Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005160
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd.
Provider Nominee:	Breda Noonan
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	3
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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 October 2015 10:00	05 October 2015 16:00
06 October 2015 09:30	06 October 2015 16:30

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

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

Summary of findings from this inspection

This report sets out the findings of an announced inspection of St. Anne's Residential Services Group O following an application by the provider to register the centre.

This inspection is also informed by a previous inspection that took place on 19 December 2014. The previous inspection was carried out in response to unsolicited information received by the Health Information and Quality Authority (the Authority) on 17 December 2014 and related to allegations of poor practice in a number of centres, including this centre. The inspection type was a triggered 'single-issue' inspection relating to safeguarding and safety and also reviewed aspects of

outcomes relevant to health and safety, governance and training. Inspectors did not find any evidence either on this inspection or the previous inspection that the allegations of poor practice as specified in the anonymous complaint were currently being practiced in this designated centre.

The centre comprises one single-level house and can accommodate 3 residents. The statement of purpose for the centre states that it can provide support to residents with behaviours that may challenge.

As part of the inspection, inspectors met with residents who were in the centre, relatives, staff on-duty the clinical nurse manager and provider nominee. Inspectors also reviewed relevant documentation included personal plans, activity timetables, communication information and documentation pertaining to restrictive practices and behaviours that challenge.

Relatives told inspectors that they were very happy with the service and support being provided to their loved one. Relatives confirmed that staff and management were approachable, kept them informed of any changes and that they would have no hesitation raising any concerns. Relatives described the progress their loved one had made since coming to live in the centre in terms of improved quality of life, for example, the use of restrictive practices had dramatically been reduced.

Since the previous inspection, a new person in charge had commenced in the centre. In addition, a new house manager had commenced in the centre three weeks prior to the inspection. Progress had been made in relation to a number of key areas. There was evidence that residents were consulted with in a meaningful way. Residents were supported to communicate their likes and dislikes, daily routine and residents' independence was maximised. Residents were part of the community in a meaningful way. Staff interactions with residents were observed to be warm and appropriate. Staff demonstrated a positive approach to behaviour that challenges.

However, a high level of non-compliance was identified at this inspection with 8 of 18 outcomes at the level of major non-compliance. The rights and safety of residents were not protected in a satisfactory way. Inspectors found that the mix of residents in the centre did not ensure that all residents were protected from injury and harm by their peers; It was evidenced that individual residents did not feel safe in the centre; Due to the level of risk identified and the impact on individual residents, the provider was required to take immediate action and submit a plan to the Authority as to how the situation would be resolved. The provider responded in an appropriate manner within the agreed timescale to mitigate the immediate risk and seek a solution within a reasonable timeframe.

Major non-compliances were also identified in relation to health and safety, the admissions process, the suitability of the centre to meet the assessed needs of residents, the design and layout of the centre and the submission of statutory notifications. It was not demonstrated that the admissions process adequately considered the needs of the individual and the safety of other residents currently living in the centre. Where residents had mobility needs, the design and layout of the premises did not meet those needs. The Authority had not been notified of all

restrictive practices on a quarterly basis, as required.

The Authority did not agree the action plan with the provider despite affording the provider the opportunity to submit a satisfactory response. The provider's response to Regulations 9(2)(c), 9(3), 5(3), 17(7), 17(6), 28(3)(a) and 8(2) under Outcomes 1, 5, 6, 7 and 8 respectively were not accepted as they did not satisfactorily address the failings identified.

Other non-compliances were also identified in relation to staff training on this, as on the previous inspection. In addition, the frequency and level of incidents of behaviours that challenge indicated that specialist behaviour support to the staff team was insufficient.

Actions required by the provider to address these risks are outlined in the action plan at the end of this report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors saw that the many practices within the centre endeavoured to respect residents' rights, privacy and dignity. There was evidence of effective consultation with residents. However, high levels of challenging behaviour in the centre impacted on other resident's rights to live in a safe environment. Inspectors found this failing to be at the level of major non-compliance.

Residents were consulted about how the centre is planned and run. Recent changes had been made to such meetings to ensure that they were held at times when all residents could attend. An inspector reviewed the meeting minutes and found that they were very meaningful and promoted resident's independence as minutes were taken by a resident living in the centre. Items discussed included planning the menu and activities for the week and whether there were any social events that residents would like to attend. It was demonstrated that issues arising at residents' meetings were followed up on by staff.

A resident had expressed at a residents' meeting that s/he was not happy living in the centre due to behaviours that challenge in the centre. Minutes reflected the impact of such challenging behaviour incidents on that resident, including that it made him/her feel "sad, terrible and afraid". The provider demonstrated that the organisation had responded to this report and a referral had been made to the relevant committees that consider such concern and welfare issues. However, this had been identified by the resident in his/her personal plan for 2014 as a key priority and so had been identified as an issue for a considerable period of time. This is further discussed under Outcome 8, safeguarding and safety.

Inspectors observed that a monitoring (listening) device was in use in the centre for one resident. A rationale was provided for this practice by the person in charge and house manger. However, given the impact of such listening devices on an individual's right to privacy, it was not demonstrated that the necessity and/or the frequency of the practice had been considered by the resident's multidisciplinary team (MDT) or that it was necessary given the fact that there was a 'waking' night-time staff member on duty every night.

Inspectors were informed that one resident was a ward of court. However, there was no documentation available in the centre in relation to the wardship and in particular whether it extended to the resident’s personal care or if it was confined to the financial affairs of the resident. There was evidence that any financial decisions made by the resident were being approved through the office of the wards of court.

Residents all had their own bedroom with personal items of furniture, lamps and pictures of family. However, an inventory of each resident’s personal possessions was not being kept up to date which meant that residents could not be guaranteed they retained control of their own personal property. For example, one resident had purchased a car and this was not included in their list of personal possessions.

Each resident had their day to day expenses accounted for in a separate log and two staff members were signing for each item purchased by and for each resident. Inspectors were informed that following a recent audit of residents’ receipts and day to day expenses one resident had been refunded €649.10 in relation to the buying of petrol for the house car and bed linen and lamps. The purchase of these items had not been in line with the St Anne’s policy on residents’ private property which outlined that the “service is obliged to provide a certain standard of basic equipment and furnishings”. Inspectors were informed that all resident’s financial records had been audited for 2014 and 2015 and these were the only errors that had been identified. In order to ensure errors would not occur in the future the house manager had introduced a new system of keeping receipts for each month. She was also going to audit each day to day expense account each month.

Each resident had a bank account and current up to date records were kept on file in relation to the account of each resident. Inspectors met with the family of one resident who said that they were kept up to date with financial spending every month.

