<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003439</td>
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<td>Centre county:</td>
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<td>Health Act 2004 Section 39 Assistance</td>
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<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Mark Blake-Knox</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary O'Mahony</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Maria Scally;</td>
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<td>Type of inspection:</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>23</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>3</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 3 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
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<tr>
<td>01 July 2015 10:00</td>
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<td>02 July 2015 10:50</td>
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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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<tr>
<td>Outcome 02: Communication</td>
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<td>Outcome 03: Family and personal relationships and links with the community</td>
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<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: General Welfare and Development</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

The Health Information and Quality Authority's (HIQA or the Authority) registration inspection of this centre, was announced. As part of the inspection inspectors met with residents, the persons in charge, the provider, the regional manager, relatives and other staff members. Inspectors spoke with the persons in charge and discussed the management and governance arrangements for supporting staff and residents. Inspectors reviewed the policies and procedures in the centre and reviewed documentation for aspects of care such as, medication management, complaints, safeguarding and safety, personal plans, staff files, fire safety management records.
and the training matrix.

The centre was located in a quiet country setting. The centre was comprised of a large house which could accommodate 13 residents, nine self-contained apartments and one house where four residents, who had transitioned from the main house, now resided. There were adequate parking spaces in the front and back of the building. One resident has a specialised car. This was driven by suitably trained members of staff or personal assistants when available. Inspectors observed that there were minibuses parked in the car park, which were available for use by all residents. Residents were also seen to be collected and brought back to the centre by other relevant, supporting services, during the day.

There were three persons in charge in the centre. One person in charge was responsible for the main house and the nine apartments. The other two persons in charge managed the four-bedroomed house, on a job sharing system. Inspectors spoke with these personnel throughout the inspection. They informed inspectors that they endeavoured to promote a person-centred ethos in the centre. The person in charge of the main house and the apartment was referenced as the person in charge, in the report, except where this was otherwise indicated.

During the three days of inspection there were 20 full time residents in the centre and two respite residents. There was one vacant bed and the centre had the capacity to support three other respite residents, if required. While the inspection was in progress the residents were seen to attend various day care and work arrangements. One resident was a student in the local university and was supported by staff in the centre while on the campus.

The action plan at the end of the report identifies areas where improvements were needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. Some areas which were not in compliance with the aforementioned Regulations were: medication management, policies and procedures, notifications, training, complaints, healthcare needs, health and safety, statement of purpose and contracts for residents, among others.

Two immediate action plans were issued to the provider following the inspection. One immediate action plan concerned the number, qualifications and skill mix of staff, in light of the dependency levels and very high medical needs of some residents. The second action plan concerned lack of provision of sufficient mandatory and other appropriate staff training. These failings will be expanded on further under the relevant outcomes in this report. Satisfactory responses were not submitted in response to these immediate action plans within the designated time frame set by the Authority. The provider was asked to provide a further more robust and acceptable response. Subsequent responses were received which indicated that appropriate actions would be carried out by certain dates. However, this matter continued to be unresolved as the Authority had not received confirmation of the completion and implementation of all these actions by the dates specified.
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:
There was a regular consultation process in place in the centre. Inspectors noted that the rights of residents were supported by staff. Minutes of a recent residents' meeting dated 22 June 2015 were viewed by inspectors. The person in charge explained how residents accessed advocacy services. Staff, spoken with by inspectors, was knowledgeable about the importance of advocacy for residents. The named advocate's contact details were displayed on a notice board in the hallway along with the complaints procedure. The person in charge informed inspectors that regular meetings with individual residents took place also and any concerns or complaints were recorded and investigated. Records to support this were viewed by inspectors. Residents with whom inspectors spoke confirmed that meetings took place. The upcoming HIQA inspection had been discussed with residents and they had filled in a number of questionnaires sent out by the Authority prior to inspection.

A folder containing accessible documents was visibly displayed in the halls of each area. This included information on how to make a complaint, residents' rights, and access to advocacy, the Resident's Guide and the statement of purpose. There was pictorial input in the documents also. A number of relatives, with whom inspectors spoke, said that residents and their representatives were involved in formulating personal care plans (PCPs) where relevant. Residents could make choices about their daily lives with support from staff. Staff with whom inspectors spoke were aware of residents' routine and abilities. The staff roster was available for viewing by inspectors and this indicated that more than 40 staff worked to support residents in the centre. The person in charge indicated that there was a new system under consideration where each of the three
areas would have a core team of staff. She stated that this would aid familiarity and more in depth relationships between staff and residents. The provider had developed policies to guide staff on the care of residents’ property and money management, as required by Regulations. The person in charge informed inspectors that personal belongings were listed and signed by the resident. Consent forms were signed for medication administration, photographs where required and financial transactions. This documentation was reviewed by inspectors.

However, activities within the centre were not readily available as the activities room was no longer available for use by residents. Residents in the main house spent long periods of time in their rooms. Facilities for occupation and recreation were inadequate for this group and staff stated that activities were sometimes dictated by the routine and resources of the centre and not by the wishes of residents or their suitability. For example, inspectors noted a complaint from a resident who could not go to the Opera House due to the unavailability of staff. In addition, there were complaints viewed about lack of activities and a resident had expressed a wish that the activity room was reopened. She stated that she missed the opportunity to do group activities.

The privacy and dignity of residents in one hall of the main house was impacted on negatively by the fact that the toilets in the corridor beyond some residents' bedrooms were used by an external care group. Inspectors observed that staff and residents had to walk or be wheeled through this bedroom area, to access these toilets.

There was access for residents to local amenities. Residents were facilitated to take part in arrange of activities. Day trips and overnight outings as well as family holidays, which were in line with their individual assessed needs, were arranged. Family members informed inspectors that they had been consulted, where appropriate, in this planning and that the person in charge was responsive to their input. Residents had access to personal transport and minibuses. However, staff shortages impeded on residents attending various events in which they had expressed an interest. In addition, this lack of staff availability impacted on achieving some of their goals. Residents, relatives and staff spoke about this with inspectors and the issue was addressed under Outcome 17: Workforce. Residents were supported to attend religious ceremonies of their choice and there was documentation available which indicated that residents were facilitated to vote. The centre received support from a variety of relevant organisations, local colleges and workplaces and some residents were seen to avail of these on a daily basis.

There was a complaints policy in operation in the centre. The policy was reviewed in February 2015. An easy-to-read version of the complaints procedure for residents and their representatives was prominently located in the entrance hall. The centre had a dedicated complaints officer and an independent nominated person and appeals process. Staff and residents with whom inspectors spoke were aware of the names of these personnel and how to initiate a complaint. Inspectors spoke with relatives also who were familiar with this procedure and they informed inspectors that the person in charge was accessible to them. The regional manager informed inspectors that there was both a regional and national response to complaints and said that the complaints were audited. A copy of the most recent audit was viewed by inspectors. Learning from complaints was recorded in most cases and discussed at staff meetings. Inspectors observed that there were complaint forms freely available in the corridors and at the
entrance to the buildings. Inspectors noted a pattern of complaints about staff interactions with residents and it was noted that a number of these had been forwarded to the Authority. Inspectors discussed on-going management of these issues with the person in charge and the provider. However, the outcome of all complaints viewed had not been documented and the satisfaction or not of the complainant had not been recorded. Inspectors noted that some complaints recorded, contained details of alleged abusive interactions which had not been notified to the Authority, in line with Regulations. In addition, had not been suitably investigated and managed. Robust safeguarding practices had not been implemented in all cases. This will be addressed under Outcome 7: Safeguarding and safety and Outcome 10: Notifications. Furthermore, it was not clear to inspectors if residents had been made aware of the appeals process, if they were not satisfied with the outcome of a complaint.

The centre had nine apartments and each had a bedroom, kitchen/dining and en suite facility. These were wheelchair accessible. There were large wardrobes, shelving and locked storage facilities available for each resident. Residents informed inspectors that they had been consulted about décor and relevant adaptations prior to completion of the building. Residents in the four bedroomed house had been assessed prior to transition to the new living arrangement and they had been consulted about living arrangements, TV usage and external outings, among other pertinent issues. Minutes of meetings confirmed that these discussions had taken place. Some residents in the main house had been assessed as suitable for other facilities and living arrangements. For example, one resident had been asked if he would move to a different corridor, when two more residents move out as planned, in the near future.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors noted that residents had access to appropriate media, such as television, radio, and assistive technology. Residents had 'tablets' also with internet availability.

There was a communication policy in the centre which had been reviewed in June 2015 and was found to be comprehensive. During the inspection, staff who spoke with inspectors demonstrated awareness of the individual communication needs of residents. Staff outlined the systems that were in place to meet the diverse communication needs of residents. In addition, inspectors noted that individual communication passports were
present in residents' personal plans which indicated what behaviours the residents might display to express their feelings. Pictures were also used for some residents to aid communication for activities and tasks.

Staff, however, did not have training in communication strategies relevant to their role and the assessed needs of residents. For example, inspectors viewed the report of an incident investigation which indicated that there was no evidence based tool in use in the centre at the time of the incident, to enable staff to evaluate the pain levels of a non verbal resident. This person was subsequently found to have had an undiagnosed fracture. In addition, where residents could not communicate verbally, appropriate training had not been afforded to staff, relative to their role.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Inspectors noted that positive relationships between residents and their representatives were enabled and encouraged in the centre. Contacts and social links were supported by a variety of means. There was an open door visiting policy in the centre and family, relatives and friends were welcomed to visit. Staff informed inspectors that they had access to phone numbers of residents' representatives and other relevant people. Relatives confirmed with inspectors that they received regular updates from staff regarding their relative's wellbeing.

This contact was supported as appropriate to each resident for example through residents' home visits, phone contact and visits to the centre. Family or residents' representatives were encouraged to attend birthdays and other special occasions such as Christmas parties. Residents were facilitated to meet family and friends in private and there was adequate space to facilitate such visits. Residents had individual bedrooms if they wished to meet their visitors in private.

Care plans read by inspectors provided evidence of family input. In addition multi disciplinary support team meetings documented the involvement and inclusion of family members in decisions regarding healthcare needs. Inspectors saw that residents were encouraged to participate in social activities provided within the local community. However, residents, relatives and staff all informed inspectors that due to low staffing levels it was sometimes difficult to participate in and organise outings. They stated that
residents did not get to go on outings in the community as often as they wished. This is discussed further under Outcome 17: Workforce.

