<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Health Service Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002463</td>
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<tr>
<td>Centre county:</td>
<td>Cork</td>
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<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Angela O'Neill</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Breeda Desmond; Maria Scally; Vincent Kearns</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>30</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 01 April 2015 07:15  
To: 01 April 2015 18:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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</thead>
<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 11. Healthcare Needs</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<tr>
<td>Outcome 13: Statement of Purpose</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
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</tbody>
</table>

Summary of findings from this inspection
On 6th November 2015, HIQA took the unprecedented step of applying to the district court under Section 59 of the Health Act 2007 for specific restrictive conditions to be placed on the registration of three centres for people with disabilities. The centres were St Raphael's Residential Centre, Oakvale and Youghal Community Hostels, all located on the grounds of St Raphael's Campus in Youghal. The provider consented to the application and the court applied the conditions.

This report relates to Oakvale and is one of the nine inspections of these centres during 2015 which identified serious concerns in relation to safety of residents and poor quality of life for residents. As a result of poor governance and oversight of the centres, management had failed to identify these issues for themselves, failed to address them effectively and failed to ensure a safe and good quality service for residents.

The centre is a single storey premises that was purpose built and located on a campus with other disability centres. The centre was bright and spacious with large windows offering a scenic view of the town and sea. The centre was decorated to a good standard and there was comfortable furnished with comfortable seating.
Overall, inspectors were not satisfied that there were adequate governance arrangements in place as evidenced by inadequate staffing with an over-reliance on overtime, significant deficiencies in staff training including adult protection and positive behavioural management; and the absence of a systematic review of the quality and safety of care in the centre. In addition the person in charge stated that she did not have the capacity to fulfil her role as person in charge of four centres.

Other areas for improvements were required, including:

- fire safety precautions
- there was no risk management policy or emergency plan available in the centre on the day of inspection
- there was an inadequate process for managing risk
- the statement of purpose did not comprehensively detail information requested in Schedule 1 of the Regulations
- medication management
- there was inadequate evidence to demonstrate that actions were taken following consultation with residents/relatives
- personal plans required improvement
- staff personnel records were incomplete.

The action plan at the end of the report includes the immediate action plan issued to the provider and identifies additional improvements required to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors visited the centre at 07:15hrs and observed that most residents were in bed. Residents were supported to get out of bed at a time of their choosing and breakfast continued late into the morning as residents awoke at various times.

Residents’ meetings had recently commenced and minutes of these meetings were available. The person in charge stated that issues raised at these meetings were addressed, however, there was no associated action plan identifying what issues were addressed, when or by whom.

An advocacy service had recently commenced meeting with residents, however, records of these meetings were not maintained and it was not possible to ascertain the level of engagement the residents from this centre had with the process and there were no records available identifying if issues raised were addressed. Contact details of an advocacy service were on display in the centre.

There was a complaints policy that identified the person responsible for managing complaints, however, the policy did not comply with all the requirements of the Regulations. For example, an independent person had not been nominated to oversee that all complaints were appropriately responded to and that adequate records were maintained. The complaints procedure was displayed, however, it was not in a format that was accessible to all residents. The centre had only recently commenced recording complaints and only a small number of complaints were recorded. Based on the sample of complaints reviewed there was inadequate evidence of action in response to all complaints and it was not recorded if the complainant was satisfied with the outcome of
the complaints process, as required by the regulations.

Inspectors observed staff interacting with residents in a respectful manner. While most resident sleeping accommodation was in single rooms, there were a number of twin-bedded rooms, however, there was no screening between the beds to support privacy and dignity.

There was a policy on residents’ personal property and possessions and there was adequate storage space for residents personal property and possessions. There was, however, no suitable storage in residents' bedrooms in which they could securely store valuables and personal belongings to support residents retain control of their money and valuables.

Residents’ religious preferences were respected and facilitated. For example, mass was celebrated weekly and residents were supported to attend.

There were limited opportunities for residents to engage in meaningful activities. Inspectors were informed by staff that there were insufficient staff numbers to support residents to participate in activities or accompany residents on trips out of the centre. Inspectors noted that there were extended periods of time when residents with significant and complex needs did not have opportunities to participate in stimulating activities. A number of residents attended day activation units within the grounds of the centre. For residents that did not attend the activation units, records indicated one-to-one activities were provided. However, based on records of residents interests and hobbies identified on assessment, there was inadequate evidence that activities/occupation programmes available suited residents' needs, interests and capacities.