Staff were observed to promote residents' privacy at all times. Inspectors observed that information relating to residents was communicated in private. Each resident had their own bedroom. Appropriate privacy locks were fitted on the bathroom door used by residents for personal care. However, there was one bathroom in the centre for three residents and due to the gender mix of residents in the centre, all residents were not happy sharing a bathroom. This was documented in residents' meetings and in that resident's personal plan and confirmed by a resident. In addition, the bathroom was limited in space. As a result, it did not provide sufficient space to enable staff to assist residents to change in that room where necessary or to meet individual resident's needs. While staff described how they endeavoured to maintain the privacy and dignity of residents in this situation, the current configuration of bathroom facilities did not fully

promote the privacy and dignity of all residents. This will also be further discussed under Outcome 6, safe and suitable premises.

Staff interaction with residents was observed and inspectors noted staff promoted residents' dignity and maximised their independence, while also being respectful when providing assistance. Information relating to rights, consent, advocacy and communication was seen to be available in an easy read and accessible format.

Inspectors reviewed the policies and procedures for the management of complaints, last reviewed in February 2015. The complaints process was user-friendly, accessible to all residents and an user friendly guide was available in a prominent location. An appeals process was outlined in the process and procedure. Inspectors observed however that an understanding of what constitutes a complaint was not demonstrated as the complaints log was being used to record issues such as training needs and required maintenance repairs. The provider nominee had identified this gap in a recent unannounced audit.

Staff were observed to provide residents with choice and control by facilitating residents' individual preferences in relation to their clothing, meals, assisting residents in personalising their bedrooms and their choice of activities. The day-to-day routine was observed to be based on individual resident's wishes and choices. Residents were supported to communicate what they wanted to do that day and those choices were facilitated, such as going swimming, shopping, to the local church or for a walk in a nearby park.

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):
No actions were required from the previous inspection.

Findings:
There was a policy on communication and in the sample of care plans reviewed there was evidence that residents were assisted and supported to communicate. There were communication strategies in place for each resident including the use of picture schedules so that residents could plan their day.

There was evidence of recent review and assessment of communication needs for each resident by a speech and language therapist. Staff were aware of the outcomes of these

reviews and were supporting residents to implement the recommendations. For example, one resident was recording the residents meetings in the house and wrote out the menu for the day on the communication board in the kitchen. Another resident used LÁMH communication (which is a manual sign system used by children and adults with intellectual disability and communication needs in Ireland) and staff were aware of the use of this system. One resident had communication notebook which included a daily diary.

The inspectors observed a communication board in the kitchen area which contained a picture rota of which staff were on duty and a picture of the meal for the day. A number of documents were available in easy to read format including parts of the person centred plan and the complaints policy. A charter of residents' rights was displayed in the centre in an easy-to-read version.

Television was provided in the main living rooms and residents had compact disk (CD) players in their bedrooms.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that positive family and personal relationships were supported. Residents were part of the community in a meaningful way.

There was a policy on visiting and it was demonstrated that families were welcome and free to visit. Relatives told inspectors that they were very happy with the service and support being provided to their loved one. Family relationships were supported by staff in various ways as applicable to each individual resident. Residents were supported to visit their family members, to stay overnight or for weekends in their family home. Residents communicated to inspectors when they were due to go home. Family were invited to attend personal planning review meetings. Relatives confirmed that staff and management were approachable and kept them informed of any changes.

Relationships with friends were also supported. For example, residents were supported to meet with friends they had made while participating in educational courses.

Residents participated in the community as part of their day to day lives. Community participation also formed part of residents' personal plans and life skills development programmes. Residents were supported to go to the bank, to go grocery shopping, to Mass, massage therapy, the hairdresser and for walks in the community. Residents accessed sports facilities in the community, including the gym, horse-riding and swimming. Residents identified courses and new opportunities they may wish to attend as part of their personal plan, such as pottery or art classes.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The organisation had a policy on admissions, transfers and discharge of residents in the service, which had been reviewed in July 2014. The policy outlined the criteria for admission but did not take account of the need to protect residents from abuse by their peers.

The statement of purpose indicated admissions were made through the Admission, Discharge and Transfer Committee and in line with the policy. The statement of purpose did not outline specific criteria for admissions to this centre.

An inspector requested information relating to an admission to the centre and this information was obtained by the person in charge and house manager. The documentation evidenced that consultation with residents and their families took place. A review of the admission took place four months following admission and no issues were identified at that time. While documentation evidenced that the supports required to support a resident moving to the centre had been considered, it was not evidenced that the potential impact of previously identified behaviours that challenge on residents already residing in this centre had been fully considered as part of the admissions process.

In addition, inspectors found that there was no evidence that the mobility needs of a resident had been considered as part of the admissions process. This was despite a letter from the resident's general practitioner (GP) that clearly outlined that the resident required accommodation specifically adapted to meet his/her complex needs, including

mobility aids and wheelchair access. Inspectors found that the centre did not provide for such needs and this will be further discussed under Outcome 6, safe and suitable premises.

Inspectors reviewed a sample of resident contracts of care and found that they had been signed either by the resident or their representative. The sample contracts seen by the inspectors included: staffing arrangements, provision for family contact, assessment/care planning, comments/complaints and how medications would be managed. The contract also outlined the residential charges for accommodation of the resident.

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):
No actions were required from the previous inspection.

Findings:
Recently updated personal plans reflected a person-centred approach. However, further improvements were required in relation to goal-setting and ensuring that the review of the personal plan was multidisciplinary. In addition, it was not demonstrated that the designated centre met the assessed needs of all residents and inspectors found this to be at the level of major non-compliance.

A specific tool was used to document each resident's assessment of their health, personal and social care needs, abilities and wishes.

Each resident had a personal plan and plans were reviewed by inspectors. Residents completed their own personal plans, where they chose to do so. An inspector reviewed a recently updated plan and found that it was both person-centred and comprehensive. The plan included key areas such as what is important to, what is important for and the best ways to support the resident. Individual likes and dislikes were clearly captured and included a wide range of areas from work to exercise, diet, information technology used, family links, hobbies, interests and social events that were enjoyed. The information was

in a pictorial format.

Some further improvement was required to the review of personal plans. For example, a key goal in relation to where a resident would like to live had been included in a personal plan for 2014 and not completed or carried forward to 2015.

In addition, while each resident was reviewed by the multi-disciplinary team (MDT), this review did not inform personal planning, as required by the Regulations. A new form had been introduced in relation to MDT goal setting and this was reviewed by inspectors. The form outlined the type of MDT supports required by residents. However, it was not clear from this form how input from the MDT was contributing to residents' personal plans or the achievement of key goals for residents.

