

**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 Health Service Executive
Centre ID:	OSV-0002459
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	John Greaney
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	17
Number of vacancies on the date of inspection:	13

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 02 July 2015 08:00 To: 02 July 2015 19:00

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 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 was a follow-up inspection to a registration inspection that had been carried out in October 2014 of a HSE centre for adults with disabilities. This was the third inspection of the centre. As part of the inspection process, inspectors met with residents and staff. Inspectors reviewed records such as residents' personal plans, medical records, policies and procedures, records of accidents and incidents, complaints log and staff rosters.

The provider had informed inspectors at the registration inspection in October 2014 that a decision had been taken to close the centre by 30th June 2015 and all residents would be transitioned to alternative more suitable accommodation in the community. Subsequent to that inspection, four out of 21 residents were transitioned to alternative accommodation. A notification was submitted to the Authority on 20

May 2015 informing the Chief Inspector that the centre would now close no later than 31st December 2015.

At a meeting between inspectors and management of Grove House in June 2015, inspectors were informed that on 1st July 2015 there would be a change in skill mix from a nursing based model of care to a social care model. This involved the introduction of social care workers/healthcare assistants to provide care in conjunction with nursing staff. Inspectors were informed that existing nurses would be redeployed elsewhere within the health service and the centre would now be staffed with nurses and healthcare assistants predominantly employed through an agency. This inspection was carried out one day after the introduction of new staff and the change of skill mix.

Some improvements were noted since the previous inspection, for example, there was evidence of consultation with residents through residents' forums and there was evidence that issues raised at the forum were addressed. However, overall, there continued to be a significant level of non-compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Due to significant non-compliances identified across three outcomes, three immediate action plans were issued and the details of these are contained in the body of this report. These relate to inadequate centre-specific fire safety training; an inadequate system of handover from previous staff to new staff coupled with inadequate staff supervision and delegation; and poor state of repair and cleanliness of the centre. The provider's responses to these actions are contained in the action plan at the end of this report.

Even though new staff had undergone an induction process in the week prior to the changeover, inspectors were not satisfied that there were adequate management systems in place to ensure the service was safe, appropriate to residents' needs, consistent and effectively monitored. This was mainly due to an inadequate system of handover from existing staff to new staff to ensure that all new staff were knowledgeable of residents individual needs. Additionally, staff had not received centre-specific fire safety training. Inspectors were informed that this was as a result of these staff not being permitted to be on-site prior to 01 July 2015, when the official staff changeover occurred.

In an effort to support continuity of care, two clinical nurse managers and a number of other staff, that had been working in the centre prior to the changeover of staff, continued to work in the centre after the changeover. However, when the changeover occurred, one of the clinical nurse managers was on annual leave and the other was due to finish working in the centre four days following this inspection. This was mitigated somewhat by the presence of the person in charge and/or the clinical nurse manager 3 (CNM 3) in the centre each day, including weekends, to supervise care delivery.

A number of additional improvements were required, including in areas such as:

- risk management
- design and layout of the centre
- contract of care

- assessment and care planning
- the centre was not suitably clean
- risk management practices
- fire safety arrangements
- activities and link with the community
- provision of education and training to residents
- statement of purpose
- governance and management
- access to advocacy
- complaints

The action plan at the end of the report identifies additional improvements required to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities 2013.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- the design and layout of the centre and care practices did not support the privacy and dignity of residents or support residents to make choices about their lives in a manner that reflected their individual preferences and diverse needs. For example:
 - the provision of care to residents with an intellectual disability in an institutional-type setting such as this, is not in compliance with evidence-based practice and does not support residents make choices about how they live
 - the locking mechanism on the doors of bathrooms and toilets were broken and therefore could not be locked to maintain the privacy of residents during personal hygiene
 - the presentation of food at mealtimes did not support the dignity of residents through practices such as adding milk to tea when it was still in large pots prior to serving residents.
- there was no evidence of a structured process of ongoing consultation with residents, relatives or advocates in relation to how the centre was planned and run.
- a number of residents had moderate to severe intellectual disability and some residents had significant communication needs and would require assistance to access advocacy services. Inspectors were not satisfied that all residents that would benefit from the support of an advocate had the support of an advocate to speak on their behalf.
- there was no evidence that the programme of activities was developed or adapted following consultation with residents to ensure they were in accordance with residents' interests, capacities and developmental needs

- the complaints log did not contain a record of whether or not residents were satisfied with the outcome of complaints as required by the regulations.