**Judgment:**
Compliant

### Outcome 04: Admissions and Contract for the Provision of Services

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

**Theme:**
Effective Services

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

**Findings:**
There was an admissions policy in the centre dated June 2015. This admission policy included the procedures for transfers, discharges and the temporary absence of residents. However, this policy required updating to take account of the need to protect residents from abuse from their peers, as required by Regulation.

Inspectors noted that residents did not have a written agreement of the terms on which they resided in the centre provided to them, as required by Regulation. In addition, the fees for services were not set out for residents. Furthermore, the statement of purpose did not include all the required elements as set out in Schedule 1 of the Regulations. The person in charge informed inspectors that this was currently under review. An updated version was received by the Authority, following inspection.

**Judgment:**
Non Compliant - Major

### Outcome 05: Social Care Needs

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

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

Findings:
Residents were facilitated to maintain maximum independence and to participate in meaningful events. Inspectors observed a group of residents enjoying a barbeque and celebrating the birthday of one resident during the inspection. The chef and other staff members were on hand to prepare the food and support those who had specialised dietary needs. Inspectors were informed by residents and staff that there were a number of options available to them in relation to activities and work. Life skills training was being facilitated for some residents and Inspectors noted that residents were fully involved in their own daily routine which included cooking, laundry and shopping where possible. One resident showed inspectors his folded and washed laundry which he had undertaken independently, following a period of support from staff. Inspectors spoke with residents throughout the inspection and they outlined their overall positive experience of living in the centre.

Residents spoke with inspectors about a number of off-site activities they enjoyed as outlined under Outcome 1: Residents' rights, dignity and consultation. Other residents spoke with inspectors about how they enjoyed relaxing at the end of the day; sometimes cooking their evening meal or watching television and listening to music. As a result of being informed about HIQA and the registration inspection, residents expressed a very positive outlook about this process and they were waiting to talk with inspectors.

There was a good supply of board games, CDs, books and DVDs on offer in the communal sitting room and in the residents' own apartments, house and bedrooms. Bedrooms were seen to be personalised with furniture, pictures and photographs. Residents showed inspectors their personal selection of books and trophies, as well as their music centres and televisions. The bedrooms were furnished with good quality furniture and residents could receive unrestricted visits. This was confirmed with inspectors by a number of visitors.

The person in charge showed inspectors a number of the PCPs in place for residents and it was evident that residents had been consulted in relation to the content of this documentation. Residents were able to access their personal plans at any time. Inspectors viewed evidence that residents had access to allied health services such as the dietician, physiotherapist, occupational therapist, dentist and the general practitioner. They were supported in their physical care by the care coordinators and care support staff. Each resident had a 'portable medical profile plan' prepared in their file. PCPs were seen to be implemented. Inspectors were informed by residents that staff were aware of and supported their personal goals where possible. There was evidence that the PCPs were reviewed regularly. The person in charge explained to inspectors that this was now being organised in a more formal manner. She showed inspectors the schedule of reviews which she had set out for the year.

Some residents had completed an 'advanced wishes' end-of life care plan and this was reviewed on a regular basis. There was an emphasis on promoting autonomy and some residents stayed out in a family member's home at weekends or had travelled abroad.
with family for holidays.

The centre housed the offices of two community transition staff who supported those residents who were moving to a different care setting or residents who intended to move to a community setting. Transition plans were comprehensive and the transition coordinators were familiar with residents' needs and different abilities when spoken with by inspectors. However, residents and their representatives expressed their disappointment at the loss of the 'activities room'. The person in charge explained that a new activity programme was planned by a member of staff. Plans for this were forwarded to inspectors following the inspection. In addition, inspectors observed that a number of residents spent periods of time alone in their bedrooms, without any interaction with staff, due to the reduced staffing levels in the afternoon. Furthermore, staff outlined to inspectors that there was a lack of staff and transport and for this reason outings were not as frequent as before. Inspectors viewed documentation and complaint forms which indicated that residents were not always able to be accommodated for planned outings due to the aforementioned reasons. Inspectors also noted that a relative had complained about lack of activities in the pre inspection questionnaire. In addition, there were complaints from residents' representatives, viewed by inspectors, that residents spent long periods alone in their bedrooms or that they were not facilitated to attend activities or outings.

**Judgment:**
Non Compliant - Major

**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:**
As described in the introduction to this report there were three distinct areas of care in the centre: the main 'period style' house, the apartment complex and the four bedded house. The garden areas were well maintained and the centre had the services of a maintenance man who attended promptly to any repairs and faults identified. The apartments were colourful and very well maintained both inside and outside and the four bedded house was modern and appropriately decorated.

The large period style house was comfortable, spacious and clean. However, the external walls of this house required painting and the basement area was in a very poor state of repair. The kitchen of the centre was located in this basement area and
inspectors formed the view that this was an unsuitable location due to the unpainted, unkempt surrounds at the entrance to the kitchen. For example, walls outside the kitchen entrance were not plastered and not painted and there were two small food preparation rooms in this area which had worn floor coverings, worktops and cabinets. The main kitchen was furnished with stainless steel cabinets and was seen to be well stocked and clean. However, the footpaths outside the basement section were unsafe and four unused large waste bins were stored there. The person in charge undertook to move these to prevent any obstruction. There were areas of the grounds which were unsafe due to open unrestricted access to this basement section. This access had not been risk assessed in the context of the safety needs of residents. There was open access to the car park area also and inspectors viewed documentation which indicated that a vulnerable resident had gone down to the car park area, stating that he/she was leaving the centre. This issue was addressed under Outcome 7: Health and Safety.

The upper floor of the main house was no longer in use. The area of the house in use for residents was located on the ground floor. There were 13 single bedrooms available for residents. The premises was laid out in three corridors of bedrooms, where eight full time residents were accommodated. There were also three residents in respite accommodation in these bedrooms, at the time of inspection. The person in charge stated that occasionally a resident would be afforded an emergency respite stay in accordance with the statement of purpose. There were eight toilets in this section, as well as four shower rooms. There were large communal rooms available for relaxation, for activities and for dining. These 'period style' rooms were spacious and impressive in their design and décor. However, the activities room and the attached enclosed garden were in use by an external group, at the time of inspection. Inspectors were informed by residents and staff that this area was no longer available to residents. As a consequence, outdoor access was limited for residents in the main house and some residents were seen sitting outside the building in their wheelchairs, near to the car park area, where traffic was circulating. This and other un-assessed risks were addressed under Outcome 7: Health and Safety.

There were nine self contained apartments on the grounds of the centre which accommodated residents of low to medium dependency levels. The apartments were accessible from an individual front door for each resident and inspectors observed that these apartments also had back doors which led out to the patio areas. Residents and some of their representatives were involved in maintaining their own garden area outside each apartment. These were well managed and contained shrubs and colourful plant pots. Inspectors were invited to view the interior of these apartments by some residents. They were modern and well maintained. Inspectors observed that they were equipped with assistive devices and appropriate furniture for the needs of residents. Residents who utilised wheelchairs for mobility reasons were also accommodated in these apartments. Residents demonstrated to inspectors that there were adjustable worktops and cupboards fitted to accommodate their needs. Residents spoke with inspectors about the fact that they were consulted by staff when their apartment was being decorated. Each apartment had access to private patio outdoor space. However, there was no communal sitting room and residents stated to inspectors that they missed having access to the activities room in the main house, for social reasons, among others.
The four bedded detached house was home to four residents. They had individual bedroom accommodation which was well decorated and personalised. Inspectors met all residents in this house who stated that they were constantly developing new life skills. One resident attended college with staff support. Residents informed inspectors that they prepared meals independently and attending to their personal laundry. These residents had been assessed as having varying dependency levels. A number of these residents were hoping to move to a setting in the community, in the future. There was a small patio area attached to this house, which was in use for a birthday celebration at the time of inspection. However, as two residents in this house had been assessed as having high needs inspectors formed the view that the night time staffing levels required review and risk assessment. Night staff informed inspectors that they would be required to go over to the house two or three times a night to attend to residents' needs. Staffing levels were addressed under Outcome 17: Workforce.

Judgment:
Non Compliant - Major

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<th>Outcome 07: Health and Safety and Risk Management</th>
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<td><em>The health and safety of residents, visitors and staff is promoted and protected.</em></td>
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**Theme:**
Effective Services

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

**Findings:**
The centre had a health and safety statement and it was relevant to the centre. There was a health and safety committee which met on a monthly basis and inspectors viewed the minutes of these meetings. There was a monthly audit of health and safety issues in the centre. A copy of this was provided to inspectors.

Procedures were in place for the prevention and control of infection. Alcohol hand gels and disposable gloves were available. Housekeeping and laundry duties were carried out by the cleaning staff and staff in the centre and the laundry was well equipped for the needs of the centre. Inspectors also observed residents attending to their own laundry needs. The centre had the services of an infection control nurse in the region.

The centre had a risk management policy and a risk register which captured some potential risks (environmental, operational and clinical) associated with the centre. There were measures in place to control risks and arrangements for identification, recording, investigation and learning from serious incidents, such as at the monthly health and safety meeting. Staff informed inspectors that incidents and adverse events were also discussed at staff meetings. Inspectors viewed minutes of these meetings.

However, all risks in the centre had not been identified and assessed and the risk register did not contain the controls in place to eliminate or minimise these risks. These
included a large area of exposed pipe work in the corner of the main kitchen area of the period house, the storage of latex gloves, a potentially dangerous step outside the kitchen exit door, unclean and unkempt cupboards and surfaces in the food storage and food preparation kitchenettes, and an unrestricted door which lead to an unsafe stairwell: this door led to a communal toilet so it was in use regularly. In addition, a call system in use by a resident was found by inspectors to be out of order. The resident had informed inspectors that she had been ringing her bell for 20 minutes. Staff spoken with by inspectors stated that the resident was using it incorrectly. However, when the staff member tested the bell it was not working. The possibility of this happening had not been risk assessed, there was no audit done on whether the call system was working. The sole reliance on the call system at night for some residents had not been properly evaluated or risk assessed. This was a significant and serious failing in view of the fact that the residents in the apartments and in the four bedded house relied predominantly on the personal call system operating correctly. In relation to this concern inspectors noted that there was no staff on duty after bedtime in the apartments and in the four bedded house. In addition, inspectors viewed incidents where residents had fallen in the apartments. For example, on one occasion a resident had been heard crying, by a passing staff member, having fallen in the apartment. This resident was not wearing the personal call system at the time. Furthermore, a resident in one apartment was a smoker and the risk assessment in relation to his smoking habits had not been updated. Window openings had not been risk assessed, particularly in view of the fact that windows were of a sash window design, which opened up from the bottom.

