**Health Information and Quality Authority**
**Regulation Directorate**

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

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

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|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0003999 |
| **Centre county:** | Cork |
| **Type of centre:** | The Health Service Executive |
| **Registered provider:** | Health Service Executive |
| **Provider Nominee:** | Angela O'Neill |
| **Lead inspector:** | Breeda Desmond |
| **Support inspector(s):** | Liam Strahan; Mary O'Mahony; Noelle Neville; Shane Grogan; Vincent Kearns |
| **Type of inspection** | Unannounced |
| **Number of residents on the date of inspection:** | 31 |
| **Number of vacancies on the date of inspection:** | 0 |

## About monitoring of compliance

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

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

| From: | To: |
|---|---|
| 25 August 2015 08:30 | 25 August 2015 19:00 |

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 14: Governance and Management |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

**Summary of findings from this inspection**

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

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

This inspection was an unannounced one day inspection. Significant risk and serious failings identified on previous inspections and failure to submit required notifications precipitated this inspection. As part of the inspection process inspectors met with residents, provider nominee, the person in charge (PIC), clinical nurse managers

(CNMs) and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, policies and procedures.

Overall inspectors continued to have significant concerns in relation to the level of serious failings in relation to the care and support of residents.

Previous inspections identified that governance and management arrangements were seriously inadequate. There had been no improvement in the governance and management since the previous inspection and the provider had not appointed a specific person in charge with sole responsibility for this centre. In addition, roles and responsibilities of persons participating in the management of the centre remained unclear, including deputising arrangements. Consequently, inspectors could not be assured that management systems were adequate to ensure that the service was safe, appropriate to residents' needs, was consistent or effectively monitored.

Work had commenced on refurbishment of the centre; bed screens and partial partitioning of bed spaces had occurred, however, bedroom accommodation remained dormitory-style large rooms which could not ensure privacy and dignity. External doors remained locked for all residents without adequate consultation or consent; communal space remained limited and there was inadequate space for residents to spend time alone should they wish to do so; there was inadequate space for residents to meet with visitors in private and limited suitable outdoor space available in one of the two units in the centre.

Residents continued to suffer injury due to frequent physical altercations between some residents. While some improvements were observed regarding care and interaction with residents, inspectors found that routines and practices continued to be institutional in nature and not person-centred. This was evidenced by the lack of interaction with residents when care or assistance was given, for example at meal times where staff talked amongst themselves while assisting residents with their meals or standing over residents while assisting them. Many of the restrictive practices had ceased since the last inspection, however, all exit doors were locked for all residents regardless of their ability and capacity.

Additional areas identified for improvement as a result of this inspection included:

- staffing levels
- programme of activities
- risk management practices
- fire safety arrangements
- staff training
- restrictive practices
- communication
- positive behavioural support plans
- links to the community
- register of residents.

The action plan at the end of the report identifies improvements necessary to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated

Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

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

**Theme:**
Individualised Supports and Care

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

**Findings:**
Refurbishment was in progress throughout the centre, however, most bed spaces remained part of large multi-occupancy dormitory-style rooms with nine and fourteen residents accommodated, so privacy and dignity could not be assured. Bed screening was now in place for many of the beds to enable privacy while personal care was delivered, however, not all beds had privacy screens. Due to the inadequate design and layout of the premises many residents with complex needs spent long periods sharing communal dormitory/day rooms.Inspectors observed that at times noise levels remained high in both units. It was reported to inspectors that some residents did not require much sleep at night time and would awake and shout, consequently, other residents would be disturbed and a good night's sleep could not be assured. One resident liked to turn on the lights regardless of whether other residents were sleeping and this was observed on inspection.

Previously, the complaint's procedure was not compliant with the Regulations whereby the nominated person responsible for overseeing complaints was not identified, this was now remedied and the CNM3 was named as the responsible person. However, a complaints procedure in an accessible format was not displayed for residents to assist them in making a complaint. The complaints log was reviewed in both units. The outcome of the complaints process and the satisfaction of the complainant was being recorded, as required by the regulations.

Recently, an advocate was appointed and details of the advocacy service were available on each unit. Two residents had accessed the independent advocate, however, it was difficult to determine the level of access all residents had to advocacy services.

Activities included art work and painting, music and massage. An activities person attended the centre twice a week for 1.5hrs both days for group work with the residents. A reflexologist attended the centre once a week. While some residents attended one of the activation centres on-site, other residents remained in their units with limited access to activities. Activation records of residents demonstrated that there was inconsistency regarding access to activation and on several days' residents appeared not to have been involved in any activities. It was reported to inspectors that a programme of activities for residents remaining in their units was envisaged, but this had yet to be rolled out. In addition, staff had not received training to enable them to develop or deliver a programme of activities relevant and appropriate to residents.