Inspectors saw and staff confirmed that closed circuit television (CCTV) was in use in the centre and there were notices on display identifying that CCTV was in use. However, there were CCTV cameras in communal areas such as sitting rooms where residents would have a reasonable expectation of privacy.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services
**Outstanding requirement(s) from previous inspection(s):**
This was the centre’s first inspection by the Authority.

**Findings:**
Based on a sample of records viewed, residents had personal support plans that included an assessment of issues such as residents' likes/dislikes, preferences, education/learning and a communication profile. There was evidence of consultation with residents and their relatives in the development of the plans through lifestyle meetings. There was evidence that residents had multidisciplinary assessments such as speech and language therapy and dietetics and their advice was incorporated into plans. There was, however, a variation in the quality of the care plans and some plans predominantly addressed medical issues and did not adequately address social care issues. There were behavioural assessments in a number of residents' plans, however, a number of these were only partially completed.

Even though residents had a comprehensive assessment however, there was not always evidence that issues identified during the assessment were addressed. For example, there was inadequate evidence that activities available to the residents corresponded with the interests of the resident that were identified during assessment. Staff members informed inspectors that there was inadequate numbers of staff to support residents to participate in activities.

Training records indicated that training had been facilitated to support staff in person centred planning, and records indicated that a significant number of staff from the centre had attended this training.

**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):**
This was the centre’s first inspection by the Authority.

**Findings:**
The centre was a single storey premises that was purpose built and was located on a campus with other disability centres. The centre comprised five units in one building.
with accommodation for six residents in each unit. Sleeping accommodation in three of the units comprised six single bedrooms and in two of the units comprised four single bedrooms and one twin-bedded room. The units were linked by a long wide corridor.

The centre was bright and spacious with large windows offering a scenic view of the town and sea. It was in a good state of repair and records were available demonstrating a programme of preventive maintenance for equipment such as speciality chairs, beds and hoists. The centre was decorated to a good standard and there was comfortable furnished with comfortable seating.

Some improvements, however, were required. For example, there was no screening between the beds in the twin-bedded rooms to support residents maintain privacy. Additionally residents in the twin bedrooms shared a wash-hand basin. There was insufficient storage for equipment and hoists were seen to be stored in residents’ bedrooms and the medicines trolley was stored in the quiet room. There was only one sluice room and this was located in one of the units, which meant that staff would have to transport items for sluicing from one unit to another.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There was an up-to-date safety statement. However, there was no risk management policy and no emergency plan in the centre on the day of the inspection. There was a risk register that identified risks and the measures in place to control the risks identified such as the risk of fire; the risk of accidental injury from slips, trips and falls; and the risk of absconding. However, improvements were required. For example, the risk register identified a control measure for violence and aggression was the provision of training to staff on the management of violence and aggression. Only a small number of staff had completed this training. Additionally, the controls for the risk associated with smoking did not identify that a suitable smoking area was required for residents in one of the units. Inspectors were informed that a portable shed for use a designated smoking area was on order. Other required improvements in relation to hazard identification included:

• daily fire safety checks were not always completed
• there were not adequate personal emergency evacuation plans in place to support staff evacuate residents in the event of an emergency
• there was no evidence that a shed used for smoking by residents was suitable for that purpose or that suitable fire fighting equipment was readily accessible from the shed
• there was an inadequate system in place to learn from accidents and incidents and to feedback to staff.

The procedure to be followed in the event of a fire was on display in the centre. Most, but not all, staff had received up-to-date training on what to do in the event of a fire. Staff spoken with were knowledgeable of what to do in the event of a fire. records were available demonstrating that there was a programme of preventive maintenance for the fire alarm, fire safety equipment and emergency lighting. Some improvements, however, were required. For example, the personal emergency plan did not always identify an appropriate means of evacuating residents with high physical needs. A number of fire doors were held open with door wedges, which was not good fire safety practice, as the use of door wedges in designated fire doors in the event of a fire potentially prevented such doors from functioning as fire doors

Inspectors also noted that the training records indicated that a significant number of staff required training in manual handling practices.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe Services

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

**Findings:**
The centre uses the HSE policy on safeguarding vulnerable persons at risk of abuse. There had been no recent allegations of abuse. However, not all staff had received up-to-date training in recognising and responding to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse.