As previously mentioned, it was not demonstrated that the designated centre met the assessed needs of all residents due to the mix of residents in the centre and in some cases, the design and layout of the centre.

The mix of residents in the centre did not ensure that residents were protected from injury and harm by their peers. The centre did not meet one resident's documented mobility needs or need for a quiet environment or another resident's expressed need to move to alternative accommodation in which s/he felt safe. A referral to the organisation's committee that oversees admissions, transfers and discharges had been made and to a review group that also considers any inappropriate placements. However, no funded plan was in place at the time of inspection to satisfactorily address the failing that the designated centre did not meet the assessed needs of all residents. As a result and due to the on-going impact on residents, this failing was identified to be at the level of major non-compliance.

Issues relating to challenging behaviour will be further discussed under Outcome 8, safeguarding and safety.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that the premises did not meet residents' individual needs in an acceptable way.

The centre was a single-storey bungalow in a community setting. There were four bedrooms in the centre. Three were resident’s bedrooms, each decorated according to resident’s personal preferences. The fourth bedroom served as the office and staff sleepover room. There was a large main sitting room which led to a kitchen/dining room. Off the kitchen/dining room was a small separate second sitting room. There was an enclosed garden area which had garden furniture and a covered dining area. The utility room was located adjacent to the garden.

Inspectors found that the bathroom facilities were inadequate to meet the needs of all residents. There was only one bathroom with a bath, hand wash basin and toilet; a shower was available but residents had to get into the bath to access the shower. In October 2014 an occupational therapist had carried out an assessment of the bathroom for one resident who could not access the bath independently. The occupational therapist identified that there was limited space in the bathroom to address the resident’s personal care needs. Inspectors were informed by staff that the resident required the assistance of two staff to get into the bath. The recommendations from the occupational therapy assessment included: replacing current tiles with non-slip tiles; fitting a rail to the side of the bath and providing a full-length walk-in bath with a low-entry inward swinging side door. To date these recommendations had not been implemented. Inspectors observed grab-rails fitted to one wall in the bathroom and to a wall alongside steps leading to the back garden. However, there was no grab-rail fitted to the wall by the front door. The house manger said that a grab-rail in this location was required by one resident. Further to the unsuitability of bathroom facilities, one resident, as part of their personal planning process, had identified that they wanted an en-suite toilet with shower in their bedroom.

Staff told inspectors that re-decoration had been carried out recently. This was in response to an infection control audit and included cleaning of the hall carpet and cooker-hood. Inspectors observed that the hall carpet, while clean, was permanently stained, in particular inside the entry door, due to the age of the carpet. While the cooker hood had been cleaned, residual grease could be felt on the head. This was due to the age of the cooker-head, as opposed to the standard of cleanliness in the centre. Inspectors observed that the exterior of the house was not well-maintained and this had also been identified by staff to the landlord.

There was adequate heating and ventilation in all areas. There were separate laundry facilities in the utility attached to the centre with adequate washing and drying facilities. Residents were supported to do their own laundry if they so wished and in accordance with their capabilities.

At the last inspection it had been identified that there was a “safe room” where one resident went if they were stressed or their anxiety levels were increasing. It was also noted on the last inspection that there was a lock on a door leading to this “safe room” and the lock could only be operated on one side. On this inspection it was observed that the “safe room” had been converted into the aforementioned second small sitting room

with a couch and television provided. The lock on the door leading to this sitting room had been removed also.

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:
Inspectors found a high risk of injury and harm to both residents and staff in the centre from behaviour that challenges. In addition, improvements were required to risk assessments and fire drills.

Inspectors reviewed incidents in the centre relating to behaviour that challenges. Between April and the date of inspection (19.4.2015 to 5.10.2015), there had been 56 incidents where one resident had injured either other residents living in the house or staff. This included 11 incidents of injury and harm by the same resident to other residents. Staff had been injured on a number of occasions, 12 incidents were categorised as staff assaults, one incident was of 5-minute duration and four incidents involved staff being pulled to the ground by their hair. The on-going risk of injury to residents and staff in the centre indicated that satisfactory measures had not been put in place following adverse events to prevent them from or reduce the likelihood of them re-occurring.

At the last inspection it was found that there were two books in use to record incidents with the potential for incidents not being appropriately recorded or reviewed. Since then, this practice had ceased and there was one recording system in place for incidents.

Improvement was required in relation to the controls in place to manage risks or risk assessment. For example one resident who had mobility issues had been identified as being at a low risk of falls in the bathroom. However, this risk assessment did not reflect the findings of an occupational therapy report (mentioned in more detail in Outcome 6, safe and suitable premises) which outlined recommendations to improve the resident's safety in the bathroom or information provided by staff. In addition, there was no manual handling risk assessment in relation to moving and handling in the bathroom.

The inspectors saw evidence that suitable fire prevention equipment was provided

throughout the centre and the equipment was adequately maintained by means of servicing of fire alarm system and alarm panel in July 2015, fire extinguisher servicing and inspection in October 2014 and servicing of emergency lighting in July 2015. However, the doors throughout the premises were not fire doors and could not be guaranteed to restrict the spread of fire and smoke in the event of a fire emergency.

Records showed that all staff had received fire training. Each resident had an up to date mobility risk assessment in place. There were monthly fire evacuation drills being undertaken involving the residents. However, the records available of drills conducted since January showed that the response time to evacuate the premises in eight of these drills was over four minutes.

There were arrangements in place for the prevention and control of infection. The centre was visibly clean. The system for cleaning was clear, with colour-coded mops and buckets and written guidance in place. Staff were able to articulate what to do in the event of an infection or outbreak. An infection control audit had been completed on 30.9.2015 and all actions had either been completed or were scheduled for completion. Protective equipment was available in the centre. Staff were all trained in hand hygiene and infection control. The centre's guidelines required amendment to reflect the standards for the prevention and control of healthcare associated infection and national guidelines and this is addressed under outcome 18.

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:
The provider failed to demonstrate that residents were protected from all forms of abuse as residents were at risk of harm from their peers resulting from behaviour that challenges. Inspectors found that this was at the level of major non-compliance due to the impact that it was having on individual residents. Also, failings in relation to staff training were identified on this inspection and on the previous inspection. Finally,

behaviour support plans required review and updating by persons with specialist training and experience in relation to behaviour that challenges.

There were organisational policies in place in relation to the protection of vulnerable adults, behaviour that challenges, restrictive practices and the provision of intimate care.

Staff had all received training in relation to the protection of vulnerable adults. Staff were aware of what to do in the event of a suspicion or allegation of abuse.