Because of the on going refurbishment of the centre, it was necessary to relocate residents from one unit to another, however, there was little evidence that this transition was done in a timely fashion or in consultation with residents. In addition, staff informed inspectors that there was inadequate consultation or communication prior to the move. For example, following the move it was reported to inspectors that staff both on day duty and night duty arrived at the wrong units for duty.

Inspectors observed that while there was some improvement regarding transition from a medical model of care of a social model, most staff interactions reflected a task-oriented model. For example, staff placed protective clothing on residents at meal time without conferring with residents; inspectors observed staff talking amongst themselves while assisting residents at meal times with no interaction with residents; another staff member was observed standing over a resident while assisting with their meal; staff were observed standing by the wall with their arms folded watching residents rather than sitting and interacting with residents. Nonetheless, one staff member was observed sitting with residents reading the newspaper to them and socially interacting.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Issues identified in the previous inspections remained unresolved. A number of residents had significant communication needs and many residents were non-verbal, some with a

hearing impairment. While staff members appeared to be aware of non-verbal cues from residents, from a sample of care plans viewed by inspectors, communication needs were not adequately highlighted or addressed. There were no records of staff training in communication with residents.

In addition, there was no evidence of the use of assistive technologies to support residents to communicate or to promote their full capabilities. Pictorial communication cards were not evidenced to enable residents participate in or make choices in their daily lives. External services to assist staff and residents regarding communication were not sought after.

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

**Findings:**
A sample of care documentation was inspected and there was documented evidence that residents and their next-of-kin were involved in the personal care planning meeting; this documentation reported person-centred information. However, personal care plans were not adequate, for example, goals were not identified for residents to achieve their wishes and aspirations recorded at the information gathering planning meeting; in addition, there was no action plan or supports put in place to enable and ensure residents could achieve quality of life or greater independence.

While care plans were evidenced for some identified care needs others were not in place, for example, one resident had a significant wound and there was no plan of care to inform appropriate dressing or frequency of review of the wound. A daily progress note was not in place for a resident on antibiotic treatment and wound care to inform staff of the resident's status, progress or response to treatment. Many of the documents were signed and dated, however, some were not.

While reviews were undertaken, however, there was no evidence that plans were assessed to determine their effectiveness; changes in residents' circumstances and developments were not recorded in plans of care.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

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

**Findings:**
Previous inspections identified that there were significant shortcomings in the design and layout of both units that directly impacted the quality of life of residents. The premises was an old hospital dating back to the 1800's and continued to largely reflect this era in it's design and layout. While some improvements were noted and refurbishment was on-going, the design and layout remained institutional in nature.

There were three units originally; one unit was closed for refurbishment. Remedial work on one unit was completed and this could accommodate 14 residents. Bed spaces here were configured as follows:

1) six single bays and two twin bays within a dormitory-style room and one hand wash basin
2) there was a twin bedded area off the dormitory which accommodated two single beds and furnishings.

Bed screens were in place around most of the bed spaces to enable privacy when personal care was delivered. There was a small quiet sitting room with comfortable seating and residents could meet their relatives here. Communal space comprised a large room with comfortable seating and two dining tables. The housekeeper’s room was secure, however, there were several bags of old clothes and other rubbish cluttering the floor and preventing adequate cleaning of the area.

Seventeen residents were accommodated in the second unit as follows:

- six single bays in a dormitory-style room

· three single rooms off the dormitory
· the annexe off the main dormitory comprised two single rooms, a quiet room, toilet and shower wet room. An unsecure store room housed chemicals and protective equipment (disposable gloves).

· six-bedded dormitory-style room and a single room off this room which was located across the courtyard from the main unit – six residents were accommodated here.
· there was a large communal room with comfortable seating and a large dining table and chairs.

The units were recently painted and some bedrooms had defined bed spaces, however, due to the dormitory style of the bedrooms and one communal room for sitting and dining, residents' freedom was significantly curtailed due to the design and layout. In addition, the exit doors were all locked preventing all residents from leaving the units regardless of their ability and capacity. In addition, entrances into both units opened directly into residents' sitting rooms/communal space.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
While incidents and accidents were being recorded, the records were not complete and were not being used to inform learning or improve safety. For example, while incident forms were completed in duplicate, with the copy being retained in the unit, the duplicate copy was often illegible and could not be used to inform learning in the unit. In addition, many of the forms were not being completed properly. For example, the section 'control measures taken or planned to reduce the likelihood or impact of recurrence' remained blank, consequently, learning from serious incidents or adverse events involving residents could not occur.

The lack of suitable review and oversight of incidents meant that there wasn't adequate assurances in relation to ensuring the safeguarding of residents or the prevention of such incidents recurring. A recent audit of incidents from May–July 2015 had been completed, however, an action plan with accountable responsibilities assigned and suitable preventive strategies had not been developed to mitigate recurrences.