Inspectors noted that incidents in the adverse incident book were recorded in detail. However, the process of any learning from these events was not clearly recorded in all cases and the satisfaction of the complainant was not always recorded. Inspectors observed that some incidents continued to occur. For example, staff allegedly failed to attend promptly to residents needs, some residents experienced falls, staff were allegedly not respectful in their interactions with residents. Staff training and supervision was discussed with the person in charge. This issue was addressed under Outcome 8: Safeguarding and Safety.

An emergency plan was in place and a safe placement of residents in the event of an evacuation had been identified. Regular fire drill training was documented and there were personal evacuation plans for residents. Records reviewed by inspectors indicated that the fire alarm was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis. The fire assembly points were identified and there was appropriate emergency lighting in place. There was evidence that arrangements were in place for daily checking of fire precautions which included the alarm panel, the fire exits, and the testing of fire equipment. Inspectors noted that fire exits were unobstructed. Staff spoken with by inspectors were aware of what to do in the event of a fire. The procedure was also displayed in both hallways to increase awareness. Residents had personal fire evacuation and emergency plans (PEEPS) available. However, not all staff had been afforded fire training. One staff member informed inspectors that she had last attending fire training session in 2013. Inspectors formed the view that this was inadequate due to the design and sprawling nature of the old house and the layout of the centre. In addition, up to 35 fire doors, which had been specified by a suitably qualified person to be required as a priority, for fire safety purposes, had not been installed. This work had not commenced by 18 August 2015, as indicated by an email
from the person in charge. This information was received in response to the inspector's request for an update into fire safety management in the centre. The person in charge stated in her response that work was to commence on installing the required fire doors by the end of September and that it was proposed that the work would be completed by the end of November 2015.

**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 person in charge informed inspectors that she was actively involved in the management of the centre. She said she was confident of the safety of residents through speaking with residents and their family members and observing the interactions between residents and between staff and residents. There was a policy on the management of allegations of abuse. A copy of the health services executive (HSE) policy on 'Safeguarding Vulnerable Persons at Risk of Abuse' 2014 was available in the centre. Residents said they felt safe in the centre and this was attributed to the fact that they were familiar with the staff and their personal assistants (P.A.). However, inspectors were informed by one resident that she no longer wanted a particular staff member supporting her care needs, due to an alleged disrespectful interaction. She stated that her wishes had been respected in this regard. In addition, incidents and notifications were reviewed, which indicated that some staff had, allegedly, raised their voice to residents and other staff, allegedly, did not provide personal care as requested, in a timely manner. This led to an embarrassing and upsetting incident for one resident. This incident form was viewed by inspectors. Notifications to the Authority of a number of these alleged abusive incidents had not been received by the Authority. In addition, not all of the incidents viewed had been addressed in line with the policy on protection of and safeguarding vulnerable residents. This was addressed under Outcome: 9: Notification of incidents.

In view of the nature of the aforementioned recurring incidents, inspectors spoke with the person in charge about the provision of training in the prevention of elder abuse and the protection of vulnerable adults. The person in charge stated that this training was
provided on a three yearly basis. Inspectors formed the view that this was inadequate in view of the nature of complaints about staff interactions and notifications received by the Authority. For example, complaints were recorded which were clearly issues of allegations of potential psychological abuse, allegations of verbal abuse, allegations of financial abuse and potential acts of neglect and omission of care which were repeated allegations. In addition, records seen by inspectors confirmed that training in positive behaviour support and in behaviours that challenge had not been made available for staff. Staff spoken with by inspectors confirmed that they had yet to be afforded this training, which was mandatory and required by Regulation. Staff members, spoken with by inspectors, confirmed that they had yet to avail of this training. Furthermore, the centre did not have a policy on positive behaviour support which was also required under Schedule 5 of the Regulations.

The centre had a policy on restrictive interventions which was dated 1 May 2015. However, notifications of restraint which was evident in the centre in the form of bedrails and lap belts had not been made to the Authority, in line with Regulations. In addition, a restraint log was not maintained in the centre to record the use of any restraints, for example, bedrails and lap belts as required by Regulation. This issue was addressed under Outcome 18: Records and documentation.

There was a policy in place for the management of residents’ finances. Some residents managed their own finances independently and receipts were retained from shopping events and outings. Inspectors were informed that the management of residents' finances was more robust since a previous allegation of financial abuse which had been notified to the Authority in April 2014. This allegedly occurred on unknown dates in 2012 and 2013 and had gone unnoticed by the management of the centre until an audit was undertaken. Inspectors noted that at the time of inspection this serious allegation had not been reported to the Gardaí. This was discussed with the person in charge in view of the fact that allegedly, a large sum of money was involved. The person in charge indicated by email that she had been instructed to inform Gardaí on 21 September 2015. This information was provided by email by the person in charge on 19 September 2015, following a request by the inspector for an update into the investigation and into the involvement or not of the Gardaí. A money management protocol had been updated in September 2015 for the resident involved and a copy of this plan was requested from the centre. Inspectors viewed a sample of the money management questionnaires which were completed to evaluate the supports required for each resident. Staff now had a protocol to follow when returning residents' bank cards to the administrator. This was explained to inspectors by the finance manager. There was now a yearly audit of financial transactions undertaken and there were money management plans seen for a number of residents. In some situations, residents’ family members took care of financial matters on their behalf, where appropriate. Suitable oversight of these financial transactions was in place for any resident with diminished capacity.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where
Theme: Safe Services

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

Findings:
There was a record of all incidents and accidents maintained in the centre.

However, a significant number of notifications were not submitted in a timely manner to the Authority, in line with Regulations.

A number of notifications of alleged abusive interactions alleged verbal abuse, alleged financial abuse, alleged neglect and alleged omission of care had not been notified to the Authority within three days as required by the Regulations. A number of these allegations had been investigated as complaints.

Judgment:
Non Compliant - Major

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

Findings:
The policy on access to education, training and development was not available at the time of inspection. Non compliance in the availability of required policies were addressed under Outcome 18.

Reviews of residents’ personal plans indicated that individual resident's education and employment goals were being fulfilled. Activities and educational programmes included literacy, computer technology and fitness. Residents were also involved in life skills training programmes. Training and development opportunities were offered to residents within the centre, where they had developed skills such as cooking, laundry, money management and gardening. Residents’ achievements were also celebrated and certificates were displayed in individual rooms. However, while residents were involved in social activities these were limited in scope. In particular, the opportunity to socialise
together in the centre as the activities room was being used by an external group and was now closed to residents, who expressed to inspectors how much they missed this facility. This was addressed under Outcome 5: Social care needs.

The ethos of the centre focused on developing skills that prepared residents for independent living. Residents spoke with inspectors about their plans for the future including living independently. A review of the directory of residents confirmed that a number of past residents had been discharged to independent living centres. These residents had been facilitated to continue education programme. In addition, the person in charge stated that a number of these residents continued to be supported by staff from the centre.

**Judgment:**
Compliant

### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

**Findings:**
Residents had access to general practitioner (GP) services and appropriate therapies, such as dentist, psychologist, dietician, occupational therapist (OT), psychiatrist and speech and language therapist (SALT). In some situations residents were enabled to independently visit their GP. There was evidence that residents had availed of allied health care services and specialist consultants. Residents could avail of the services of a local dentist. Residents had been assessed by the dietician and inspectors observed that care plans had been developed to support residents with diabetes and coeliac disease. The SALT had provided guidelines for safe swallowing for a resident with dysphagia (swallowing difficulties) and the OT had documented recommendations for suitable chairs and assistive devices. Regular multidisciplinary input was evident in residents' personal plans.

Some residents had documented their advanced care wishes. Inspectors were informed by the persons in charge that these were revisited at the yearly personal care plan review meetings. Residents confirmed with inspectors that they were central to the care planning process. Inspectors spoke with most of the residents in the centre throughout the inspection and they provided an in-depth picture of life in the centre and how their needs were attended to. They spoke freely with inspectors about issues which could be improved in the centre and inspectors noted that they were an articulate and interesting group of people.
Inspectors spoke with relatives during the two days of inspection and they were praiseworthy of staff and of the freedom to visit and to personalise rooms, where appropriate. However, visitors and residents both expressed that they felt that more staff were necessary as the needs of the residents had changed over time. They also expressed concerns about the uncertainty of future arrangements. This comment was also repeated in the pre-inspection questionnaires reviewed by inspectors. This issue will be addressed under outcome 17: Workforce.

Inspectors noted that residents had access to refreshments and snacks with a selection of fresh fruit and home baked bread. Residents, spoken with by inspectors, indicated that their individual likes and dislikes were taken into account when shopping and that they were encouraged to buy fruit and vegetables. Staff informed inspectors that they would accompany residents on shopping trips. However, inspectors were informed by a resident that a weekly regular shopping trip, which she looked forward to, had to be postponed, due to unavailability of transport and staff. These were required for another resident. Residents explained how important these trips out of the centre were and how upsetting it was if these could not be facilitated, as planned. This issue was addressed under Outcome 17: Workforce.

There was a central kitchen in the main house and all residents were welcome to attend the dining room for meals. Inspectors noted that residents had a choice of three meals at lunchtime and there was a menu board available in the dining room. The meals looked appetising and modified diets were carefully prepared. Staff were seen to support residents with their meals as a number of residents required significant assistance at meal times. However, inspectors noted that staff were not readily available to support one resident as they were occupied helping others to eat. Inspectors had to intervene to prevent this resident's plate falling or the food slipping from the plate. Some residents were observed to avail of snacks and late meals, where required. However, the training matrix confirmed that only four staff of the total number of staff in the centre had received training in safe eating and swallowing. Due to the identified needs of residents and from observing the level of support required during mealtimes it was clear to inspectors that residents would not be able to avail of timely support, due to the inadequate number of suitably trained staff. The person in charge confirmed with inspectors that only trained staff could assist residents. In addition, this significant issue was compounded by the fact all staff had not been afforded training in first aid of a resident who was choking, training in the use of the suction machine or training in the administration of oxygen, if required. This matter was also very significant in view of a previous serious aspiration incident in the centre. This training issue was addressed under Outcome 17: Workforce.