Some, but not all, of the above actions were satisfactorily addressed.

On this inspection, inspectors found that improvements had been made to the consultation process with residents and relatives, however, the remaining areas of non compliance were not satisfactorily implemented. Inspectors saw minutes of residents' meetings which began in May 2015. There was a record of four meetings since that date. Issues discussed included menu preferences, smoking facilities and social outings. There was evidence in the minutes that residents' requests were acted on. For example, a number of residents raised the matter of providing a coffee machine in the activities area. Minutes from a following meeting showed that this had been provided.

There was evidence to show engagement with family and relatives in the running of the centre. As mentioned elsewhere in the report, plans were in place to close this centre and the residents were to be transitioned to different services within community settings. Inspectors viewed minutes of meetings where residents' families were invited to discuss the proposals.

The centre had an easy-to-read complaints procedure prominently displayed in a number of areas in the centre. There was a complaints log which contained details of all complaints and correspondence relating to the complaints. Inspectors were satisfied that the complaints were appropriately documented and that complainants received updates on the progress of their complaints. However, as found on the last inspection, the complaints log did not record whether or not the complainant was satisfied with the outcome.

The last inspection found that the design and layout of the centre did not meet the privacy and dignity needs of the residents. There had been no substantive work carried out on the premises in the interim and, as such, there was no change to this finding. The providers had placed thumb-turn locks on all bathroom doors, however, as will be discussed under Outcome 6, most of these had been disabled.

There was no substantial change to the programme of activities. The programme of activities included aromatherapy, literacy, music, art, baking, horticulture and outings to local parks and amenities. Other than outings, most activities were facilitated on site either in the vegetable garden and polytunnel (greenhouse) or in the prefabricated building located in the garden at the rear of the centre. While residents appeared to enjoy participating in the available activities, there was no evidence that the programme of activities was developed or adapted following consultation with residents to ensure they were in accordance with residents' interests, capacities and developmental needs.

On the day of inspection the residents had a meeting with a number of advocates. Staff advised that there had been a number of such meetings and that it was the residents' preference that they meet with the advocates without staff being present. In addition, staff advised that three residents now had access to an advocate on a one-to-one basis and plans were in place for all residents to have access to an advocate on an individual basis however, this was not yet in place.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- residents with communication difficulties were not adequately supported to communicate, for example:
 - there was no evidence of the use of visual aids, such as pictorial menus, to communicate with residents
 - staff were seen to interact with residents and were aware of the communication needs of residents, however, they were not equipped to always meet those needs, such as the ability to communicate with residents through sign.
- there was no evidence of the use of assistive technology or other aids and appliances to promote residents' full capabilities in relation to communication.

Some of the above issues were addressed satisfactorily, however, a number of required improvements remained outstanding.

The centre had a communications policy which was reviewed in May 2015. There were a number of residents in the centre who were non-verbal. Experienced staff were capable of communicating with these residents and were familiar with their differing communication techniques. However, recently appointed staff within the centre had limited knowledge of the communication needs of these residents and relied on the experienced staff to assist in interactions. Furthermore, inspectors did not find any evidence that residents had access to assistive technologies that would aid the residents' communication needs.