Some proposed solutions in the audit referenced the behavioural strategy programme. However, many staff had not completed the training in positive behavioural support and they could not implement the necessary strategy programme. As staff had not completed training in positive behavioural support, the risk assessments associated with this could not be comprehensively completed and this was evidenced on inspection. In addition, there were recorded incidents of unexplained bruising that were not investigated to determine if a safeguarding strategy was necessary. (This is also discussed under Outcome 8 Safeguarding and Safety.)

There was inadequate risk assessment of the living environment. There was no evidence that the newly refurbished environment was risk assessed to identify any hazards for residents. For example, the emergency call bell in one dormitory was positioned so high over a resident's bed, it would be difficult for many staff to reach; furniture had been placed in bed areas without consultation with residents or staff to ensure that it was not partially obstructing access to the bed area.

As found on previous inspections, fire safety training records demonstrated that all staff had not completed their mandatory fire safety training. This was a particularly significant failing given that residents and staff had recently moved to a different part of the premises and fire drills had not been completed since moving.

The policy regarding self-harm was not available on one unit; the HSE policy on physical restraint for disability centres had not been reviewed since 2010 and was out-of-date .

There were inadequate infection control measures in place. Some hand hygiene was observed but several opportunities for hand hygiene were not performed, in line with best practice guidelines; occasionally disposable gloves were not changed between tasks. One staff member wore a plastic disposable apron but did not wear it appropriate to ensure their clothing was covered.

Some pillows were unclean and one pillow did not have a protective pillow case. While laundry was segregated at source, one staff member was observed taking unclean laundry from one bag to another without wearing gloves and did not wash their hands subsequently. There was foam wrapped around the bed end of one residents' bed to protect him from hurting his legs. However, this arrangement was unsuitable as the partially wrapped bed end was covered in cling film and secured with twine; this was not assessed for health or safety.

Sash windows were not risk assessed to ensure safety of residents. One resident was observed to stand up on a chair, open the sash window and lean out the window for fresh air.

Residents have access to transport, however, it was reported to inspectors that the safety harness to secure the wheelchair was broken for some time, consequently residents requiring wheelchair mobility could not be facilitated to be taken out.

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

**Findings:**
As found on all previous inspections all staff had not received training regarding behaviours that challenge, the antecedents to challenging behaviours, or responses and appropriate interventions to such behaviours; this was especially relevant as many residents had positive behavioural support plans which described the necessary staff actions in terms of this training. The positive behavioural support assessment plan reviewed for one resident reported that the resident had behaviours that challenge which was described as 'inappropriate behaviour'. However, a plan to ensure the safety, dignity and privacy of the individual was not in place; there was no evidence to suggest that this resident was supported to manage their behaviour as required in the Regulations. Another residents' behavioural risk assessment was last completed in November 2011.

Some residents had the 'positive behavioural support service – behaviour risk assessment' form as part of their documentation, however, this was not comprehensively completed, for example, 'contributory factors' remained blank. Consequently, there could be no learning to inform staff regarding future episodes of behaviours that challenge. As many staff had not completed training in positive behavioural support, they could not implement the directions described in the support plans and could not complete the positive behavioural support risk assessments.

In addition, all staff had not received training in adult protection. This was highlighted in all previous inspections. Inspectors observed two incidents of peer-on-peer assault, a resident with significant behaviours that challenge, and some residents shouting and becoming increasingly animated. However, in all three incidents observed, inspectors noted that there was little or no staff intervention to prevent, support or de-escalate these behaviours.

Following review of the incident and accident logs over the three month period of May - August 2015 for this centre the following incidents were identified:
- 30 incidents of peer-on-peer hits/slaps/kicking/punching

- 7 incidents of unexplained bruising/scratches
- 20 of these recorded incidents were perpetrated by two residents
- 24 other incidents of concern.

However, an effective monitoring and management system to effectively respond, trend or analyse such data and to ensure that residents were safeguarded within the service was not in place.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

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

**Findings:**
Residents had timely reviews by the GP and psychiatrist. Residents' notes demonstrated that they had access to speech and language therapy; dental, vision and hearing assessments were evidenced. From records reviewed, inspectors noted that there was limited access to the physiotherapist the occupational therapist. There was evidence that recommendations for further reviews by the physiotherapist in relation to the management of falls were not being facilitated.

Clinical risk assessments were in place for example, falls risk assessment, pressure and skin integrity, nutritional assessment, however, many of these were not completed comprehensively or occasionally completed inappropriately, for example, one resident's falls risk assessment had scores recorded, but the scores remained unchanged regardless of changing conditions. Assessments did not give an accurate reflection of the mobility of residents or the need for aids to mobilise. Similarly, the medical history of records reviewed did not provide sufficient evidence in relation to the illnesses or conditions of residents. Medical reviews were not being conducted regularly for residents with medical conditions.