Inspectors observed that the ethos of the centre encouraged and enabled residents to make healthy living choices, in relation to exercise, weight control and dietary considerations. This observation was supported by information in the personal plans viewed by inspectors. Staff with whom inspectors spoke were knowledgeable about residents’ health and social care needs and were observed to provide care as outlined in the personal plans. The persons in charge and the staff members spoken with provided relevant information about each resident’s medical and social needs. Residents said that they were afforded opportunities to participate in activities, which included concerts, watching television and DVDs, cooking, holidays, support groups, art, regular outings,
music and shopping. However, as discussed previously these opportunities were dependent on staff or volunteer availability.

Inspectors spoke with a staff member who stated that some nights only two night staff would come on duty and that they could then be very busy attending to residents needs, until a replacement staff came on duty. She outlined to inspectors that there were a number of residents who required two and sometimes three members of staff to attend to their needs during the night. This was particularly significant as a resident could not use the call bell/alarm system, relying instead on calling out for a staff member. This resident would have to wait for staff to come from the other parts of the centre, before her needs could be attended to. Staffing levels were addressed under Outcome 17: Workforce.

The privacy, dignity and confidentiality of residents were safeguarded as information and documentation, relating to residents, was stored in the staff office. Residents were able to access their individualised personal plans and understood that their personal information and their confidentiality would be respected by the Authority.

**Judgment:**
Non Compliant - Major

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
The medication management policy was up to date. Residents were supported to attend the pharmacy where possible and there was evidence that residents' medications were reviewed regularly. A pharmacy audit had been done and inspectors saw evidence that issues identified were addressed. The prescription sheet indicated the maximum 24 hr. dose of medication to be administered and when drugs were discontinued the GP had signed to this effect.

Most staff members were trained in medication administration however, not all staff had been afforded this training or the supervision required. Inspectors noted that there were a number of residents who may require the administration of oxygen and a number of residents who suffered from epilepsy. However, not all staff had been afforded training in the administration of oxygen or in the administration of emergency epilepsy medication. Inspectors observed medication errors in the sample of files viewed. A significant number of medication errors were recorded in the adverse incident book however; this record also indicated that similar medication errors were being repeated.
Inspectors found that the system of audit was not robust and there was no evidence of learning from these errors as records demonstrated that similar errors were being repeated. The person in charge informed inspectors that training and refresher training where required would be provided for all staff following the inspection. From a review of the medication errors inspectors noted that an important medication had been omitted for one resident. The night staff recognised the error and sought advice from the manager and the GP with no adverse effect on the resident, due to the timely action.

Residents had been assessed for the ability to self-administer their medications and the person in charge said that a number of residents were assessed as suitable to self-administer. These assessments were filed and viewed by inspectors in the personal plans of residents. Unused or out of date medication was segregated for return to pharmacy as required. However, inspectors noted that a number of medications were disposed of in the yellow 'sharps' bin, which was designated for the disposal of sharp objects, such as syringes and needles.

The centre had controlled drugs in use. There was a bound register for the recording of these drugs and there was a record kept of the drug count, at the changeover of each shift. The key to the controlled drugs cupboard was kept safely. However, inspectors noted that the total column for individual drugs was incorrect, in some cases. For example, the total column had not been adjusted when drugs were returned to pharmacy or when residents had left the centre. This was brought to the attention of the nurse on duty.

The maximum dose in 24 hours for PRN (when necessary) medication was stated for some psychotropic medications and there was a system in place to record the effect of administering these PRN medications to a resident. The crushing of some medication was prescribed by the GP as required. However, there was no record of resident's allergies on all the medication administration charts reviewed. There was no signature list of staff members available. In addition, there were no staff signatures seen for some medication that had been administered. These measures were required under the centre's policy and An Bord Altranais agus Cnaimhseachais na hEireann Guidelines 2007 on best evidence based practice in medication administration.

Judgment:  
Non Compliant - Major

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):  
This was the centre’s first inspection by the Authority.
Findings:
A recently updated statement of purpose was available and reviewed by inspectors. The statement of purpose described and reflected the day-to-day operation of the centre and the services and facilities provided for residents.

The person in charge confirmed that she kept the statement of purpose under review and provided inspectors with a copy of the most up to date version following the inspection. Inspectors noted that there was a copy of the statement of purpose available for residents in the centre.

While the statement of purpose outlined most of the items listed in Schedule 1 of the Regulations, it did not adequately address the following:
- a description of the rooms (either in narrative form or a floor plan in the designated centre, including their size and primary function)

In addition, parts of the statement of purpose were inaccurate, for example it stated how many residents were currently residing in the centre and this was no longer correct.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There was a governance and management structure in place which was in accordance with the structure outlined in the statement of purpose. The person in charge of the main house and the apartments informed inspectors that her post was full time and she was engaged in the governance, operational management and administration of the centre on a consistent basis. The person in charge said she had good support from the provider and the regional manager who participated in the management of the centre in her absence. The person in charge was qualified for her role. Inspectors spoke with her about her previous experience and her qualifications and commitment to residents. Staff and residents were able to identify her as being the manager and staff stated that she was supportive. She demonstrated to inspectors that she was committed to her
professional development. However, all documentation as required by Regulation was not available, as addressed under Outcome 18: Records and documentation. In addition, inspectors were not assured that the governance and management system effectively supported and delivered safe, quality care services to residents. Furthermore, there was no clearly defined management structure in the centre as inspectors noted that notifications to the Authority were consistently late. Inspectors were informed that the person in charge did not have the authority and accountability to submit these notifications to the Authority without them being reviewed initially, by a senior manager in the organisation. This led to prolonged delays in some instances due to the lack of knowledge of Regulations and lack of role definition.

There were two persons in charge for the four bed roomed house. One of these persons in charge held a dual role and was the acting services manager. She informed inspectors that she worked two days a week. She had nine years experience in the centre and was suitably qualified for her role. She stated that she also worked with residents in the community. The second person in charge shared the role and they worked in a job sharing arrangement. She was suitably experienced and qualified.

The provider was present in the centre on the second day of inspection and inspectors spoke with him about the management of risk, incidents, late notifications, notifications of concern and staffing levels. He was found to be familiar with the centre and had been informed of ongoing investigations. He was working with the organisation for many years. He stated that he was knowledgeable of the Regulations and Standards for the sector. He outlined future plans for the centre and stated that the health service executive (HSE) worked with them in providing suitable community settings for those residents who wished to transition out into the community. He outlined that the centre was funded mainly by the HSE and also by fundraising. The person in charge and the regional manager were made aware of the HIQA guidance documents on what constituted a designated centre, for assessing the needs of residents' in community houses.

Staff informed inspectors that they were facilitated to discuss issues of safety and quality of care at handover meetings, which the person in charge and senior staff nurses facilitated. Staff appraisals had commenced. There was a regular review of the quality and safety of care in the centre and audit of areas such as infection control, health and safety and medication management. Inspectors reviewed a health and safety audit, a fire safety audit (dated May 2015) medication management audit and an infection control audit carried out by the HSE infection control nurse in 2015. However, all actions recommended from these audits had not been implemented, as addressed under Outcome 7: Health and Safety and Outcome 12: Medication management.

As discussed in detail under Outcome 17 and Outcome 18, lack of sufficient staffing levels was highlighted to inspectors, throughout the inspection. The regional manager for the organisation and the provider stated that this would be reviewed and the needs of residents would be assessed, in relation to the staffing levels, qualifications and skill mix. Immediate action plans were issued to the provider on the issue on skill mix, staffing levels and staff training. This was addressed in detail under Outcome 17: Workforce. Lack of resources to support the delivery of safe and quality care was addressed under Outcome:16: Resources.
**Judgment:**
Non Compliant - Major

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The provider was aware of his responsibility to inform the Authority of the absence of the persons in charge, in line with the requirements of the legislation and to notify the Authority of the arrangements in place for the absence.

The Authority had been notified of this in the past and arrangements had been put in place for the management of the centre during the absence of the persons in charge.

However, during the absence of the person in charge notifications to the Authority continued to be submitted late in contravention of the Regulations.

**Judgment:**
Compliant

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

**Theme:**
Use of Resources

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

**Findings:**
The centre was not resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

The facilities and services did not reflect the centre's statement of purpose. Inspectors
found that there were insufficient resources in the centre to meet the needs of residents. This issue had been addressed in detail under Outcome 17: Workforce, Outcome 18: Staffing, Outcome 7: Health and safety and Outcome 5: Social care needs.

Some examples were, lack of activities, lack of staff, lack of transport, lack of appropriate training including mandatory training, lack of resources to install the required fire doors, to paint the external area and to relocate the kitchen to a more suitable area. The lack of funding for the kitchen relocation and fire door provision was discussed and confirmed by the provider and person in charge.

The evidence of a lack of resources was obtained from observations by inspectors, care plans, incident forms and notifications reviewed, survey results and interviews with staff, residents and relatives.

**Judgment:**
Non Compliant - Major

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**Outcome 17: Workforce**

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

**Theme:**
Responsive Workforce

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

**Findings:**
An immediate action plan was issued to the provider in relation to the inadequate number, qualifications and skill mix of staff in the centre. An unsatisfactory response to this was received by the Authority on 8 July 2015 and the provider was requested to submit a further response. This second response received on 29 July 2015 indicated that only suitably trained staff would be on duty at night and that a staff nurse would also be on duty in the centre seven days of the week. The provider also stated that a staff nurse would be on call each night to support the care staff on duty. This second response indicated that a roster review and a needs assessment of all residents would be undertaken and completed by 7 September 2015 to evaluate the needs of residents in relation to the staffing mix and levels required. This had yet to be received by the Authority as part of the provider’s response to the immediate action plan.