There were adequate systems in place to manage residents' finances. Inspectors observed staff interacting with residents in a positive and respectful manner.
There was a multi-disciplinary review of residents requiring behavioural support plans which included the psychiatrist, psychologist and care staff. While a number of residents presented with behaviour that challenged, only a small number of staff had received up-to-date training on identifying and alleviating the underlying causes of behaviours that challenge.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 11. Healthcare Needs</th>
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<tbody>
<tr>
<td>Residents are supported on an individual basis to achieve and enjoy the best possible health.</td>
</tr>
</tbody>
</table>

**Theme:**
Health and Development

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

**Findings:**
Residents had access to the services of a general practitioner (GP), including out-of-hours.

Residents had access to multidisciplinary services. For example, an occupational therapist visited at weekends, a psychiatrist was available two days each week, a psychologist was available for one session each week and there was good access to dental services. The services of a dietitian had recently been obtained and was scheduled to visit in the days following this inspection.

Meals were prepared in the main kitchen on campus and were delivered to the unit in heated food trolleys. Food appeared to be nutritious, was available in sufficient quantities and offered choice at mealtimes. Residents had a comprehensive nutritional assessment including monthly weights.

**Judgment:**
Compliant
Outcomes 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
There was a written policy relating to medication management, however, it didn’t explicitly identify who could prescribe in the centre. There was evidence that residents’ prescriptions were regularly reviewed.

Medication administration practices observed by inspectors were in compliance with professional guidance.

Judgment:
Substantially Compliant

Outcomes 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):
This was the centre’s first inspection by the Authority.

Findings:
A written Statement of Purpose was in place. While it outlined some of the items listed in Schedule 1 of the Regulations, it did not adequately address the following:

- criteria used for admission to the designated centre including the designated centre’s policy and procedures (if any) for emergency admissions
- a description of the rooms in the designated centre, including their size
- any separate facilities for day care.
- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing complements as required in Regulation 14 and 15
- the organisational structure of the designated centre
- arrangements made for dealing with reviews of the residents' personal plan
- Details of any specific therapeutic techniques used in the designated centre and arrangements made for their supervision
- the arrangements made for respecting the privacy and dignity of residents
- arrangements for residents to access training and employment

The statement of purpose was also not centre-specific as it referred in a number of places to another designated centre that was on the same campus.

**Judgment:**
Non Compliant - Moderate

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**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a clearly defined management structure in place. A new provider nominee had been appointed in October 2014. The person in charge of this centre was appointed person in charge of this and three other HSE disability centres in October 2014. The person in charge confirmed during interview that due to inadequate resources, insufficient staffing and the complexity of the centres involved, that it was not appropriate for one person to be in charge of the four centres.

The person in charge confirmed that there was no annual review of the quality and safety of care as required by the regulations. An unannounced visit to the designated centre at least every six months, by the provider or a nominated person, to ensure the safety and quality of care and support provided in the centre, as described in the Regulations, was not undertaken. There was minimal evidence of an audit process to evaluate the quality of life and the quality of the service provided to residents. Inspectors were not satisfied that there were adequate systems in place for a review of the quality and safety of care in the designated centre.
**Outcome 17: Workforce**

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

**Theme:**
Responsive Workforce

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

**Findings:**
Inspectors reviewed a sample of staff rosters, observed practices and spoke with a number of staff. There was insufficient whole time equivalent staff to meet the requirements of the roster and the staffing shortfall was filled by staff working overtime. Based on observations of inspectors and interviews with staff, inspectors were not satisfied that there were sufficient staff on duty in each of the units to meet the physical, psychological and social needs of the residents. This was supported by the fact that activities both within the centre and external to the centre were limited due to inadequate staffing.

Staff members spoken with by inspectors were knowledgeable of residents individual needs, preferences and triggers for behaviours that challenged. However, there was inadequate evidence of a coordinated strategy for staff development to ensure staff had the required training to support residents maximise their independence. For example, there was poor attendance at training in relation to the provision of positive support to residents and in the recognition and response to abuse.

This was a HSE centre and operated under the HSE national policy for the recruitment and selection of staff. Inspectors reviewed a sample of personnel records and noted that from a sample of five files reviewed two did not contain evidence of a person’s identity, including a recent photograph and three did not contain a vetting disclosure in accordance with the National Vetting Bureau.

**Judgment:**
Non Compliant - Major
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
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</tr>
<tr>
<td>Date of Inspection:</td>
<td>01 April 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>25 May 2015</td>
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</table>

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Even though residents had a comprehensive assessment there was not always evidence that issues identified during the assessment were addressed.

1. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
A review of all residents’ assessments and care plans is currently being undertaken. Arrangements will be made where appropriate to ensure appropriate interventions are provided. Documentation will be updated to ensure that any interventions are noted.