**Judgment:**
Non Compliant - Moderate

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

*medication management.*

**Theme:**
Health and Development

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

**Findings:**
Medication management was reviewed on both units. Medication trolleys were securely maintained with the nurses' station. However, inspectors noted on the medication trolley in one unit there were six foil wrapped tablets (anti-psychotic medication) without resident details, in addition, this medication was not prescribed for any resident on this unit; staff on the unit were unable to explain the presence of these medications. The person in charge was requested to investigate this issue.

While the rationale for non-administration of medications was recorded, it was not signed by the nurse, in line with professional best practice guidelines.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Previous inspections identified that governance and management arrangements were seriously inadequate to ensure a service that was safe, appropriate to the assessed needs of residents or was effectively monitored. This remained unchanged even though the provider was requested to appoint a person in charge with sole responsibility for this centre, however, this had not occurred. The person in charge described significant and serious concerns in relation to her capacity to fulfil her role as required by Regulation. This lack of capacity had been identified on each of the previous inspections, however,

this serious failing remained unresolved. In addition, roles and responsibilities of persons participating in the management of the centre remained unclear, including deputising arrangements. Consequently, inspectors could not be assured that management systems in place were adequate to ensure that the service was safe, appropriate to residents' needs, was consistent or effectively monitored.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Responsive Workforce

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

**Findings:**
While there was some improvement in staffing levels since the previous inspection, the induction process for new staff was wholly inadequate to ensure the safety of staff and residents. Staff rotas on both units did not reflect the staff on duty. As previously described in this report, staff had not received training to enable them to fulfil their roles, such as the development and implementation of a programme of activities relevant and meaningful to residents who remained in the centre during the day.

Staff training matrix was reviewed on inspection and it was not possible to determine staff training needs or if mandatory training was in date for all staff. There was no evidence that staff professional development was a priority to ensure the safety and welfare of residents or to enable staff to deliver up-to-date research-based care.

Staff files remained non-compliant; items missing included photographic identification, dates when employment commenced, full employment history, two written references and one staff member did not have any employment details available in the centre.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Use of Information

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

**Findings:**
The register of residents was wholly inadequate and did not contain most of the requirements listed in the Regulations.

**Judgment:**
Non Compliant - Moderate

## Closing the Visit

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

**Acknowledgements**

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

***Report Compiled by:***

Breeda Desmond
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

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

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | A designated centre for people with disabilities operated by Health Service Executive |
| **Centre ID:** | OSV-0003999 |
| **Date of Inspection:** | 25 August 2015 |
| **Date of response:** | 28 September 2015 |

## Requirements

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

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

## Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Because of the on-going refurbishment of the centre, it was necessary to relocate residents from one unit to another, however, there was little evidence that this transition was done in a timely fashion or in consultation with residents.

**1. Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
•Transition meetings are currently taking place prior to the next move which will occur in approximately 3 weeks' time (i.e. early October 2015).
•Transition plans will be in place for all residents which will take into account factors to be considered prior to and following the proposed unit moves.
•Residents and their next of kin/family members will be informed of the move and consulted in relation to their opinions regarding this move prior to it occurring.
•All unit transfers will be evaluated post-transfer to ensure that the placements are successful and any issues arising will be dealt with in a timely manner.

**Proposed Timescale:** 31/10/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents had accessed the independent advocate, however, it was difficult to determine the degree of access all residents had to advocacy services.

**2. Action Required:**
Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

**Please state the actions you have taken or are planning to take:**
•Residents will be informed of the availability of an advocacy service. Information will be available on each of the units and easy-read information regarding this service will be put up on notice boards in the units.
•Letters will be sent out to the family members of all residents to ensure that they have information with regard to accessing an independent advocate for their family member if they so wish to engage one.
•Staff will support residents to access advocacy where appropriate.

**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:**
While bed screening was now in place for many of the beds to enable privacy while personal care was delivered, not all beds had privacy screens.

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

consultations and personal information.

**Please state the actions you have taken or are planning to take:**
All beds have screens in place as of 26th August 2015.

**Proposed Timescale:** 26/08/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some residents did not require much sleep at night time and would often be awake and shouting, consequently, other residents would be disturbed and a good night's sleep could not be assured. One resident liked to turn on the lights regardless of whether other residents were sleeping and this was observed on inspection.

**4. 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:**
•The third unit will be opened in approximately three weeks (i.e. early October 2015). All units in the centre will then have been refurbished and will have fewer residents. These refurbishments will allow increased space for residents and improved privacy. Sound dampening measures will reduce noise levels in the units.
•Transition meetings have commenced on appropriate resident placement within these units.
•This placement will consider the needs of the residents being accommodated in each unit, including sleeping patterns and preferences, with a view to alleviating, where possible, disturbance to other residents at night.
Note: It remains the plan that this centre will close and all residents will move to more appropriate accommodation.

**Proposed Timescale:**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Most staff interactions reflected a task-oriented model for example, staff placed protective clothing on residents at meal time without conferring with residents; inspectors observed staff talking amongst themselves while assisting residents at meal times with no interaction with the resident; another staff member was observed standing over a resident while assisting with their meal; staff were observed standing by the wall watching residents rather than sitting and interacting with residents.