A second immediate action plan was issued to the provider in relation to the lack of provision of mandatory and appropriate training for staff. An unsatisfactory response to this was received by the Authority on 8 July 2015 and the provider was requested to submit a further response. This second response was received by the Authority on 29
July 2015 which indicated that training needs would be addressed by 21 September 2015. In addition, mandatory training was to be provided following the inspection. A training matrix received by the Authority on 29 July 2015 following the inspection, indicated that a number of staff had yet to receive mandatory and appropriate training. Furthermore, the provider stated that there would be a staff member on duty each night who was trained in medication management including the administration of emergency epilepsy medication. A nurse would be rostered on duty if there was no suitably trained person on duty. The provider was asked for confirmation that this had occurred and for an updated training matrix.

A sample of staff files reviewed by inspectors generally complied with the requirements of Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) with Disabilities) Regulations 2013. However, not all the required documents were available for staff. For example, qualification certification was not available on one file and there was no Garda vetting or signed specific role descriptions in the files of three volunteers in the centre. However, inspectors noted that two of the volunteers had filled out the required vetting forms. Inspectors viewed the policies on staff recruitment and saw that staff had fulfilled the required vetting procedures and had the required references. The staffing rota viewed by inspectors indicated that staff were not always replaced when someone was absent on sick leave. This was confirmed by staff who spoke with inspectors.

Records reviewed indicated that staff had attended a range of training however, this did not include all the mandatory training required by Regulations, for example training on de-escalation techniques and supporting residents with behaviour that challenged. However, the person in charge stated that this training had been scheduled for a group of staff later in the month. This documentation confirming that such training was scheduled was viewed by inspectors. However, all staff members, spoken with by inspectors, had not received training or refresher training in the recognition and response to adult abuse. Not all staff had received medication management training and had not completed their supervision sessions for this training. Staff had not been afforded training in communication needs of residents and in the use of essential equipment for an emergency situation such as a resident choking or a resident requiring resuscitation, where necessary. In addition, inspectors noted that staff supervision was not consistent. Not all staff had supervision or appraisal records available in their files. Nevertheless, some staff appraisals had commenced and these were viewed by inspectors.

There were three staff members on duty in the centre after ten at night and the person in charge stated that she was satisfied that all risks had been assessed for night time needs. Inspectors formed the view that staffing levels required to be reviewed in light of the assessed needs of residents particularly in the afternoons and at night time. For example, there were no specific night staff members on duty in the apartments and in the four bedded house despite records being available of residents falling, one resident's needs requiring the use of a hoist and a resident who could not independently use the toilet or adjust his bedclothes unaided, during the night. In addition, inspectors saw evidence that complaints had been made about missed days at activation centres, prolonged waiting for care needs to be met at night and the provision of activities. Residents and staff stated that residents were previously facilitated to go out on the bus
in the afternoon. They stated that this does not happen now due to lack of staff to drive
the bus, lack of available transport and the care requirements of residents with high
needs, in the centre. Residents and relatives had also indicated that staff shortage was
an issue of concern to them, in the pre inspection questionnaires sent to the Authority.
A relative informed inspectors that her family member had very high needs due to her
disability. She expressed concerns to inspectors that the resident might be moved to a
community house, where she felt her needs would not be sufficiently supported.

Inspectors viewed the planned roster for the following week. Inspectors found that staff
had an understanding of their role and of the needs of residents. Staff demonstrated an
awareness of the centre's policies and had access to a copy of the Regulations and the
National Standards for the sector. Residents were familiar with the staff on duty on the
day of inspection, which indicated continuity of care for residents. However, throughout
the inspection residents informed inspectors that there was not enough staff on duty to
facilitate outings, appointments and to organise activities. Staff confirmed with
inspectors that there was not sufficient staff to enable them to spend more quality time
with residents. Residents spoke with inspectors about the impact of not being able to
avail of transport for shopping and activation.

**Judgment:**
Non Compliant - Major

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

**Findings:**
The directory of residents was reviewed by inspectors. It contained some elements
required by Schedule 3 of the Health Act 2007 (Care and Support of Residents in
Designated Centres for Persons (Children and Adults) with Disabilities) Regulations
2013. However, it did not contain the gender and marital status of residents or
residents' general practitioners' (GPs) phone numbers, the date on which the resident
first came to reside in the designated centre and the name and address of any authority,
organisation or other body which arranged the resident's admission to the designated
centre.
All other records required under Schedule 3, had not been maintained. For example, a restraint log had not been maintained, as previously addressed under Outcome: 8: Safeguarding and safety.

The majority of records listed in Schedule 4 of the Regulations were maintained in the centre. However, inspectors found that a record of the designated centre's charges to residents, including any extra amounts payable for additional services and the amounts paid by or in respect of each resident was not maintained. This was discussed further under Outcome 4: Admissions and contracts of care.

The designated centre did not have a policy on provision of behavioural support, the provision of information to residents, access to education training and development and the creation of, access to, retention of, maintenance of and destruction of records. All other 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 were in place in the centre. However, none of the policies reviewed by inspectors were found to be centre-specific.

There was a Resident's Guide available in the centre. This guide was compliant with regulatory requirements. Inspectors viewed the insurance policy and noted that the centre was adequately insured against accidents or injury to residents, staff and visitors.

**Judgment:**
Non Compliant - Major

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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:**

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider's response to inspection report

Centre name: A designated centre for people with disabilities operated by The Cheshire Foundation in Ireland

Centre ID: OSV-0003439

Date of Inspection: 01 July 2015

Date of response: 27 October 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident’s privacy and dignity was not respected in relation to, but not limited to, his or her personal and living space, professional consultations and personal information.

For example, personnel who were not members of staff in the centre and clients from

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
an outside agency had to enter the personal bedroom space of residents to use the toilets. This impacted on the privacy of residents who could be availing of a consultation with their GP, having a visit from friends or availing of personal care from staff members.

1. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
1. Staff and Management of the external agency were advised by Person in Charge on the 14th October 2015 that they are not permitted to enter this corridor to use the bathroom facilities. If they wish to use the bathroom they are to use the main house bathroom facilities.

2. It has been agreed that the external agency will be vacating the premises on the 30th October 2015.

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**Proposed Timescale:** 27/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all residents were provided with access to facilities for occupation and recreation.

2. **Action Required:**
Under Regulation 13 (2) (a) you are required to: Provide access for residents to facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**
1. The Community Integration Coordinator is now in post and has developed individual plans for each person who is in receipt of the Provider’s Service in relation to their recreation and social needs. Personal Plans have been updated to reflect this.

2. The activity room and garden area is currently available for use from Friday through to Sunday and will be vacated fully by the external agency on the 30th October 2015.

3. The Community Integration coordinator is currently meeting with all of the residents and has developed a questionnaire to go through with the residents regarding the best use of the activity room. From this she will be compiling a list of activities that the residents would like to see taking place within the service.

4. Following the review of this information, a plan shall be put in place in order to facilitate the needs of the residents, which will include determining the number of support hours required to meet these needs and if the current roster and staffing levels can meet this need.

5. The care needs assessment has been completed which identified that there is a requirement for more staff in the afternoons. The new roster has been updated to
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents were provided with opportunities to participate in activities in accordance with their interests, capacities and developmental needs.

3. Action Required:
Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

Please state the actions you have taken or are planning to take:
1. The Community Integration Coordinator is now in post and has developed individual plans for each person who is in receipt of the Provider’s Service in relation to their recreation and social needs. Personal Plans have been updated to reflect this.
2. The activity room and garden area is currently available for use from Friday through to Sunday and will be vacated fully by the external agency on the 30th October 2015.
3. The Community Integration coordinator is currently meeting with all of the residents and has a developed a questionnaire to go through with the residents regarding the best use of the activity room. From this she will be compiling a list of activities that the residents would like to see taking place in this space.
4. Following the review of this information, a plan shall be put in place in order to facilitate the needs of the residents which will include determining the number of support hours required to meet these needs and if the current roster and staffing levels can meet this need.
5. The care needs assessment has been completed which identified that there is a requirement for more staff in the afternoons. The new roster has been updated to reflect this and the roster now has an additional staff from mid-morning to afternoon. This person is a floating staff and their start and finish times will depend on the needs of the residents and the activities they are participating in on a particular day.

Proposed Timescale:
1. Completed
2. 30th October 2015
3. 15th November 2015
4. 30th November 2015
5. Completed
2.31st October 2015  
3.15th November 2015  
4.30th November 2015  
5. Completed  

**Proposed Timescale:** 30/11/2015  
**Theme:** Individualised Supports and Care  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was insufficient evidence available to inspectors to indicate that that complainants were informed promptly of the outcome of their complaints and that details of the appeals process had been explained to them.

4. **Action Required:**  
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:  
1. All documentation regarding whether residents are satisfied or dissatisfied with the outcome of their complaints is now being recorded locally as well as on the electronic complaints management system.  
2. The Complaints Policy and Procedure will be updated to reflect this change. (Quality & Compliance Task Force)

Proposed Timescale:  
1. Completed  
2. 19th October 2015  

**Proposed Timescale:** 27/10/2015  

### Outcome 02: Communication  
**Theme:** Individualised Supports and Care  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
Staff in the centre had not been afforded training in assisting and supporting each resident at all times to communicate in accordance with the residents' needs and wishes.

5. **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:
1. Pain Management and Persons with specific communication needs training will be delivered to all care support staff.
2. ‘General Communications & communications with people who are Non Verbal’ Training has been sourced externally and will be rolled out to all management and staff. (Quality & Compliance Task Force)

Proposed Timescale:
1. 30th November 2015
2. 23rd December 2015

| Proposed Timescale: 23/12/2015 |

Outcome 04: Admissions and Contract for the Provision of Services

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admissions policy required updating to take account of the need to protect residents from abuse from their peers as outlined in the Regulations.

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

Please state the actions you have taken or are planning to take:
1. Admissions Policy to be updated to meet the regulatory requirement. (Quality & Compliance Task Force)

| Proposed Timescale: 01/11/2015 |

| Theme: Effective Services |

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have a written agreement of the terms on which they resided in the centre.

7. **Action Required:**
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
1. Service Agreement Template amended to meet regulatory requirement. (Quality &
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have a written agreement which included the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.

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

Please state the actions you have taken or are planning to take:
1. Service Agreement Template amended to meet regulatory requirement. (Quality & Compliance Task Force)
2. The registered provider to assign an individual to work with each service user in order to develop an individualised service agreement. (Quality & Compliance Task Force)

Proposed Timescale: 30/10/2015

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have a written agreement which provided for, and was consistent with, the residents’ assessed needs.

