:**
Individual referrals made for each resident to the advocacy service on 16/09/2015.

Proposed Timescale: 16/09/2015 and ongoing

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<th>Proposed Timescale: 16/09/2015</th>
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**Outcome 02: Communication**

| Theme: Individualised Supports and Care |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personalised documentation was not developed referencing each resident’s communication gestures and sounds to assist their communication with those less familiar with them.

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

**Please state the actions you have taken or are planning to take:**
Each resident’s personalised documentation has been developed to include each resident’s communication gestures and words to assist their communication with those less familiar with them.
Proposed Timescale: 24/08/2015

**Outcome 03: Family and personal relationships and links with the community**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was an absence of exploration of appropriate alternative contacts outside of the designated centre for residents, in the absence of family.

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

**Please state the actions you have taken or are planning to take:**
Referrals made to advocacy services to explore alternative supports outside of the designated centre for residents, in the absence of family.

Proposed Timescale: 16/09/2015

**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 tailored activation plan in place to meet the specific needs of residents who had retired from attendance at structured day programmes.

**5. 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:**
A tailored activation plan has been put in place to meet the specific needs of residents who have retired.

Proposed Timescale: 25/08/2015

**Theme:** Effective Services

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

6. 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:
Prior to any further care planning meetings an invitation will be extended to each discipline and this will be ongoing.

Proposed Timescale: 09/10/2015 and Ongoing

Proposed Timescale: 09/10/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents personal plans were not in accessible format on the days of inspection

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

Please state the actions you have taken or are planning to take:
The development of personal plans for each resident in accessible format has commenced.

Proposed Timescale: 30/10/2015

Outcome 06: Safe and suitable premises
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A toilet area used by a resident with mobility needs did not have grab rails fitted. There was an absence of handrail supports to assist residents with mobility support needs.

Assessment of need for handrails on corridors to support residents with mobility support needs was not available

8. Action Required:
Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities
and independence of residents.

**Please state the actions you have taken or are planning to take:**
Toilet areas and corridors have been assessed in terms of grab rails. Where assessment dictated the need for grabrails these will be fitted. Work commenced 16/09/2015.

**Proposed Timescale:** 25/09/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed that a resident's bedroom in one community house was accessed from the utility area which contained laundry equipment.

9. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
Infection Control Risk Assessment completed and recommendations received. Utility area to undergo construction to close off the utility room and entrance to this bedroom will be into a newly developed hallway.

**Proposed Timescale:** 30/10/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some furniture and fittings were found to be in need of repair.

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

**Please state the actions you have taken or are planning to take:**
Furniture and fittings that were in need of repair have now been replaced.

**Proposed Timescale:** 16/09/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The layout of furniture in one sitting room did not ensure residents comfort or to ensure residents could safely access the sitting room through a door from the kitchen.

The external area of one community house needed review in terms of provision of sufficient seating for residents.

There were inadequate storage facilities in the designated centre

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

**Please state the actions you have taken or are planning to take:**
The layout of furniture was changed to ensure residents comfort and to ensure residents could safely access the sitting room through a door from the kitchen 22/06/2015.
Additional seating for the external area of one community house was provided on 23/06/2015.
Storage facilities have now been provided in the designated centre.

**Proposed Timescale:** 21/09/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed a persistent malodour in one resident's en-suite which staff had made ongoing efforts to disperse

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

**Please state the actions you have taken or are planning to take:**
Ensuite revamped and new ventilation system in place. Work commenced on 14/09/2015. To be completed by 25/09/2015

**Proposed Timescale:** 25/09/2015

**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:
Not all potential risks were identified and assessed with concomitant controls stated to mitigate level of risks found.
13. **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:**
Any potential risks have been identified and assessed with current controls in place to mitigate level of risks found.

Proposed Timescale: July 2015 and ongoing

**Proposed Timescale:** 31/07/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The recommendations of the National Standards for the prevention and control of infection were not implemented in some areas of practice in the centre.