**5. Action Required:**
Under Regulation 09 (1) you are required to: Ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

**Please state the actions you have taken or are planning to take:**
•Discussions will be held with all staff members regarding their interactions with residents throughout their activities of daily living.
•Discussions will be held with all staff members specifically with regard to interactions with residents at mealtimes. The need to interact and engage residents at mealtimes will be highlighted to staff.
•Communication Training for all staff will commence in October/November 2015 with an emphasis on non verbal communication strategies, use of visual cues and an introduction to the PECS (picture exchange) method of communication.
•The Speech & Language Therapist will engage with staff to promote positive interactions at all times. There will also be a focus on optimal posture and seating, appropriate consistencies and pacing while assisting at mealtimes.
•Staff nurses will model appropriate behaviour/interaction with residents to promote engagement in all activities of daily living.
•Residents will be consulted about their preferences including in relation to the use of protective clothing at mealtimes.

Residents are being grouped in smaller numbers when they move to refurbished existing accommodation. This will allow for care to be delivered in a more person-centred manner.
Note: It remains the plan for this service to close and transfer residents to alternative accommodation. As part of the overall closure plan residents will be facilitated to move to alternative placements. It is anticipated that some residents will move to alternative service providers. The de-congregation of residents within this service will facilitate the provision of an alternative model of care. As the numbers of residents in each area is reduced, this will allow for care to be delivered in a more person-centred manner.

**Proposed Timescale:** 31/01/2016
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While some residents attended one of the activation centres on-site, other residents remained in their units with limited access to activities. Activation records of residents demonstrated that there was inconsistency regarding access to activation and several days' residents appeared not to have been involved in any activities.

**6. 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:**
•Keyworkers will assess residents' likes/dislikes with a view to implementing further activities on the units and to evaluate these activities for effectiveness.
•These activities will be compatible with the goals, aspirations and wishes of the residents.
•Activity staff from the day services will visit the units to support unit staff in the implementation of activities and in identifying alternative activities which will increase the opportunities for all residents.
•All involvement by residents in activities will be documented in residents' files, where applicable.

**Proposed Timescale:** 31/01/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure was not in an accessible format for residents.

**7. Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
An accessible format of the complaints procedure is now available on notice boards in the units.

**Proposed Timescale:** 28/09/2015

**Outcome 02: Communication**

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While staff members appeared to be aware of non-verbal cues from residents, from a sample of care plans viewed by inspectors, communication needs were not adequately highlighted or addressed.

**8. 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:**

The recruitment of a speech & language therapist with the necessary skills to work in this area has taken some time. A therapist has now been recruited on a part-time basis to assess each resident's communication skills where appropriate. Visual schedules will be created for use on the units to detail daily events, staff on duty and meal choices. It will take a number of months for this therapist to undertake comprehensive and appropriate assessments. This will include observation of the resident in their environment, assessment of the resident's verbal and non-verbal communication skills and completion of communication checklists by staff and family members in respect of each resident.
In the interim Communication Training for all staff will commence in October/November 2015 and additional courses are being planned for January 2016. The emphasis of this training will be on non verbal communication strategies, use of visual cues and an introduction to the PECS (Picture Exchange Communication System) method of communication. This training will facilitate staff to support residents' communication while awaiting a full SLT assessment.

**Proposed Timescale:** 28/02/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were no records of staff training in communication with residents and many residents had significant communication needs.

**9. 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:**
The recruitment of a speech & language therapist with the necessary skills to work in this area has taken some time. A therapist has now been recruited on a part-time basis to assess each resident's communication skills, where appropriate. Training will be arranged in consultation with the SLT on effective communication strategies. Communication Training for all staff will commence in October/November 2015 and additional courses are being planned for January 2016. The emphasis of this training will be on non verbal communication strategies, use of visual cues and an introduction to the PECS (Picture Exchange Communication System) method of communication. It is anticipated that the majority of staff will attend this training in October / November.

**Proposed Timescale:** 31/01/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of the use of assistive technologies to support residents to

communicate or to promote their full capabilities.

Pictorial communication cards were not evidenced to enable residents participate in or make choices in their daily lives.

External services to assist staff and residents regarding communication were not accessed.

**10. Action Required:**
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

**Please state the actions you have taken or are planning to take:**
•A Speech and Language Therapist has been recruited on a part-time basis and will be engaged to assess residents' communication needs and provide advice and training to staff in relation to this area.
•A trial with an assistive technology device has taken place with one resident in consultation with the Occupational Therapist.
•A trial using the Picture Exchange Communication System (PECS) will be commenced with another resident who has demonstrated a readiness to utilise this approach, in consultation with the SLT.
•Residents will be facilitated to access SLT as appropriate immediately. However, it will take a number of months for the therapist to undertake comprehensive assessments and where necessary trial augmentative systems including PECS, communication charts, assistive technology etc. A period of intervention by the SLT will then be required to support residents to use these systems effectively.