9. Action Required:
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident’s assessed needs and the statement of purpose.

Please state the actions you have taken or are planning to take:
1. Service Agreement Template amended to meet regulatory requirement. (Quality & Compliance Task Force)
2. The registered provider to assign an individual to work with each service user in order to develop an individualised service agreement (Quality & Compliance Task Force).

Proposed Timescale:
1. Completed
2. 30th October 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:
The person in charge failed to ensure that all areas of the designated centre was suitable for the purposes of meeting the assessed needs of each resident.

10. Action Required:
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
1. The Community Integration Coordinator is now in post and has developed individual plans for each person who is in receipt of the provider's service in relation to their recreation and social needs. Personal Plans have been updated to reflect this.
2. Each resident has access to transport. The transport is provided through several options which includes access to the provider's transport or private wheelchair accessible taxi firms. All residents are encouraged to inform management if there are issues with their transport or there is a lack of transport so that alternatives can be explored.
3. The activity room and garden area is currently available for use from Friday through to Sunday and will be vacated fully by the external agency on the 30th October 2015.
4. The Community Integration coordinator is currently meeting with all of the residents and has a developed a questionnaire to go through with the residents regarding the best use of the activity room. From this she will be compiling a list of activities that the residents would like to see taking place in this space.
5. Following the review of this information a plan shall be put in place in order to facilitate the needs of the residents which will include determining the number of...
support hours required to meet these needs and if the current roster and staffing levels can meet this need.
6. The care needs assessment has been completed which identified that there is a requirement for more staff in the afternoons. The new roster has been updated to reflect this and the roster now has an additional staff from mid-morning to afternoon. This person is a floating staff and their start and finish times will depend on the needs of the residents and the activities they are participating in on a particular day.

Proposed Timescale:

1. Completed
2. Completed
3. 30th October 2015
4. 16th November 2015
5. 30th November 2015
6. Completed

Proposed Timescale: 30/11/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable arrangements were not in place to meet the assessed needs of each resident. Residents had complex medical and social needs and the skill mix of staff and the lack of trained personnel on all shifts required assessment and review.

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

Please state the actions you have taken or are planning to take:
1. The centre completed an “Analysis of Care Needs Assessment” in August 2015. The purpose of the assessment was to:
   - To determine the dependency level and total care hours required by the residents in the centres.
   - To determine if the current roster is adequate to meet the needs of the residents.
   - To determine if the nursing supports are adequate to meet the needs of the residents. Following consultation with staff and residents, the Care Coordinators and the CNM1 observed episodes of care with all residents. The adapted version of the Northwick Park Care Needs Assessment Tool (NCPNA) was used to collect data and a Northwick Park Dependency Score was calculated for each resident. Data collection was enhanced through discussion with care staff and nursing staff. The score was reassessed again before compiling data to ascertain if there were any changes in dependency levels at that time to ensure current needs were reflected.
2. In response to the care needs analysis specific action has been taken by management in the centre. Since 4th October 2015 management have increased the number of hours
available on the care support staff roster. In the Main House the number of residents has decreased since the needs assessment was completed. However, the number of care hours available has increased for the Main House. This will have most benefit for residents who wish to partake in activities outside of the centre as there will be more staff available to accompany them. There will also be more time for staff to spend with residents on in-house activities. In an effort to meet residents changing routines and planned activities or appointments, a ‘floating’ shift has been introduced which can vary in length and start/finish times depending on residents’ plans. A decision was made on 29th July 2015 to increase the nursing hours in the service to 12 hours per day over 7 days. This increase and consistency in nursing presence in the service will have added benefits for the residents as it will ensure that the staff supporting them is well mentored and supported. Nursing staff will work alongside the care staff assessing their care delivery skills and knowledge, identifying training needs where required, supporting care staff in the planning and management of care, working alongside their colleagues in the multi-disciplinary team and improving practice through the audit and analysis of care delivery.

3. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See Appendix 1)

4. The Management Structure in the centre has been reviewed in light of the recent inspection. (See attached Appendix 3)

5. During the recruitment process an additional 0.62 clinical nurse manager will be recruited for a period of four months in order to assist with addressing clinical issues as identified in the inspection.

Proposed Timescale:
1. Completed
2. Completed
3. 30th November 2015
4. Completed
5. Completed

Proposed Timescale: 30/11/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to provide all areas of the premises which were designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

12. 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
Please state the actions you have taken or are planning to take:
1. All of the people who live in the centre have been provided with the opportunity to access the activity room which is currently being operated as a day activation service by an external disability agency. This external agency shall be vacating the premises on the 30th November 2015. The external agency was using the facility whilst they were awaiting the building of their own centre. All of the residents who currently access this day service will continue to access the service in the new premises.
2. The activity room and gardens are available for use by those living in the centre from Friday through to Sunday. The centre shall be reopening the activity room fully to the residents from the 31st October 2015.
3. The community integration coordinator is currently meeting with all of the residents and has developed a questionnaire to go through with the residents regarding the best use of the activity room and garden in the main house, regarding how they would like to spend their day, discussing with the residents opportunities to become involved in external services and day activation services in other services.
4. Following the analysis of the data collected from the questionnaires, the provider shall provide resources in order to facilitate the needs of the residents. This shall include staff either through the current staffing, which has been increased, or through the use of volunteers.

Proposed Timescale:
1. 30th October 2015
2. 31st October 2015
3. 16th November 2015
4. 30th November 2015

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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to ensure that the designated centre adhered to best practice in achieving and promoting accessibility. The garden and grounds were inaccessible to most of the residents due to the sloping grounds and unsafe accessible outdoor areas which presented a high risk of injury or falls.

13. **Action Required:**
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
1. The pathways outside of the basement area have been cleared and the bins
2. The unrestricted access to the basement has been assessed and controls are in place in order to restrict access to this area.
3. The car park has been assessed for risk and controls are in place.
4. The residents are encouraged to use the garden area as opposed to the front entrance. This has been assessed for risk and all residents are encouraged to remain vigilant when moving between the apartments and the main house.

**Proposed Timescale:** 27/10/2015

**Theme:** Effective Services

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

The provider had failed to ensure that the premises were of sound construction and kept in a good state of repair externally and internally:

For example:
- the main house required external repainting
- the basement area and kitchen entrance area was in a very poor state of repair
- there were unsafe surfaces and pathways around the basement area

**14. 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:

1. The pathways outside of the basement area have been cleared and the bins removed.
2. The unrestricted access to the basement has been assessed and controls are in place in order to restrict access to this area.
3. The car park has been assessed for risk and controls are in place.
4. The residents are encouraged to use the garden area as opposed to the front entrance. This has been assessed for risk and all residents are encouraged to remain vigilant when moving between the apartments and the main house.

**Proposed Timescale:** 27/10/2015

**Theme:** Effective Services

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

The provider had failed to ensure that the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) were met.

For example:
- the main kitchen was located in an unkempt, unsuitable basement area.
- the food preparation and the meat preparation area were not well maintained, for example the cabinets, flooring, painting and work surfaces in these side kitchenettes
required replacement and repair.
-adequate communal social and recreational space was not provided

15. 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:
1. The activity room and garden area is currently available for use from Friday through to Sunday and will be vacated fully by the external agency on the 30th October 2015.
2. The registered provider has hired an external consultant to complete a feasibility study on the basement area of the main house, with a view to moving the kitchen upstairs.
3. In the interim renovation of this area is currently being undertaken and a new cleaning regime is in place. All of the issues identified on the day of the inspection have been dealt with.
4. A maintenance plan has been put in place to address areas in the short term whilst we await the feasibility report on the re-location of the kitchen area.

Proposed Timescale:
1. 30th October 2015
2. 1st November 2015
3. Completed
4. 1st December 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:
All risks in the centre had not been assessed and controls had not been put in place. For example:
-unsuitable and unkempt kitchenettes
-exposed piping
-uneven outdoor surface near the entrance
-general public having access to residents' bedroom areas
-dangerous step outside the kitchen exit door
-an unsecured door which led to a unsafe stairwell:
-the personal call system in use by residents
-unsafe basement area outside the kitchen
-access to the parking lot
-access to an external stairwell
-lack of the required fire doors
16. **Action Required:**
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
1. All of the short term immediate issues which were identified during the inspection have been addressed in the short term.
2. With regards to the issues which could not be addressed on the day of the inspection, an assessment of risk has been completed and controls put in place in order to reduce any identified risks.
3. The registered provider has hired an external consultant to complete a Feasibility study on the basement area of the main house, with a view to moving the kitchen upstairs.
4. In the interim renovation of this area is currently being undertaken and a new cleaning regime is in place.
5. A maintenance plan has been put in place in order to address areas that can be addressed in the short term whilst we await the feasibility report on whether the kitchen can be moved up to the first floor.
6. As of the 31st October 2015 there will be no external groups accessing the activity room.
7. In the interim controls have been put in place in order to reduce the risk of external groups entering the bedroom area of the residents home.
8. The call bells for each resident is now checked each day and the recording of same is completed at handover. Two people who cannot use the call bells have been risk assessed and a plan is in place whereby the person will call out if they require assistance, staff will check in with the person every half hour.
9. A new weekly check of the system to be introduced and an audit tool for the monitor of the call bells and response times is being introduced into the service. (Quality & Compliance Task Force)
10. Fire Consultants have completed a fire risk assessment of the main house and controls have been put in place in order to address any risks whilst the work on the fire doors is being completed.
11. The registered provider has commenced work on replacing the fire doors in the main house.

**Proposed Timescale:**
1. Completed
2. Completed
3. 31st November 2015
4. completed
5. 31st December 2015
6. 31st October 2015
7. Completed
8. Completed
9. 1st November 2015
10. Completed
11. 30th November 2015
Proposed Timescale: 01/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The area in the basement where food was prepared and stored was unclean and required painting.
- these kitchenette areas had worn stained work tops, worn floor coverings and shabby cabinets.

The basement area leading into the kitchen area was un plastered, unpainted and generally dusty and unclean.

In one corner of the kitchen there were large exposed pipes which required casing. This corner appeared dusty and unkempt.