At the previous inspection, it was found that all staff did not 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. Due to the risk involved to staff and residents, the provider was issued with an immediate action letter at the previous inspection and required to take immediate action to address this failing. This failing was also included in an 'improvement notice' issued to the Daughters of Charity by the Authority at that time.

At this inspection, it was found that regular staff had received training in behaviour that is challenging and the use of any breakaway techniques and physical interventions, specifically, the therapeutic management of aggression and violence (TMAV). Staff told inspectors that they felt confident in their ability to support residents to manage their behaviour and to respond to behaviours that are challenging. However, inspectors found that this failing had not been adequately addressed for all staff who work in the centre due to the use of relief and agency staff.

As outlined in the last inspection, behaviour management plans for one resident approved the use of "hands-on" re-direction called the therapeutic management of violence and aggression (TMAV). It was recorded in the incident reporting forms that these TMAV methods had been used on five occasions when a resident had been attempting to assault either other residents or staff. It was noted by inspectors that on one occasion when staff attempted to implement the TMAV method the resident had grazed their back when the resident fell. The house manager had confirmed that this staff member had not been trained in the use of TMAV methods. On another occasion a staff member had injured themselves while using the TMAV methods.

As previously mentioned under Outcome 1, as a result of behaviours that may challenge, a resident told staff that s/he did not feel safe living in the centre. The provider demonstrated that the issue was being given serious attention; a referral had been sent to the organisations' committees that deal with both concern and welfare matters and admissions, transfers and discharges. In addition, an emergency MDT meeting was held on 6.10.2015 for the resident causing concern. However, due to the negative impact that this was having on other residents, the on-going associated high risk of injury and harm to those living and working in the centre and the absence of a plan to satisfactorily resolve the situation, inspectors found that this failing was at the level of major non-compliance. The provider nominee acknowledged the seriousness of the situation at the close of the inspection.

At the time of inspection, all residents were not in the centre together and there was no risk of challenging behaviour incidents occurring; inspectors observed at such times that

remaining residents appeared to be very happy and content.

Physical and chemical interventions were in use and had been approved by suitably qualified professionals. Physical restraint had been used on five occasions during the same period (19.4.2015 to 5.10.2015). There was evidence of regular access to and review by a psychiatrist. Staff said that they received support and input from psychology. However, it was not demonstrated that given the nature and level of behaviours that challenge in this house that such support was sufficient. This was evidenced by inconsistent practices, gaps in required documentation and the frequency and scale of incidents in the centre. In addition, some required documentation needed to provide an accurate picture of the pattern of behaviours in the centre had not been consistently maintained during times of staff changes. For example, documentation relating to the use of physical restraint was not being completed as per the organisation's policy on 'Therapeutic Management of Aggression and Violence', dated 22.9.2014. Also, charts that recorded the antecedent, behaviour and consequences of an event (known as 'ABC' charts) had not been maintained for a period of time, although they were now being completed. Mood charts had also not been maintained for a period of time, although they were now being completed. This failing is relevant as it was not evidenced during discussions with staff or following a review of relevant documentation that the psychiatrist was consistently in receipt of sufficient accurate information relating to a resident's behaviours, as required to inform psychiatry reviews.

The person in charge and house manager described recent changes that had helped to manage incidents of challenging behaviour and these included the development of an activities timetable and review of the daily schedule. In addition, residents had a multi-element behaviour support plan where required. An inspector reviewed a sample of behaviour support plans. For one resident, the behaviour support plan was overall very comprehensive and contained key information such as skills teaching, what the resident liked and enjoyed, and the function of behaviour, precursors, proactive and reactive strategies. Improvements were required in that the communication supports outlined in the plan had not been updated to reflect recent changes and there was no information in relation to how and when to use approved chemical restraint.

For another resident, two behaviour support plans were on file. Improvements were required to the most up to date behaviour support plan. Some phrases were broad and did not provide adequate guidance for staff, such as "offer re-assurance" and the inspector found that the older plan provided more specific guidance for staff. Reactive strategies outlined could not be described as reactive strategies. There was no reference in the plan in relation to how and when to use approved chemical restraint.

Risk assessments relating to challenging behaviour required improvement. There were also two challenging behaviour risk assessments in place for one resident. One was filed behind another document and while specific, needed to be updated and completed in full. The controls in the second risk assessment were generic and contained broad statements such as "challenging behaviour training", "incident reporting policy", "maintain staffing levels". The type of training required in this centre, the actual staffing levels required and the documentation to be completed following an incident or following the use of physical restraint was not specified.

Care plans relating to challenging behaviour required improvement. For one resident, the direction in relation to the completion of mood charts and ABC charts was not specific. For another resident, the care plan had not been updated where it had been identified that older behaviours had re-emerged.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

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

Findings:
A record of all notifiable incidents was maintained in the centre. While a quarterly report was provided to the Authority, this did not include all restrictive procedures in place in the centre. A number of restrictive procedures approved by the organisation's restrictive practices committee had not been included in the quarterly report pertaining to each occasion that environmental, chemical and physical restraint was used.

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):

Findings:
Residents’ opportunities for new experiences, social participation, education, training and employment were facilitated and supported. Improvements were required to ensure that the day service provided was suitable to meet each resident's capabilities, interests,

preferences and where applicable, challenging behaviour needs.

The policy on access to education, training and development was made available to inspectors. Improvements were required to the policy to ensure that it addressed relevant regulatory requirements. Residents had access to education, training and development. One resident participated in paid work and also had completed an advocacy course.

Support was provided for residents to attend a day service where applicable. Where residents did not wish to avail of a day service, an individualised service was provided from the centre. Inspectors observed residents being supported to communicate what they wanted to do that day and those choices were facilitated, such as going swimming, shopping, to the local church or for a walk in a nearby park.

However, it was not clear to inspectors whether day services provided met the needs of residents as an assessment of each resident's training and development needs and goals was not available in the centre for each resident. Documentation indicated that incidents of challenging behaviour had recently escalated in the day service also.

Residents were supported to develop life skills and new skills and this was incorporate into residents' personal plans. Skill development included gardening, shopping and household tasks such as setting the table, loading the dishwasher, putting laundry in the laundry basket and preparing meals.

Judgment:
Non Compliant - Moderate

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' healthcare and nutritional needs were met in the centre. However, the care planning process required further improvement.

Healthcare plans were variable in quality. While some were specific, such as plans pertaining to healthy eating and exercise, others had not been developed in line with residents' needs. Healthcare records indicated that residents had assessed healthcare needs but these needs were not always written in a plan to direct care. For example, one resident had an epilepsy profile record. While this recorded when the person last

had an epileptic seizure it did not reference a review by a consultant specialist in July 2015 when the person's emergency medication was changed.