**Proposed Timescale:** 28/02/2016

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Goals were not identified for residents to achieve their wishes and aspirations recorded at the information gathering planning meeting; in addition, there was no action plan or supports put in place to enable and ensure residents could achieve quality of life or greater independence.

**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:**
•Keyworkers will assess residents' likes/dislikes with a view to updating care plans.
•A staff member with PCP training will be engaged to coordinate the creation of PCPs in

collaboration with other staff members to ensure that the goals and aspirations of all residents are recorded.
•Supports to ensure residents achieve greater independence will also be identified by the staff teams.

**Proposed Timescale:** 31/12/2015
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While reviews were undertaken, there was no evidence that plans were assessed to determine their effectiveness; changes in residents' circumstances and developments were not recorded in plans of care reviewed.

**12. Action Required:**
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

**Please state the actions you have taken or are planning to take:**
•Keyworkers will audit care plans for evaluation of effectiveness of care plans and actions in place.
•Plans will be updated as the residents' needs or circumstances change.

**Proposed Timescale:** 31/01/2016
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Smoking risk assessment were completed, however, the assessment of the resident's capacity to make decisions could not be reconciled with the hazards/risks identified for this resident.

**13. Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
The smoking risk assessment for the identified resident has been updated to reflect his capacity.

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Clinical risk assessment were in place for example, falls risk assessment, pressure and skin integrity, nutritional assessment, however, many of these were not completed comprehensively or occasionally completed inappropriately, for example, one resident's falls risk assessment had scores recorded, but as the scores were the same regardless of the condition, the reader could not determine if the resident was fully mobile, used aids to mobilise, had restrictive mobility as none of these were highlighted. Similarly, it could not be determined if the resident had diabetes, organic brain disease/confusion, or was unable to co-operate as none of these were highlighted in the medical history. The second part of this risk assessment was not completed at any review since 23/01/14.

**14. Action Required:**
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
•Keyworkers to audit all care plans with a view to updating any assessments that require this.
•Falls risk assessment and manual handling assessment forms to be reviewed and updated, as required.
•Staff to be briefed on process for completion of forms.

**Proposed Timescale:** 31/01/2016

**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 design and layout of the centre did not meet the aims and objectives of the service and the number and needs of residents.

**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:**
•A third unit is opening in approximately early October 2015 which will house fewer residents per unit.
•This third unit will enhance space available to residents and afford greater

opportunities to meet the assessed needs of the residents.
Note: It remains the plan that this centre will close and all residents will move to more appropriate accommodation.

**Proposed Timescale:** 31/10/2015

**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:**
Sash windows were not risk assessed to ensure safety of residents.

One unsecure store room alongside the twin accommodation contained cleaning solutions.

**16. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
•A risk assessment has been carried out in consultation with the estates department, in relation to sash window safety for residents.
•Cleaning solutions have been removed and door locked of storeroom alongside the twin accommodation.
•The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including risks, incidents, complaints or any other significant issues that occurred in the previous week.
•The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any identified risks, incidents, staffing issues or complaints that have occurred.
•The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of risks, incidents, safeguarding, staffing and other operational issues that may arise.
•The registered provider will attend these meetings monthly. This meeting will include a review of all red risks, serious reportable events and HIQA notifications.
•Anything highlighted as a red risk will be flagged to senior HSE management

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While residents have access to transport, it was reported to inspectors that the safety harness to secure the wheelchair was broken for some time, consequently residents requiring wheelchair mobility could not be facilitated to be taken out.

**17. Action Required:**
Under Regulation 26 (3) you are required to: Ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.

**Please state the actions you have taken or are planning to take:**
•Wheelchair harness will be repaired / replaced as appropriate by 31st October 2015. (This requires specialist equipment and will mean that the vehicle is unavailable to the centre for a number of days.) In the interim residents will be supported to access a wheelchair accessible taxi in the town.
•Additional transport will be available following the closure of another facility in December.
Repair - October 31st 2015
Additional Vehicle - December 31st 2015

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy regarding self-harm was not available on one unit; the HSE policy on physical restraint for disability centres had not been reviewed since 2010 and was out of date.

**18. 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:**
•Policy currently in place in relation to self harm is found in the Positive Behaviour Support policy (February 2015) which includes a self injurious behaviour protocol. This will be made available on all units.
•The policy that contains protocol on the use of physical restraint is in the Prevention of /Use of Restrictive Interventions (2015) which is available on the unit.

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that the new environment was risk assessed to ensure the staff could safeguard residents.

**19. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
•The new environment has now been risk assessed.
•Hazards have been identified and relevant departments notified where changes are required.