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not available to residents in an accessible format.

2. **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 residents’ personal plans have been recently updated and are available in accessible format. These will be subject to regular review. The next review will be completed by 30/10/15

**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:**
Some improvements were required in the premises, for example:

- there was no screening between the beds in the twin-bedded rooms
- residents in the twin bedrooms shared a wash-hand basin
- there was insufficient storage for equipment
- the medicines trolley was stored in the quiet room
- there was only one sluice room

3. **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:**
Screening has been ordered and is awaiting installation.

Management are currently assessing each area to identify a more appropriate area to store the drug trolley.

Estates department have been contacted to give an overview of the area with a view to identify more suitable storage areas.

In consultation with the infection control nurse 1 sluice room has been deemed as adequate however we will engage with Estates re access to this room. In the interim The CNM2 will engage with the Infection control officer to develop a comprehensive practice guideline with regards to the use of this room.

**Proposed Timescale:** 30/08/2015

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Improvements were required in relation to risk management, such as:</td>
</tr>
<tr>
<td>• there was no emergency plan available in the centre on the day of inspection</td>
</tr>
<tr>
<td>• the risk register identified a control measure for violence and aggression was the provision of training to staff on the management of violence and aggression, but only a small number of staff had completed this training</td>
</tr>
<tr>
<td>• the controls for the risk associated with smoking did not identify that a suitable smoking area was not available for residents in one of the units</td>
</tr>
<tr>
<td>• there was an inadequate system in place to learn from accidents and incidents and to feedback to staff.</td>
</tr>
<tr>
<td><strong>4. Action Required:</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The emergency plan is stored in the Director of Nursing office, copies of this will be made available to each area.</td>
</tr>
<tr>
<td>Staff training in the area of Aggression and Violence will be rolled out across the service and all staff will receive updated training by 01/12/2015</td>
</tr>
<tr>
<td>The HSE Risk Manager is working with nurse management to review risk assessments and put appropriate systems in place.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 01/12/2015</td>
</tr>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
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</tbody>
</table>
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was only one sluice room in the centre.

5. 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:
Currently the sluice room is utilised for equipment for 3 residents (1 day 2 night). The CNM2 will engage with the Infection control officer to develop a comprehensive practice guideline with regards to the use of this room

**Proposed Timescale:** 30/08/2015  
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were held infrequently.

6. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A review of the fire evacuation plans will be undertaken which will incorporate schedules of fire drills at 6 monthly intervals. Fire records will include details of fire drills, alarm testing and servicing of fire safety equipment.

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that a shed used for smoking by residents was suitable for that purpose or that suitable fire fighting equipment was readily accessible from the shed

7. 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:
Sheds that comply with fire regulations have been ordered.
The HSE Estates dept have prepared the bases and the centre is awaiting delivery.
Fire extinguishers/fire blankets have been ordered and will be in place on installation of
the shed.

**Proposed Timescale:** 19/06/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of fire doors were held open by door wedges.

**8. Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
Staff have been informed to cease this practice and talks are ongoing with the HSE Estates department to install magnetic brackets on the doors in question.

**Proposed Timescale:** 31/07/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date training in fire safety.

**9. 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:
Training in fire evacuation has taken place with a further date scheduled for the 25/05/2015

Fire prevention training will take place over the next number of weeks.

**Proposed Timescale:** 31/07/2015

**Theme:** Effective Services
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Daily fire safety checks were not always completed.

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

**Please state the actions you have taken or are planning to take:**
The CNM2 now ensures that these checks are completed daily.

**Proposed Timescale:** 30/04/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were not adequate personal emergency evacuation plans in place to support staff evacuate residents in the event of an emergency, such as a fire.

11. **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:**
Personal emergency plans will be updated to reflect the residents’ requirements. Supports available to staff in the event of a fire evacuation will also be identified and documented. This work is being done in consultation with the Fire & Safety Officer.

**Proposed Timescale:** 31/07/2015

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up-to-date training in recognising and responding to abuse.

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

**Please state the actions you have taken or are planning to take:**
Training in safeguarding and protection is ongoing and a number of staff from this area have attended training.
All staff will have completed this training by September 2015

**Proposed Timescale:** 30/09/2015

### 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 medication trolley was stored in the quiet room.

**13. Action Required:**
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

**Please state the actions you have taken or are planning to take:**
Management are currently assessing each area to identify a more appropriate area to store the drug trolley.