In the sample of resident healthcare files, each resident had access to a general practitioner (GP) who saw residents at regular intervals. There was evidence that residents were supported to attend appointments and had been referred to hospitals and consultant specialists if required. However, one resident had been reviewed by their doctor in February 2015 and it been recommended that the resident have a chest x-ray and be further referred for review by a consultant specialist. There was no indication in the healthcare records if these recommendations had been followed.

There was evidence of good access to specialist care in psychiatry with regular reviews being undertaken as required.

There was evidence that residents were referred for treatment by allied health professionals including physiotherapy in relation to mobility difficulties. Some residents had recommendations available from a dietician regarding diet and meal planning. Two residents had been prescribed oral nutritional supplements.

Residents were involved in the day to day activities around mealtimes including going shopping for groceries. Menu plans were available in the kitchen with pictures of the meal available so residents knew what was for dinner. The inspectors found adequate quantities of food available for snacks and refreshments.

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:
There was a written policy in place relating to the ordering, prescribing, storing, administration and disposal of medications.

Medication was dispensed from the pharmacy in a monitored dosage system which packaged the medication for each resident for the correct time each day. The medication was checked by staff on delivery from the pharmacist and was kept securely in a locked cabinet. However, for one resident the checks were not completed as the date of birth on the medication dosage system did not match the date of birth on the

prescription sheet.

One resident's personal information profile identified an allergy to a particular medication. However, this information was not specifically included in the resident's acute hospital communication booklet which was designed to give all relevant information about the resident if they were to be admitted to an acute hospital. There was a potential that the resident could be administered the medication if this information was not given to hospital staff. This was previously addressed under Outcome 7 in the context of risk management.

While the person in charge was a registered nurse in intellectual disability, there were no other staff employed as nurses on the roster. Records indicated that all staff had received training on the administration of medication. The house manager said to inspectors that one agency staff member did not have training on the administration of emergency medication to manage epilepsy. This was a significant issue as two of the three residents were prescribed this emergency medication. This will be addressed under Outcome 17 in the context of staff training.

There had been five recorded medication errors between April 2015 and October 2015, three of which incidents related to drugs not being given. There was evidence of learning from such incidents. As required (or PRN) medication to manage the behaviour of residents was administered as prescribed and monitored by the resident's doctor.

Medication that required refrigeration was put into a fridge. The temperatures on the fridge were being recorded daily to ensure that the medication was being kept at the appropriate temperature.

The inspectors saw that adequate systems were in place to minimise the risk associated with the practice of transcription in line with guidance issued by An Bord Altranais agus Cnáimhseachais. Medication prescription records contained the signature of the nurse who transcribed the record with additional controls with a second nurse verifying the prescription.

A medication management audit had been completed in September 2015 with a number of findings and actions identified.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
There was a written statement of purpose the outlined the aims, objectives and ethos of the centre and the services provided in the centre. However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, the criteria used for admission to this centre were not specified and the staff training requirements were too broad.

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

Findings:
There was a clearly defined management structure in place that identified the lines of authority and accountability in the centre. It was not clearly demonstrated that where the person in charge was in charge of more than one centre, that this arrangement ensured the effective governance and management of this centre. In addition, improvements were required to the annual review of the quality and safety of care and support in the designated centre.

The centre is run by the Daughters of Charity Disability Support Services Limited. The Service Manager is the nominee appointed to act on behalf of the provider in all interactions with the Authority. The provider nominee is dual qualified in general and intellectual disability nursing and has extensive experience in service provision to persons with an intellectual disability.

The person in charge was suitably qualified and experienced to fulfil the role. The person in charge is a clinical nurse manager (CNM2) and is qualified in intellectual disability nursing and had relevant previous experience at CNM1 (clinical nurse manager) level supporting residents with behaviours that may challenge. The post of the person in charge was full-time. The person in charge had commenced in that role four months prior to the inspection date.

Until recently (four weeks prior to the inspection), the person in charge was in charge of three designated centres, comprising four high support houses in total. At the time of inspection, a more suitable arrangement was in place as the area of responsibility of the person in charge had been reduced to two designated centres, comprising two high support houses in total. However, a vacant house manager post in the other centre was having an impact on the time the person in charge could spend in this centre. Given the high support needs of residents in this centre, the effectiveness of the governance and management arrangements in this centre had yet to be demonstrated.

The person in charge was supported in her role by the house manager, who works full-time in the centre. The house manager was identified as a person participating in the management of the centre. The house manager holds the post of social care leader and has experience in supporting residents who display behaviours that challenge. The house manager reports to the person in charge. The person in charge reports directly to the CNM3, who in turn reports to the provider nominee.

Regular (monthly) house meetings took place and inspectors reviewed minutes of such meetings. Minutes demonstrated that meetings were purposeful and considered how to continuously improve the quality and safety of care in the centre. Structured meetings also took place between the person in charge and CNM3 and involved discussion of relevant topics, such as time management, concern and welfare referrals, restrictive practices and placement reviews.

The person in charge outlined priorities that she had identified since she commenced in the role and provided examples of actions that she had completed within the previous 10 weeks. Actions included review of staffing arrangements, addressing gaps staff training needs, development of timetables and schedules for residents and the introduction of practical approaches aimed at reducing behaviours that challenge in the centre. Identified priorities included care planning and the issues relating to the premises.

The provider nominee had completed an unannounced visit to the centre within the previous six months. Inspectors reviewed the subsequent report and found that the review considered all aspects of the quality of care and support provided in the centre. Issues identified on this inspection had also been identified as part of the provider's review including in relation to personal plans and training gaps. Inspectors noted one area of improvement however, whereby it was recorded that no assistive aids or equipment were required in the centre, which was in fact a key problem that needed to be addressed.

Improvements were required to the annual review of the quality and safety of care and support in the designated centre. The annual review did not review all aspects of quality and safety of care in the centre and result in an action plan to address any identified deficits. For example, the annual review did not consider identified issues relating to the accessibility of the premises. Key areas were not reviewed as part of the annual review, including effective management of the centre, staffing, the use of resources and medication management. In addition, the annual review did not provide for consultation with residents and their representatives nor had a copy of the review had not been

made available to residents and/or their representatives.

A number of audits had been completed as part of monitoring of the service. These included audits relating to infection control, fire safety, health and safety and medication management. Inspectors reviewed a sample of audits and found that they effectively contributed to monitoring of specific areas.