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was foam wrapped around the bed end of one residents' bed to protect him from hurting his legs, however, this was partially wrapped in cling film and secured with twine; this was not assessed for health or safety.

**20. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
•An Occupational Therapist has been consulted and an alternative protection is being created for this resident.
•The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including risks, incidents, complaints or any other significant issues that occurred in the previous week.
•The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any identified risks, incidents, staffing issues or complaints that have occurred.
•The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of risks, incidents, safeguarding, staffing and other operational issues that may arise.

•The registered provider will attend these meetings monthly. This meeting will include a review of all red risks, serious reportable events and HIQA notifications.
•Anything highlighted as a red risk will be flagged to senior HSE management.

**Proposed Timescale:** 31/10/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some incident forms were not being completed properly

**21. Action Required:**
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

**Please state the actions you have taken or are planning to take:**
•Staff will be briefed on accurate completion of incident forms.
•The PIC will meet with the CNM for this centre and other relevant staff on a weekly basis. The agenda for this meeting will include a review of all operational issues, including risks, incidents, complaints or any other significant issues that occurred in the previous week.
•The PIC/ADON will have at least daily face-to-face contact with the CNM in the centre to discuss operational issues including any identified risks, incidents, staffing issues or complaints that have occurred.
•The PICs for all of the designated centres in this area will meet with the Acting DON weekly. (The Acting DON is currently PIC for 2 centres. This will change when a further CNM3 is recruited.) The CMN3 rosters will be reviewed to facilitate this weekly meeting. This group will meet with the CNS on a weekly basis. The agenda for this meeting will also include a review of risks, incidents, safeguarding, staffing and other operational issues that may arise.
•The registered provider will attend these meetings monthly. This meeting will include a review of all red risks, serious reportable events and HIQA notifications.
•Anything highlighted as a red risk will be flagged to senior HSE management.

**Proposed Timescale:** 31/10/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some hand hygiene was observed but several opportunities for hand hygiene were not performed, in line with best practice guidelines; occasionally disposable gloves were not changed between tasks.

One staff member wore a plastic disposable apron but did not wear it appropriate to

ensure their clothing was covered.

**22. 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:**
•Staff have all been briefed in relation to proper use of PPE.
•Infection Control Nurse has begun working in this unit and will continue education and training sessions for staff on the unit in relation to infection control management.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some pillows were unclean and one pillow did not have a protective pillow case.

While laundry was segregated at source, one staff member was observed taking unclean laundry from one bag to another without wearing gloves and did not wash their hands subsequently.

**23. 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:**
•All Pillows have a protective cover; however, some residents remove this at times.
•Soiled pillows have been disposed of.
•Staff in units have been briefed in relation to proper use of PPE.
•Infection Control Nurse has begun working in the unit and will continue education and training sessions for staff on the unit in relation to infection control management.

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

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire safety training records demonstrated that all staff had not completed their mandatory fire safety training.

Given that residents and staff had recently moved to a different part of the premises fire drills had not been completed since moving.

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

**Please state the actions you have taken or are planning to take:**
•List of staff who have not received recent fire safety training is being compiled with a view to training being organised as soon as possible.
•Fire officer has been contacted in relation to fire drills and training to be completed as soon as possible.

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

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff had not received training regarding behaviours that challenge, the antecedents to challenging behaviours, or responses and appropriate interventions to such behaviours; this was especially relevant as many residents had positive behavioural support plans which described the necessary staff actions in terms of this training.

**25. 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:**
•Staff training in positive behaviour support will be arranged with an external consultant.
•In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

**Proposed Timescale:** 31/01/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed two incidents of peer-on-peer assault, and a resident with significant challenging behaviour shouting and becoming increasingly animated,

however, in all three incidents observed, there was little or no staff intervention to prevent or de-escalate behaviours.

**26. Action Required:**
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

**Please state the actions you have taken or are planning to take:**
•Staff training in positive behaviour support will be arranged with an external consultant.
•In the interim the CNS (Positive Behaviour Support Specialist) will continue to work with staff in all units to facilitate the identification of triggers and techniques for de-escalation.

**Proposed Timescale:** 31/01/2016

**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 training in adult protection.

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

**Please state the actions you have taken or are planning to take:**
Training in the Safeguarding of Vulnerable Adults will be delivered in the unit for both existing and new staff to attend.

**Proposed Timescale:** 31/12/2015

## 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:**
Recommendations for review by health professionals such as physiotherapists were not being implemented.

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

arrangement with the Executive.

**Please state the actions you have taken or are planning to take:**
•A further physiotherapy appointment has been made for this resident
•Access to multidisciplinary supports is now available for all residents as appropriate.

**Proposed Timescale:** 28/09/2015

**Outcome 12. Medication Management**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
On the medication trolley in one unit there were six tablets (anti-psychotic medication) without resident details, in addition, this medication was not prescribed for any resident on this unit; staff on the unit were unable to explain the presence of these medications.