**Proposed Timescale:** 30/06/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Prescriptions did not contain the residents' photographs and a drug intended to be given "stat" was prescribed in the "PRN" section.

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

**Please state the actions you have taken or are planning to take:**
The prescription in question was written by an attending GP and was rectified by the centre’s Medical Officer the following day. A review will be undertaken by the CNM2/CNM1 to ensure that the medication policy will be adhered to. Photographs are in place on all residents prescription charts

**Proposed Timescale:** 02/04/2015
### 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 person in charge confirmed during interview that due to inadequate resources, insufficient staffing and the complexity of the centres involved, that it was not appropriate for one person to be in charge of the four centres.

15. **Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
A CNM3 will assume the role of Person In Charge for this area: documentation to reflect same to follow

**Proposed Timescale:** 01/04/2015

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#### Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care in the designated centre and that such care and support is in accordance with standards.

16. **Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
A system of regular audit is currently being explored in consultation with other service providers and the HSE Quality Improvement Team.
The HSE Quality Manager is providing training for nurse management in audit systems.
The training being provided by the Quality manger and Risk manager will facilitate the development of an appropriate review system.

**Proposed Timescale:** 30/09/2015

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#### Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no unannounced visit to the designated centre at least once every six months to monitors the safety and quality of care and support provided in the centre.

17. **Action Required:**
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**
An unannounced visit will be facilitated within the coming months.

**Proposed Timescale:** 30/09/2015

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were insufficient numbers of staff to meet the needs of residents.

18. **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 following recruitment plan for this and three other designated centres in the area has been approved by HSE management.
1. Recruitment of 12 Registered Nurses in ID through
   • national and local competitions
   • engagement of recruitment agency on ‘finder fee basis’
   Target date for completion: 31.07.15

2. Increasing Care Assistant Complement
   • recruit 13 additional support staff (housekeeping role)
   • re-assign 13 staff with FETAC qualifications from housekeeping to Care Assistant
   Target date for completion: 30.6.15

3. Social Care Workers
   • recruit 12 additional Social Care Workers and assign to replace nurses in community houses
   • reassign nurses from community houses to St Raphael’s Centre

The above recruitment will strengthen the existing staff compliment and reduce reliance
on overtime. With this recruitment the additional allocation of 2 staff (either care assistants, social care workers) working on day duty between all bungalows and an additional staff on night duty will result in an overall improvement in staffing numbers to meet the residents’ needs.

**Proposed Timescale:** 31/07/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all information outlined in Schedule 2 of the regulations was available for all members of staff.

19. **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:**
The majority of staff files are compliant with schedule 2. Those who are not are currently being reviewed and will be compliant by 30/6/15.

**Proposed Timescale:** 30/06/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was an inadequate system in place to support professional development to ensure staff had training in relevant areas such as adult protection, behavioural support and communication.

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

**Please state the actions you have taken or are planning to take:**
A comprehensive staff training policy is currently being developed and will encompass a broad range of training. Training in the area of safeguarding and challenging behaviour has been prioritised as with training in the area of communications

A CNS in Positive Behaviour support planning has been appointed since Nov 2014 and is currently assessing residents’ needs with regards to challenging behaviour and will work in conjunction with an external organisation.

Plans are in place to deliver training in relation to behaviours that challenge via an external training consultant. This training includes a focus on the causes of challenging behaviour, and positive behavioural supports. The training will be a two day
programme.
The following training dates are as scheduled.
11 and 12th June
9th and 10th July
13th and 14th August
10th and 11th September
8th and 9th October
22nd and 23rd October
12th and 13th November
26th and 27th November

A trainer from this course will work in SRC for 10 days, commencing May 6th, and continuing on the following dates:
18/05/15
3/6/2015
8/6/2015
19/6/2015
25/6/2015
3/7/2015
6/7/2015
17/7/2015
24/7/2015

He will assist staff in translating the principles of person-centred practice and positive behavioural supports from training into day-to-day work.

The impact of this training and ongoing support work will be that person centred plans for individuals will be implemented more effectively. Staff will be better placed to identify the causes of challenging behaviour and diffuse incidents, leading to better quality of life for residents with behaviours that challenge and reduced incidents of peer abuse.

In association with an external organisation additional training in physical interventions will be sourced.

Consultation has taken place with an agency who can facilitate training in physical interventions and dates will be agreed

Manual handling training/fire training and hand hygiene training are currently ongoing.

The impact of the training and progress on person centred planning will be monitored through the Quality Improvement Team.

**Proposed Timescale:** 01/12/2015