14. **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:**
Storage facilities have now been provided in the designated centre. Ensuite revamped and new ventilation system in place. Work commenced on 14/09/2015. To be completed by 25/09/2015

**Proposed Timescale:** 25/09/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A perspex panel was located in an area over a door from a kitchen to a utility room containing a washing machine/dryer and resident's bedroom which had not been addressed in the fire documentation.

15. **Action Required:**
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.
Please state the actions you have taken or are planning to take:
A Perspex panel has now been replaced with a fire proof glass panel in an area over a door from a kitchen to a utility room and this has been highlighted in the risk register for the designated centre.

**Proposed Timescale:** 17/08/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A door designated as a fire exit between the kitchen and sitting room was semi obstructed by the positioning of a chair in the sitting room of one community house.

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

Please state the actions you have taken or are planning to take:
The layout of furniture was changed in a sitting room of one community house 22/06/2015 and a fire evacuation was conducted using a wheelchair to ensure that residents could safely access the sitting room through a door designated as a fire exit 30/07/2015.

**Proposed Timescale:** 30/07/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements were not assured to safely evacuate residents at night when one member of staff was on duty.

17. **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:
In house fire drills are completed on an ongoing basis by staff as part of our overall fire safety training programme. The purpose of completing these fire drills is to allow the residents to become familiar with the sounds of the fire alarm system and to practice the evacuation for the unit. However, given the nature of residents who reside in our unit, we sometimes are confronted with challenging behaviour during this exercise. Evidence from previous fire drills shows that one resident may refuse to evacuate. A simulated fire evacuation representative of night-time conditions ie one staff on duty carried out on 23/09/15 (ensured that residents could be evacuated safely). These will continue to take place on a regular basis.
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:
A resident with complex nutritional needs did not have adequate access to review by a dietician.

18. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
Resident reviewed by dietician on 19/09/2015.

Proposed Timescale: 19/09/2015

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 centre's pharmacist did not complete their obligations including quarterly audits of medications in the community houses.

19. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
The centre’s pharmacist will conduct regular audits of medications in the designated centre and this will be on an ongoing basis.

Proposed Timescale: 22/09/2015 and ongoing.

Proposed Timescale: 22/09/2015
### 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:**
The system to monitor the quality and safety of care and quality of life for residents was not adequate. Some actions were taken to address deficits identified but it was not clear if all deficits were addressed as action plans were not developed clearly identifying the action to be taken and to enable tracking to satisfactory completion.

#### 20. 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 system has been put in place to monitor the quality and safety of care and quality of services. This has been developed to identify any deficits and the action to be taken and this is ongoing.

Proposed Timescale: 30/09/2015 and Ongoing.

### Outcome 16: Use of Resources

**Theme:** Use of Resources

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all aspects of the service were appropriately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

**Please state the actions you have taken or are planning to take:**
The skill mix of staff in the designated centre at night have been reviewed to ensure the evacuation and healthcare needs of residents are met.

Proposed Timescale: 24/09/2015
**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The numbers and skill mix of staff in the designated centre at night required review to ensure the evacuation and healthcare needs of residents were met.

22. **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 skill mix of staff in the designated centre at night have been reviewed to ensure the evacuation and healthcare needs of residents are met.

In house fire drills are completed on an ongoing basis by staff as part of our overall fire safety training programme. The purpose of completing these fire drills is to allow the residents to become familiar with the sounds of the fire alarm system and to practice the evacuation for the unit. However, given the nature of residents who reside in our unit, we sometimes are confronted with challenging behaviour during this exercise. Evidence from previous fire drills shows that one resident may refuse to evacuate. A simulated fire evacuation representative of night-time conditions ie one staff on duty carried out on 23/09/15 (ensured that residents could be evacuated safely). These will continue to take place on a regular basis.

**Proposed Timescale:** 24/09/2015

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**Outcome 18: Records and documentation**

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of policy documents did not inform practice due to the absence of adequate information.

A policy document advising on residents' access to education and training was not available.
A policy on smoking in the centre was not available

23. **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:
All policies identified, Nutrition, Communication, Education and Training, Admissions and Discharge inclusive of temporary absence are currently being reviewed. A smoking policy is currently being developed for the centre.

**Proposed Timescale:** 30/10/2015