**29. 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:**
•An investigation has taken place in relation to the documented medication discrepancy.
•The medication has been transferred back to the pharmacy.
•An email with full details in relation to this was sent to HIQA on 8-9-2015.
•A weekly medication audit will be carried out on units to ensure compliance with best practice for medication management.

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

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While the rationale for non-administration of medications was recorded, it was not signed by the nurse, in line with professional best practice guidelines.

**30. 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:**

•Staff nurses on the units have been briefed about this issue and this has been rectified.
•All medication will be signed for whether administered or withheld in line with medication management policy.

**Proposed Timescale:** 28/09/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Previous inspections identified that governance and management arrangements were inadequate to ensure a service that was safe, appropriate to the assessed needs of residents or was effectively monitored, and this remained unchanged. The provider had not appointed a person in charge with sole responsibility for this centre.

**31. Action Required:**
Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

**Please state the actions you have taken or are planning to take:**
A Person in Charge has been appointed for the centre. Relevant paperwork is to be submitted to HIQA.

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

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Roles and responsibilities of persons participating in the management of the centre remained unclear, including deputising arrangements.

**32. 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:**
•A PIC at CNM3 level has been appointed for this centre. The PIC is supported by nursing staff, including CNM2, CNM1 and staff nurses; agency specials, care assistants and housekeeping staff. The PIC receives support and input from the CNS in Positive Behaviour Support. The PIC reports directly to the Director of Nursing for the centre. The DON reports to the Provider Nominee, who in turn reports to the Chief Officer.

•Discussions with staff at CNM2 and CNM1 level have highlighted the need for day to day operational issues to be addressed at that level. This will allow the CNM3 to focus on the PIC responsibilities.
•Team meetings are held between all staff members at unit level. The PIC and CNM will have daily face-to-face contact to discuss any operational issues/incidents that have occurred. A weekly unit management meeting is held between the PIC and the CNM2. A weekly Managers' meeting is held with the Director of Nursing and PICs for each of the units in the centre. A Management Governance Group meeting is held monthly which comprises the Provider Nominee, Director of Nursing, Administrator and Persons in Charge for all units in the centre.
•Items discussed at these meetings include, and are not limited to, safeguarding of residents, review of Serious Reportable Events, HIQA notifications, risk management and Quality Improvement.

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

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Because roles and responsibilities of persons participating in the management of the centre remained unclear, including deputising arrangements, inspectors could not be assured that management systems in place were adequate to ensure that the service was safe, appropriate to residents' needs, was consistent or effectively monitored.

**33. Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
A Person in Charge has been appointed for the centre. Relevant paperwork is to be submitted to HIQA.
The identification of two additional PICs for other centres in the area will facilitate a system of cross cover. The structure of regular meetings at unit level will facilitate the mentoring & development of staff at CNM2 level so that over time they will be able to cover for the PIC.

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

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff rotas on both units did not reflect the staff on duty.

**34. Action Required:**
Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

**Please state the actions you have taken or are planning to take:**
•Staff rotas to be managed by CNM2s who are in charge of areas to ensure more accurate rostering.
•A sign in sheet will be used on all units to facilitate updating of staff schedules and to ensure accuracy for fire safety purposes.

**Proposed Timescale:** 01/10/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff files remained non-compliant; items missing included photographic identification, dates when employment commenced, full employment history, two written references and one staff member did not have any details available in the centre.

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

**Please state the actions you have taken or are planning to take:**
Staff files that were non compliant are being updated in line with regulation.

**Proposed Timescale:** 31/10/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The induction process for new staff was wholly inadequate to ensure the safety of staff and residents.

**36. 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:**
Induction package will be updated to ensure that all new staff are aware of relevant policies and procedures and have been briefed in relation to all residents' profiles.

**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 were not trained to develop or implement a programme of activities relevant and meaningful to residents who remained in the centre.
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**37. 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:**
•Keyworkers will assess residents' likes/dislikes with a view to implementing further activities on the units and to evaluate these activities for effectiveness.
•These activities will be compatible with the goals, aspirations and wishes of residents.
•Activity staff from the day services will visit the units to support unit staff in the implementation of activities and in identifying alternative activities which will increase the opportunities for all residents.

**Proposed Timescale:** 31/01/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff training matrix was reviewed on inspection and it was not possible to determine staff training needs or if mandatory training was in date for all staff.

**38. 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:**
Staff training matrix has been updated.

**Proposed Timescale:** 28/09/2015

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that staff professional development was a priority to ensure the

safety and welfare of residents or to enable staff to deliver up-to-date research-based care.

**39. 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:**
The process of staff recruitment is on-going. The recruitment of additional staff will facilitate the release of staff to attend training as required.

**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:**
The register of residents was wholly inadequate and did not contain most of the requirements listed in the Regulations.

**40. 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:**
Directory of residents in place

**Proposed Timescale:** 28/09/2015