17. 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:
1. All of the short term immediate issues which were identified during the inspection have been addressed in the short term.
2. With regards to the issues which could not be addressed on the day of the inspection, an assessment of risk has been completed and controls put in place in order to reduce any identified risks.
3. The registered provider has hired an external consultant to complete a Feasibility study on the basement area of the main house, with a view to moving the kitchen upstairs.
4. In the interim renovation of this area is currently being undertaken and a new cleaning regime is in place.
5. A maintenance plan has been put in place in order to address areas that can be addressed in the short term whilst we await the feasibility report on whether the kitchen can be moved up to the first floor.

Proposed Timescale:

1. Completed
2. Completed
3. 1st November 2015
4. Completed
5. 1st December 2015
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Effective fire safety management systems had not been put in place:

For example:
- all staff had not been afforded appropriate fire training and refresher fire training
- fire safety measures outlined by an external suitably qualified person had not been implemented such as the installation of 35 fire doors. The installation of these had been given a priority rating by the suitably qualified person.

18. **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:
1. All staff have received fire training, both full and refresher training.
2. FCC (External Fire Safety Consultants) have completed a fire risk assessment of the main house and controls have been put in place in order to address any risks whilst the work on the fire doors is being completed.
3. The registered provider commenced work on replacing the fire doors in the main house and other fire safety related work which has been identified.

Proposed Timescale:
1. Completed
2. Completed
3. 30th November 2015

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**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

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

19. **Action Required:**
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.
Please state the actions you have taken or are planning to take:
General Communications & communications with people who are Non Verbal’ Training has been sourced externally and will be rolled out to all management and staff. (Quality & Compliance Task Force)
2.18 Staff have received in Communication and Conflict. 17 Staff will receive this training in November 2015.

Proposed Timescale: 30/11/2015
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Due to the fact that appropriate training had not been provided staff did not have up to date knowledge and skills, appropriate to their role, to respond to behaviour that was challenging and to support residents to manage their behaviour.

20. Action Required:
Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:
1. ‘General Communications & communications with people who are Non Verbal’ Training has been sourced externally and will be rolled out to all management and staff. (Quality & Compliance Task Force)
2.18 Staff have received in Communication and Conflict. 17 Staff will receive this training in November 2015.

Proposed Timescale: 30/11/2015
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that residents were protected from all forms of abuse, for example alleged psychological abuse, alleged financial abuse, alleged incidents of omission and neglect and alleged verbal abuse. This view was informed by interview, documentation and notifications reviewed,

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

**Please state the actions you have taken or are planning to take:**
1. All of the provider's staff have completed Adult Protection Training.
2. The frequency of Adult Protection Training will be changed from 3 yearly to annually i.e. all staff who received this training in 2014 will receive refresher training in November 2015.
3. The current induction process for new staff is currently being reviewed by the organisation and the process will be amended to ensure that all new staff will complete Adult Protection Training as part of their induction training prior to taking up care positions. (Quality & Compliance Task Force - role of group: to address areas of non-compliance within recent HIQA inspections)
4. In the interim the current induction module regarding adult protection will be amended to place more emphasis on safeguarding.

**Proposed Timescale:**
1. Completed.
2. Completed.
3. 23rd December 2015
4. Completed

**Proposed Timescale:** 23/12/2015

**Theme:** Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. The training provision was not afforded at appropriate intervals, in view of incidents seen by inspectors. Inspectors formed the view that a three year interval for this training did not afford effective or appropriate training for staff.

22. **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:**
1. All the provider's staff have completed Adult Protection Training.
2. The frequency of Adult Protection Training will be changed from 3 yearly to annually
i.e. all staff who received this training in 2014 will receive refresher training in November 2015.

3. The current induction process for new staff is currently being reviewed by the organisation and the process will be amended to ensure that all new staff will complete Adult Protection Training as part of their induction training prior to taking up care positions. (Quality & Compliance Task Force - role of group: to address areas of non-compliance within recent HIQA inspections)

4. In the interim the current induction module regarding adult protection will be amended to place more emphasis on safeguarding.

Proposed Timescale
1. Completed.
2. Completed.
3. 23rd December 2015
4. Completed

Proposed Timescale: 23/12/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident had not been assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection by the provision of information and advice on such issues.

23. Action Required:
Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:
1. A Self Care & Protection Workshop will be delivered by the Provider's Quality Officer.

Proposed Timescale: 30/11/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.
24. **Action Required:**
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

**Please state the actions you have taken or are planning to take:**
1. A Management & Notification Review was completed by an external investigator in September 2015. From the resulting report an action plan to address the findings has been submitted to the CEO for approval and will be forwarded to HIQA when agreed with the CEO.

2. The PIC and Regional Manager to discuss local procedures regarding the management of complaints and adverse events to ensure that communication and information is managed effectively locally which results in notifications being submitted in a timely manner.

**Proposed Timescale:**
1. 23rd October 2015
2. Completed.

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**Proposed Timescale:** 27/10/2015  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

25. **Action Required:**
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Retrospective notification submitted regarding this incident.
2. A Management & Notification Review was completed by an external investigator in September 2015. From the resulting report an action plan to address the findings has been submitted to the CEO for approval and will be forwarded to HIQA when agreed with the CEO.
3. The PIC and Regional Manager to discuss local procedures regarding the management of complaints and adverse events to ensure that communication and information is managed effectively locally which results in notifications being submitted in a timely manner.
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

26. **Action Required:**
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
1. A Management & Notification Review was completed by an external investigator in September 2015. From the resulting report an action plan to address the findings has been submitted to the CEO for approval and will be forwarded to HIQA when agreed with the CEO
2. The PIC and Regional Manager to discuss local procedures regarding the management of complaints and adverse events to ensure that communication and information is managed effectively locally which results in notifications being submitted in a timely manner.

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not given notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

27. **Action Required:**
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of
misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
1. A Management & Notification Review was completed by an external investigator in September 2015. From the resulting report an action plan to address the findings has been submitted to the CEO for approval and will be forwarded to HIQA when agreed with the CEO
2. The PIC and Regional Manager to discuss local procedures regarding the management of complaints and adverse events to ensure that communication and information is managed effectively locally which results in notifications being submitted in a timely manner.

Proposed Timescale:
1. 23rd October 2015
2. Completed

Proposed Timescale: 27/10/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge provided a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

28. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
1. All of the residents have been assessed regarding the use of restraints and updated plans have been put in place for each resident.
2. The quarterly notifications database will be updated as per the restraints register.

Proposed Timescale:
1. Completed
2. 31st October 2015

Proposed Timescale: 31/10/2015

Outcome 11. Healthcare Needs
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Numbers, skill mix and qualifications of staff were not in line with the assessed needs of residents as indicated by staff members and by a review of a sample of care plans and serious incidents. Inspectors were not assured that adequate support was available to residents at times of illness and at the end of their lives in a manner which met their physical, emotional, social and spiritual needs and respected their dignity, autonomy, rights and wishes. For example, a resident who could not use the call bell/alarm system had to rely on calling out for assistance.

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

Please state the actions you have taken or are planning to take:
1. The provider completed an Comprehensive Care Needs Assessment in August 2015. The purpose of the assessment was to:
   - Determine the dependency level and total care hours required by the residents across all centres
   - Determine if the current roster is adequate to meet the needs of the residents.
   - Determine if the nursing supports are adequate to meet the needs of the residents.
   Following consultation with staff and residents, the Care Coordinators and the CNM1 observed episodes of care with all residents. The adapted version of the Northwick Park Care Needs Assessment Tool (NCPNA) was used to collect data and a Northwick Park Dependency Score was calculated for each resident. Data collection was enhanced through discussion with care staff and nursing staff. The score was reassessed again before compiling data to ascertain if there were any changes in dependency level at that time to ensure current needs were reflected.
2. In response to the findings of this assessment specific action has been taken by management. Since 4th October 2015 management have increased the number of hours available on the care support staff roster. In the Main House the care needs has decreased since the needs assessment was completed due to the discharge of one resident with high needs. However the number of care hours available has increased for the Main House in the all parts of the day. This will have most benefit for residents who wish to partake in activities outside of the centre as there will be more staff available to accompany them. There will also be more time for staff to spend with residents on in-house activities. In an effort to meet residents changing routines and planned activities or appointments a ‘floating’ shift has been introduced which can vary in length and start/finish times depending on residents’ plans.
3. In considering the needs of the people residing in the centre and the ongoing demands of the current respite service it has been decided that there will be no further new referrals to the respite service.
4. In considering the needs of the people residing in the centre and the ongoing demands of the respite service, the provider engaged with the funders of the service, the HSE to discuss and agree an action plan which will address the challenges of the
service, the current model of service and resources – see attached appendix regarding the Provider's Respite Action plan.

5. On 29th July 2015 nursing hours were increased in the service to 12 hours per day over 7 days. This increase and consistency in nursing presence in the service will have added benefits for the residents as it will ensure the staff supporting them are well mentored and supported. Nursing staff will work alongside the care staff assessing their care delivery skills and knowledge, identifying training needs where required, supporting care staff in the planning and management of care and working alongside their colleagues in the multi-disciplinary team and improving practice through the audit and analysis of care delivery.

6. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).

7. The Management Structure in the centre has been reviewed in light of the recent inspection. (See attached Appendix 3).

8. Members of management have attended workshops on End of Life delivered by the Irish Hospice Foundation. The current service review process reflects the need for discussion and informed decision making regarding choices about end of life. The agreed actions will be recorded in the person’s individualised personal plans and will be reviewed regularly with the person to ensure that their wishes and needs are met.

Proposed Timescale:
1. Completed
2. Completed
3. Completed
4. 1st January 2016
5. Completed
6. 30th November 2015
7. Completed
8. 23rd December 2015

Proposed Timescale: 01/01/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some or all of residents healthcare needs were not met. For example, where residents require assistance with eating or drinking, the persons in charge had not ensured that there was a sufficient number of trained staff present when meals and refreshments were served, to offer assistance in an appropriate and safe manner.

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

1. The registered provider completed an “Analysis of Care Needs Assessment” in August 2015. The purpose of the assessment was to:
   - Determine the dependency level and total care hours required by the residents in the centres.
   - Determine if the current roster is adequate to meet the needs of the residents.
   - Determine if the nursing supports are adequate to meet the needs of the residents.