A certificate of planning has not been submitted to the Authority, as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. There had not been any period where the person in charge was absent for 28 days or more since the last inspection. The person in charge and the nominated registered provider were aware of the obligation to inform the Chief Inspector if there was any proposed absence of the person in charge. There were clear arrangements to cover for the absence of the person in charge with the clinical nurse manager (CNM3) having responsibility for management of the centre during any such periods of absence.

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):
No actions were required from the previous inspection.

Findings:
Inspectors formed the opinion that the centre was resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. There was a maintenance system in place and contract cleaning had recently taken place. Equipment and furniture was provided in accordance with residents' wishes. Maintenance requests were dealt with promptly. There were suitable social care staff and nursing staff available to assist residents.

Judgment:
Compliant

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

Theme:
Responsive Workforce

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

Findings:
Staffing levels were maintained in accordance with an assessment of residents' needs.

Mandatory and additional training required to support residents had been provided for all regular staff working in the centre since the previous inspection, including in relation to manual handling, food safety, advocacy, infection control and fire safety.

However, training gaps were identified in respect to agency and relief staff who worked intermittently in the centre.

As previously included in the action under Outcome 8, relief and agency staff working in the centre did not always have the required training or skills to support residents with behaviour that is challenging and to carry out any approved techniques. As previously mentioned under Outcome 12, relief and agency staff working in the centre did not always have the required training or skills to support residents with epilepsy and administer required medication in the event of an emergency. This was particularly relevant as two of the three residents were prescribed this emergency medication.

Staff turnover in the centre also provided challenges in ensuring consistent delivery of care and an adequate skill mix in the centre. This was previously discussed under Outcome 8 and is particularly relevant as the importance of consistent familiar staff was highlighted in residents' behaviour support plans. The provider nominee outlined the recruitment process currently underway by the service to reduce the use of agency staff and improve continuity of care and support.

Judgment:
Non Compliant - Moderate

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

Theme:
Use of Information

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

Findings:
Some improvements were required in relation to the management of records and policies.

Staff records were held centrally in the Dublin office of the Daughters of Charity. A sample of staff files were reviewed and found to meet the requirements of Schedule 2 of the Regulations.

Records were kept securely and were kept for the required period of time. Residents' records were stored securely. The inspector found that work had commenced in relation to organising records and residents' files.

Residents' records as required under Schedule 3 of the Regulations were maintained. The residents' directory was not complete and did not contain the correct date on which a resident first came to reside in the centre. As mentioned in Outcome 8, improvements were required to the documentation pertaining to behaviour that challenges and restrictive practices. For example, documentation relating to the use of physical restraint was not being completed as per the organisation's policy on 'Therapeutic Management of Aggression and Violence'. Also, charts that recorded the antecedent, behaviour and consequences of an event (known as 'ABC' charts) or mood charts had not been completed for a period of time, although they were now being completed. Care plans and risk assessments required review and updating. Behaviour support plans required

review, streamlining and updating by persons with specialist training and experience in relation to behaviour that challenges.

Healthcare records also required improvement. While some medical files had been streamlined, others had not and some reviews that had been completed by the psychiatrist were not available in the resident's file. There were subsequently however made available by the person in charge. Inspectors saw that “sticky paper” was being used on the front cover of the healthcare records of one resident to indicate that a medical examination was required in an acute hospital in 2018. This practice could not guarantee the confidentiality of resident healthcare information but also could potentially mean that residents were not getting the treatment that their healthcare needs required.

Records listed in Schedule 4 to be kept in a designated centre were all made available to the inspector.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

All of the key policies as listed in Schedule 5 of the Regulations were in place and were made available to staff who had signed each policy as read and understood. However, improvements were required to a number of policies. The policy on admissions, transfers and discharge of residents in the service did not take account of the need to protect residents from abuse by their peers. The guidance on infection control did not reflect current national policy in relation to hand hygiene training or audits. The policy on access to education, training and development required development to ensure that it addressed all regulatory requirements.

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd.
Centre ID:	OSV-0005160
Date of Inspection:	05 October 2015
Date of response:	16 November 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:
Arrangements in place in relation to protecting residents' rights were not satisfactory. There was no documentation available in the centre in relation to one resident's wardship and in particular whether the wardship extended to the resident's personal

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

care or if it was confined to the financial affairs of the resident.

1. 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:
The Person in Charge has contacted a member of the service user's ward of court committee, and she has forwarded the information regarding the terms of the ward of court agreement on 23/10/2015 to the person in charge. The documentation clarifies the terms of the ward of court. The Clinical nurse manager 3 and the person in charge are meeting all staff in the centre on 13/11/2015 to outline clearly what the ward of court covers.

Proposed Timescale: 23/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The resident's rights as an adult were not protected. There was evidence that consent for the taking of bloods was sought from the resident's family

2. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:
Service users will consent for blood extraction themselves and where this is not possible blood extraction will be based on a medical decision by the G.P.

Proposed Timescale: 12/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
High levels of challenging behaviour in the centre impacted on other resident's rights to live in a safe environment.

3. Action Required:
Under Regulation 09 (2) (c) you are required to: Ensure that each resident can exercise his or her civil, political and legal rights.

Please state the actions you have taken or are planning to take:

The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the use of a monitoring (listening) device had been considered by MDT or that it was necessary given the fact that there was a 'waking' night-time staff member on duty every night.

The current configuration of bathroom facilities did not fully promote the privacy and dignity of all residents.

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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inventory of each resident’s personal possessions was not being kept up to date which meant it could not be guaranteed that residents could retain control of their own personal property.

5. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
Following the inspection the Person in Charge and house manager reviewed the inventory of each resident’s personal possessions and all are now up to date.

Proposed Timescale: 20/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An understanding of the complaints procedure was not demonstrated.

6. Action Required:
Under Regulation 34 (2) (c) you are required to: Ensure that complainants are assisted to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
The Nominee Provider and Director of Nursing delivered staff training around the area of complaints and the complaints policy on the 29/09/2015. The Person in Charge will monitor the staff teams understanding of what constitutes a complaint. The complaints log will be reviewed by the Nominee Provider to ensure it is understood and completed properly by staff.

Proposed Timescale: 29/09/2015

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 organisation's policy on admissions, transfers and discharge of residents in the service did not took account of the need to protect residents from abuse by their peers. It was not evidenced that the potential impact of previously identified behaviours that challenge on residents already residing this centre had been fully considered as part of the admissions process.

7. 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:
The organisations policy on admission, transfers and discharge is being reviewed and completed and now takes into account the need to protect residents from abuse by their peers.

Proposed Timescale: 29/10/2015

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A new form had been introduced in relation to MDT goal setting and this was reviewed by inspectors. The form outlined the type of MDT supports required by residents. However, it was not clear from this form how input from the MDT was contributing to residents' personal plans or the achievement of key goals for residents.

8. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
The Assistant Chief Executive Officer is Chair of the PCP group and will raise this with the team at the next Steering Committee meeting on 26/11/2015. The process will be revised to ensure that it is clear how MDT input contributes to service users personal plan and achievement of key goals for residents.

Proposed Timescale: 26/11/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that the designated centre met the assessed needs of all residents due to the mix of residents in the centre and in some cases, the design and layout of the centre.

9. 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:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some further improvement was required to the review of personal plans. For example, a key goal in relation to where a resident would like to live had been included in a personal plan for 2014 and not completed or carried forward to 2015.

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

Please state the actions you have taken or are planning to take:
Clinical Nurse Manager 3 is coming to the centre on 02/11/2015 to do further training with staff team, Person In Charge and the House Manager on goals setting and planning of goals with service users. The finding regarding goal setting and tracking will be referred to Regional PCP Steering Group. The Nominee Provider made this referral to the Chair person of PCP Steering Group. The next meeting of this group is on 26/11/2015.

Proposed Timescale: 26/11/2015

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 centre did not fully meet the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centres). There was an insufficient number and standard of baths, showers and toilets to meet the needs of all residents.

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

Please state the actions you have taken or are planning to take:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no grab-rail fitted to the wall by the front door, as required.

12. Action Required:
Under Regulation 17 (4) you are required to: Provide equipment and facilities for use by residents and staff and maintain them in good working order. Service and maintain equipment and facilities regularly, and carry out any repairs or replacements as quickly

as possible so as to minimise disruption and inconvenience to residents.

Please state the actions you have taken or are planning to take:
The Person in Chare has linked with the Maintenance supervisor and a grab rail will be fitted to the wall by 13/11/2015. The Person in Charge will link with the Occupational therapist re placement of same.

Proposed Timescale: 20/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Parts of the premises could no longer be effectively cleaned due to their age and condition. In addition, the exterior of the house was not well-maintained.

13. 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:
The Person in charge and the maintenance supervisor will carry out an audit of maintenance requirements. A plan for completion will be implemented.

Proposed Timescale: 04/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The bathroom facilities were not accessible to all residents.

14. 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:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management system was not sufficiently robust. Risk assessments required improvement or completion.

15. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Risk assessment training scheduled for 041/11/2015. The Person In Charge and the Clinical Nurse manager 3 will review all risk assessments in the designate centre with the home manager and staff team. All staff have received training in risk management but further training will be delivered to all staff of the centre by the Clinical Nurse Manager 3 to ensure an understanding of identification of hazards and completion of risk assessments to include control measures to reduce the risk.

Proposed Timescale: 04/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident's personal information profile identified an allergy to a particular medication. However, this information was not specifically included in the resident's acute hospital communication booklet which was designed to give all relevant information about the resident if they were to be admitted to an acute hospital.

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:
Service user who has allergy has had this included in their acute hospital communication booklet on 06/10/2015 post the inspection.

Proposed Timescale: 06/10/2015

Theme: Effective Services

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

Inspectors found a persistent high risk of injury or harm to both residents and staff in the centre from behaviour that challenges. Adequate measures had not been put in place following adverse events to prevent them from or reduce the likelihood of them re-occurring.

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

Please state the actions you have taken or are planning to take:
All residents have a behaviour support plan. All are being reviewed on 30/11/2015 by Psychologist and Person in Charge and staff team. All will have a full multidisciplinary meeting by 20/11/2015.

All incidents recorded in the centre will be reviewed as part of multidisciplinary review.

All challenging behaviour risk assessments are scheduled to be reviewed and completed on 13/11/2015.

Proposed Timescale: 20/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The doors in the centre were not fire doors, as required to contain fire in an area.

18. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not being completed as required by needs of residents.

19. 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:
The Service Director of Logistics who is an fire engineer will review fire evacuation practices and plan for the centre with local Health and Safety Officer, Person in Charge and staff team.

Proposed Timescale: 20/11/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff who worked in the centre had received training in behaviour that is challenging and the use of any breakaway techniques and physical interventions, specifically, the therapeutic management of aggression and violence (TMAV). On one occasion, a staff member had carried out a technique without being trained to do so.

20. 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:
Since inspection all staff working in the centre including agency staff have been scheduled to receive training in behaviour management and the Therapeutic Management of Aggression and Violence. All staff will have completed this training on 17/11/2015

Proposed Timescale: 17/11/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of physical restraint was not recorded in line with the organisation's policy on 'Therapeutic Management of Aggression and Violence'.

21. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Training to all staff in the centre on restrictive practices and use of physical restraint

was delivered by the Nominee Provider on the 08/10/2015 and 13/10/2015. There will be further input from the Clinical Nurse Manager 3 to the staff in the centre to ensure that staff comply with the organisation policy on the recording, reporting and documenting the use of physical restraint.

Proposed Timescale: 27/11/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that staff had the knowledge and skills and received the necessary MDT input to support residents with behaviours that may challenge. This was evidenced by improvements required to documentation, including care plans and risk assessments relevant to behaviours that may challenge and other documentation required to monitor any behaviours that may challenge. Behaviour support plans required review and updating by persons with specialist training and experience in relation to behaviour that challenges.

22. 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:
The psychologist, staff team and Person In Charge are reviewing the behaviour support plan of all service users in the centre on 30/11/2015.

Staff in the centre will receive training in risk assessment on 04/11/2015. The Clinical Nurse Manager and Person In charge will then review with staff all risk assessments and control measures in the centre.

The Clinical Nurse Manager 3 will deliver training to all staff in the centre on care planning, completing assessments of need and plans of care. The Clinical Nurse manager 3 and Person In Charge will support keyworkers in the review of care plans for service users.

Proposed Timescale: 30/11/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not protected from injury and harm by their peers as a result of behaviours that challenge in the centre.

23. 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:
The response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response.

Proposed Timescale:

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:
While a quarterly report was provided to the Authority, this did not include all restrictive procedures in place in the centre.

24. 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:
All restrictive practice in the centre are being reviewed by the Person In charge and home manager and will be reviewed by the restrictive practice team in November.

All restrictions in place were reported in the quarterly for the end of October.

Staff training has been delivered since inspection on restrictive practice. The Clinical Nurse Manager 3 will continue to monitor with the Person In Charge the use of and recording of restrictive practices in the centre.

Proposed Timescale: 27/11/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required to ensure that the day service provided was suitable to meet each resident's capabilities, interests, preferences and where applicable, challenging behaviour needs.

25. Action Required:
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to

access opportunities for education, training and employment.