   Following consultation with staff and residents, the Care Coordinators and the CNM1 observed episodes of care with all residents. The adapted version of the Northwick Park Care Needs Assessment Tool (NCPNA) was used to collect data and a Northwick Park Dependency Score was calculated for each resident. Data collection was enhanced through discussion with care staff and nursing staff. The score was reassessed again before compiling data to ascertain if there were any changes in dependency level at that time to ensure current needs were reflected.

2. In response to the needs analysis specific action has been taken by management in the registered centre. Since 4th October 2015 management have increased the number of hours available on the care support staff roster. In the Main House the number of residents has decreased since the needs assessment was completed, however, the number of care hours available has increased for the Main House in the all parts of the day.

   This will have most benefit for residents who wish to partake in activities outside of the centre as there will be more staff available to accompany them. There will also be more time for staff to spend with residents on in-house activities. In an effort to meet residents changing routines and planned activities or appointments a ‘floating’ shift has been introduced which can vary in length and start/finish times depending on residents’ plans.

3. In considering the needs of the people residing in the registered centre and the ongoing demands of the current respite service it has been decided that there will be no further new referrals to the respite service – see attached appendix regarding the registered provider's Respite Action plan.

4. In considering the needs of the people residing in the registered centre and the ongoing demands of the respite service, the provider have engaged with the funders of the service (HSE) to discuss and agree an action plan which will address the challenges of the service, the current model of service and resources.

5. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).

6. The Management Structure at the registered centre has been reviewed in light of the recent inspection. (See attached Appendix 3).

Proposed Timescale:
1. Completed
2. Completed
3. 1st January 2016
4. Completed
5. 30th November 2015
6. Completed

**Proposed Timescale:** 01/01/2016

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## 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 controlled drugs register contained errors in the total column. The total column had not been adjusted when controlled drugs were returned to pharmacy, when a resident had died, when a resident had left the centre or when a resident no longer required these medications.

### 31. Action Required:
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

**Please state the actions you have taken or are planning to take:**
1. A comprehensive medication audit was conducted in the service on August 2015 by the Provider's Clinical & Educational Facilitator and an action plan implemented. (see attached Appendix 2)

Proposed Timescale: Completed

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**Proposed Timescale:** 27/10/2015

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Unused medications were not disposed of in accordance with relevant national legislation or professional guidance. A number of drugs were seen by inspectors in the yellow 'sharps' bin.

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

Please state the actions you have taken or are planning to take:
1. Issue around this poor practice has been addressed and all staff have been informed of how to correctly dispose of medication and the proper use of the bins provided.

Proposed Timescale: Completed

Proposed Timescale: 27/10/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre had not put in place appropriate and suitable practices relating to administration of medicines to ensure that medicine that was prescribed was administered as prescribed to the resident for whom it is prescribed and to no other resident.

Inspectors viewed medication errors which indicated that a resident had received the wrong medication, a significant medication had been omitted and not all staff had signed as to whether prescribed medication had been administered or not.

There was no staff signature sheet available with the signatures and initials of all staff.

33. 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:
1. A comprehensive medication audit was conducted and an in the service on August 2015 and an action plan implemented by the Provider's Clinical & Educational Facilitator. (See Appendix 2)

Proposed Timescale: completed

Proposed Timescale: 27/10/2015

Outcome 13: Statement of Purpose
Theme: Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain all items as listed in Schedule 1 of the Regulations.

34. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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:
The statement of purpose & function to be updated and resubmitted.

Proposed Timescale: 23/10/2015

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:
Inspectors findings indicated that the person in charge did not have the resources or authority to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

35. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
The Management Structure in the centre has been reviewed in light of the recent inspection. (See attached Appendix 3).

Proposed Timescale: 27/10/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had not put in place a clearly defined management structure in the designated centre that identified the lines of authority and accountability, specified roles, and detailed responsibilities for all areas of service provision.
36. **Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
1. The Management Structure at the registered provider has been reviewed in light of the recent inspection. (See attached Appendix 3).

**Proposed Timescale:** 27/10/2015
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider had failed to put management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

37. **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:**
1. The Management Structure at the registered provider has been reviewed in light of the recent inspection. (See Appendix 3).
2. The registered provider have established a team of auditors external to provider's services who will carry out bi-annual audits of all aspects of the service. This is in addition to the regular service checks which are carried out by the Regional Manager. (Quality & Compliance Task Force)

**Proposed Timescale:**
1. Completed
2. Implemented

**Proposed Timescale:** 27/10/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that the designated centre was not resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Some examples were, lack of meaningful and consistent activities, lack of staff, lack of transport, lack of appropriate training including mandatory training, lack of resources to install the required fire doors, to paint the external area and to relocate the kitchen to a more suitable area. The lack of resources for the kitchen and fire doors was discussed and confirmed by the provider and person in charge.

38. **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:**
1. The Community Integration Coordinator is now in post and has developed individual plans for each person who is in receipt of the registered provider’s service in relation to their recreation and social needs. Personal Plans have been updated to reflect this.
2. The Community Integration Coordinator is currently meeting with all of the residents and has developed a questionnaire to go through with the residents regarding the best use of the activity room. From this she will be compiling a list of activities that the residents would like to see taking place in this space.
3. Following the review of this information a plan shall be put in place in order to facilitate the needs of the residents which will include determining the number of support hours required to meet these needs and if the current roster and staffing levels can meet this need.
4. The activity room and garden area is currently available for use from Friday through to Sunday and will be vacated fully by the external agency on the 30th October 2015.
5. Each resident has access to transport. The transport is provided through a several options which include access to the registered provider’s transport, local transport companies or private wheelchair accessible taxi firms. All residents are encouraged to inform management if there are issues with their transport or there is a lack of transport so that alternatives can be explored.
6. The management structure has been reviewed in order to ensure that the service can meet all the needs within the service. (See Appendix 3)
7. The care needs assessment has been completed which identified that there is a requirement for more staff in the afternoons. The new roster has been updated to reflect this and the roster now has an additional staff from mid-morning to afternoon. This person is a floating staff and their start and finish times will depend on the needs of the residents and the activities they are participating in on a particular day.
8. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).
9. Maintenance Plan has been agreed.
10. Feasibility Study regarding re-location of the kitchen area has been actioned.
11. Review of major works needed underway and currently seeking quotes.
Proposed Timescale:
1. Completed
2. 15th November 2015
3. 30th November 2015
4. 30th October 2015
5. Completed
6. Completed
7. Completed
8. 30th November 2015
9. Completed
10. 1st November 2015
11. 1st December 2015

Proposed Timescale: 01/12/2015

Outcome 17: Workforce
Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors formed the view that the number, qualifications and skill mix of staff was not appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.
An immediate action plan was issued to the provider following the inspection.

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

Please state the actions you have taken or are planning to take:
1. The care needs assessment has been completed which identified that there is a requirement for more staff in the afternoons. The new roster has been updated to reflect this and the roster now has an additional staff from mid-morning to afternoon. This person is a floating staff and their start and finish times will depend on the needs of the residents and the activities they are participating in on a particular day.
2. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).
3. The Management Structure in the provider's centre has been reviewed in light of the recent inspection. (See attached Appendix 3)

Proposed Timescale:
1. Completed
2. 30th November 2015
3. Completed

### Proposed Timescale: 30/11/2015

**Theme:** Responsive Workforce

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

Staff did not have access to appropriate training, including training on de-escalation techniques, behaviour that challenges, communication, safe swallowing and first aid.

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

**Please state the actions you have taken or are planning to take:**
1. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).

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### Proposed Timescale: 30/11/2015

**Theme:** Responsive Workforce

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

Staff appraisals and supervision was not completed. Supervision of staff, post training was not adequate as there had been a large number of medication errors in the centre. Not all staff on night duty were trained appropriate to the needs of residents.

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

**Please state the actions you have taken or are planning to take:**
1. A decision was made on 29th July 2015 to increase the nursing hours in the service to 12 hours per day over 7 days. This increase and consistency in nursing presence in the service will have added benefits for the residents as it will ensure that the staff supporting them are well mentored and supported. Nursing staff will work alongside the care staff assessing their care delivery skills and knowledge, identifying training needs where required, supporting care staff in the planning and management of care, working alongside their colleagues in the multi-disciplinary team and improving practice through the audit and analysis of care delivery.
2. Training of Care Support Staff has also been reviewed to ensure all staff have the skills and knowledge to meet the needs of all the residents. This program of training
has commenced and will continue until all staff have received initial training or refresher training. (See attached Appendix 1).

3. An organisational performance management process has been established and will be rolled out to all care support workers in the service. (Quality & Compliance Task Force)

Proposed Timescale:
1. Completed
2. 30th November 2015
3. 31st December 2015

Proposed Timescale: 31/12/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all written operational policies as required by Schedule 5 were available in the centre.

42. **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:
The required policies will be developed and implemented.

Proposed Timescale: 30/11/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not contain all of the information as required by Schedule 3 of the Regulations.

43. **Action Required:**
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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:
The current register to be reviewed and updated to meet the regulatory requirement. (Quality & Compliance Task Force)

**Proposed Timescale:** 30/11/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff files did not contain all items as required by Schedule 2 of the Regulations.

44. **Action Required:**
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:**
Garda Vetting Process in place for all staff and volunteers

**Proposed Timescale:** 27/10/2015

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All records specified under Schedule three of the Regulations had not been maintained. For example, a log and records of restrictive procedures had not been maintained.

45. **Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
A Restraints Register was now commenced in October 2015 following this inspection, which contains a log of all restraints in use in the registered centre for each particular resident as required. The information from this log will be submitted to the Authority at the end of each quarter to indicate the restrictive procedures which have been implemented in the service in the previous three months. Only physical restraints are used in this service and each have been reviewed by the multidisciplinary team with the residents and their family representatives if applicable. The risks associated with these restraints have been explained to them along with the controls the provider have put in place in an attempt to reduce these risks to them and potential alternatives to these restraints. All residents or their family representative if applicable have provided consent for the registered provider to apply these restrictive measures where
necessary. The log will be reviewed on a three monthly basis prior to submission to the Authority. Each resident re-assessed on a six monthly basis unless there is a change in the residents’ circumstances whereby the use/applicability of the restraint will be reviewed immediately.

**Proposed Timescale:** 27/10/2015