Please state the actions you have taken or are planning to take:
The Nominee Provider has referred the review of access to education, training and development policy to the Quality and risk Officer to ensure it meets regulatory requirements.

An additional staff resource has been introduced to the centre since inspection to increase the access to activities in the community for each service user.

The service is piloting an assessment tool to establish a service user's education and training needs, this will be piloted with the service users in the centre also.

Proposed Timescale: 04/12/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Healthcare plans were variable in quality. While some were specific, others had not been developed in line with residents' needs.

26. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
The Clinical Nurse Manager 3 will deliver training specifically to the centre on care planning on completion of assessments and plan of care around same. The Person In Charge and Clinical Nurse Manager 3 will support in house keyworkers in the completion of care plans ensuring that they are developed in line with resident's needs.

Proposed Timescale:

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 checks were not completed as the date of birth on the medication dosage system did not match the date of birth on the prescription sheet.

27. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable

practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
The Person In Charge and house manager have informed the pharmacy of the error. All staff on return of medication from the pharmacy will check and ensure that identity, date of birth match that of the service user as on the prescription sheet.

Proposed Timescale: 02/11/2015

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:
There was a written statement of purpose the outlined the aims, objectives and ethos of the centre and the services provided in the centre. However, it did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, the criteria used for admission to this centre was not specified and the staff training requirements were too broad.

28. 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:
A revised statement of purpose is being prepared and will be sent to the Authority by 06/11/2015.

Proposed Timescale: 06/11/2015

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:
A certificate of planning has not been submitted to the Authority, as required under Regulation 5(3)(c) of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

29. Action Required:

Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to: Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Nominee Provider will liaise with the Director of Logistics and arrange for same to be submitted to the Authority.

Proposed Timescale: 30/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the area of responsibility of the person in charge had been reduced recently to two designated centres comprising two high support houses in total, a vacant house manager post in the other centre was having an impact on the time the person in charge could spend in this centre. Given the high support needs of residents in this centre, the effectiveness of the governance and management arrangements in this centre has yet to be demonstrated.

30. 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:
Recruitment process has commenced for the house manager vacant post .In the interim an acting housed manager will be appointed in the centre with effect from 23/11/2015.

The house manager post in the other house in this centre has been advertised both internally and externally. Closing date for this advertisement is 02/11/2015.

If an external candidate is successful due to Garda Clearance the new appointment will not be in post until the end of December.

If an internal candidate is successful the new appointment will be at the end of November 2015.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

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

Improvements were required to the annual review of the quality and safety of care and support in the designated centre. The annual review did not review all aspects of quality and safety of care in the centre and result in an action plan to address any identified deficits.

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

Please state the actions you have taken or are planning to take:
The annual review audit has been commenced by the Assistant Chief Executive Officer, Nominee Provider, Quality and Risk Officer and Director of Nursing and finalised document will be in place by 02/11/2015.

Proposed Timescale: 02/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review did not provide for consultation with residents and their representatives.

32. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
Review of annual review document has ensured that there is provision for consultation with service users and their representatives. Service users and their representative's views will be included through questionnaires circulated from the centre to input to review.

Proposed Timescale: 13/11/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the annual review had not been made available to residents and/or their representatives.

33. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made

available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
A copy of review was made available to all service users and will be made available to their representatives. Content of review will be shared with families by the house manager and the Person In Charge. The contents of the 2014/2015 review was shared with residents at house meeting and the 2015/2016 review will be discussed at their residents meeting.

Proposed Timescale: 06/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff turnover in the centre and the use of agency and relief staff provided challenges in ensuring consistent delivery of care and an adequate skill mix in the centre.

34. Action Required:
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

Please state the actions you have taken or are planning to take:
The recruitment process for additional staff is near completion. When staff are appointed this will displace agency staff. Staff are currently at the garda vetting process of recruitment. All staff, including all agency staff working in the centre will receive the training necessary to ensure that they are equipped with the skills and knowledge necessary to support the needs of residents in the centre. Staffs in the centre are currently being supported to complete a FETAC level 5 course, to develop their knowledge and skills in supporting service users in the centre

Proposed Timescale: 16/12/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff working in the centre had the required training and skills to meet the assessed needs of residents. There were occasions when relief and agency staff did not have training on the administration of emergency medication to manage epilepsy or to support residents with behaviour that is challenging.

35. 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 training records of all staff in the centre will be reviewed by the Person In Charge and training scheduled for all to complete the training in emergency medication management and challenging behaviour and TMAV training. Staff in the centre are also completing a FETAC Level 5 training, same commenced in September 2015.

Proposed Timescale: 30/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the key policies as listed in Schedule 5 of the Regulations were in place and were made available to staff who had signed each policy as read and understood. However, improvements were required to a number of policies. The policy on admissions, transfers and discharge of residents in the service did not took account of the need to protect residents from abuse by their peers. The policy on access to education, training and development required development to ensure that it addressed all regulatory requirements. The guidance on infection control did not reflect current national policy in relation to hand hygiene.

36. 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 organisations policy on admission, transfers and discharge has been reviewed by the Admissions Discharge and Transfer Committee to take into account the need to protect residents from abuse by their peers.

Proposed Timescale: 29/10/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' directory was not complete and did not contain the correct date on which a resident first came to reside in the centre.

37. 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 Person in Charge will complete the resident's directory; ensure it contains the correct information and the correct date of admission to the centre for all service users.

Proposed Timescale: 10/11/2015

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' records as required by the Regulations required improvement. Improvements were required to the documentation pertaining to behaviour that challenges and restrictive practices. Care plans and risk assessments required review and updating. Behaviour support plans required review, streamlining and updating by persons with specialist training and experience in relation to behaviour that challenges. Healthcare records also required streamlining. Inspectors saw that "sticky paper" was being used on the front cover of the healthcare records of one resident to indicate that a medical examination was required in an acute hospital in 2018. This practice could not guarantee the confidentiality of resident healthcare information but also could potentially mean that residents were not getting the treatment that their healthcare needs required.

38. 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:
The Clinical Nurse Manager will deliver training and support to all staff and the Person In charge in the centre with particular emphasis on challenging behaviour documentation and documentation around restrictive practices.

The Person In Charge will review with key workers all care plans and risk assessments and ensure that all up to date information is included and all plans are with review dates.

The Psychologist involved in the centre is working with the staff team at present reviewing all behaviour support plans.

The Clinical Nurse Manager 3 has developed a one page recording sheet to record all appointments scheduled which will be located in each service user's care plan.

"Stick paper" had been removed from the centre post inspection as directed by the

Nominee Provider.

The current care plan template for the centre will be reviewed in January 2016

Proposed Timescale: 04/12/2015