The centre had made efforts to provide easy-to-read and pictorial/visual aids in places throughout the centre. For example, the complaints policy was displayed in a number of locations in an easy-to-read format. There were also pictorial signs displayed to identify the two dining rooms in the centre. Staff showed inspectors a book with pictorial menus where residents could make a choice of meal. However, the pictorial menus were not used consistently. In addition, there was a blackboard in each dining room which staff

advised was where they wrote the menu options. However, there was nothing written on the blackboards on the day of inspection. In addition, the fire evacuation procedure was not displayed in an easy-to-read format.

Judgment:

Non Compliant - Moderate

Outcome 05: Social Care Needs

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- personal plans did not address all needs identified on assessment, such as the total communication approach recommended for one resident
- the centre was not suitable for all residents living in the centre and did not have the capacity to meet their needs, for example:
 - the institutional design and layout of the centre did not support the privacy and dignity of residents
 - the noisy environment contributed to episodes of challenging behaviour
 - institutional practices contributed to the diminution of residents' potential for independence.
- personal plan reviews did not include an assessment of the effectiveness of the plan.
- residents were not adequately involved in developing their personal plans and there was minimal evidence of the involvement of relatives, where appropriate. Relatives were not always kept informed of progress in relation to personal plans, for example in relation to progress with transitioning to the community.
- personal plans were stored in residents records, which were stored in the nurses' office making them inaccessible to residents and they were not written in a format accessible to each resident.
- personal plan reviews were not always multidisciplinary
- improvements were required in relation to ongoing nursing assessment and review:
 - all sections of the nursing assessment were not completed for each resident
 - some elements of the nursing assessment for a number of residents, such as manual

handling assessment and oral health check, were not dated and it was therefore not possible to determine if all assessments were reviewed as appropriate and up-to-date - the personal plan of one resident did not accurately reflect the resident's current nutritional needs, as it had not been updated following the most recent review by a SALT.

- while records indicated that many recommendations of a multidisciplinary team (MDT) assessment were implemented, there was no systematic process to ensure that all of these recommendations were addressed.
- while inspectors were informed that there would be a transition process to support residents move to alternative accommodation, this was not documented and staff members were not familiar with the planned process. There was minimal evidence that there was a programme in place to support.

Inspectors found that there were some improvements on this inspection, however, a number of the improvements required from the previous inspection remained outstanding.

Based on a sample of personal plans reviewed, residents received a comprehensive assessment that included details of important people in the resident's life, how the resident communicates, interests, likes and dislikes, and nutrition. In addition to the detailed assessments, each personal plan contained a synopsis of relevant information to support staff that were unfamiliar with the resident gain a brief overview of the resident's needs.

The centre remained unsuitable to meet the individual needs of residents due to the institutional design and layout of the centre. There were 17 residents living in the centre on the day of inspection and even though each resident had a single bedroom, routines and practices were based on the collective rather than on individual preferences. For example, lunch and evening tea were delivered from a central kitchen on the grounds of the campus in which the centre was based and there was minimal evidence that residents had a say in the menu choices offered each day. There were periods when there was excessive noise due to one of the residents shouting making it difficult to comfortably hold a conversation.

While there was evidence that personal plans were reviewed, there was minimal evidence that the review took into consideration the effectiveness of the plan for all residents. There was evidence that residents were involved in the development of personal plans and there was evidence of consultation with relatives, where relevant. There were records of phone calls and meetings with relatives to keep them informed of progress in relation to the transition of residents to community settings.

Residents at an advanced stage in the transition to alternative accommodation had access to their personal plans in an accessible format however, this was not the case for all residents living in the centre. Personal plans for these residents remained stored in the nurses' office and were not in an accessible format.

A process of review had commenced whereby residents were reviewed by multidisciplinary team members such as psychology, speech and language therapy and occupational therapy. While there was evidence that some of the recommendations of

these assessments had been implemented, this was not the case for all. For example, a psychological review of one resident contained a recommendation for the use of visual cues to communicate with the resident and to deescalate behaviour that challenges. Inspectors were informed that the reports from the psychological reviews had only been delivered to the centre in the days prior to this inspection.

A small number of residents were at an advanced stage in transitioning to alternative accommodation and there was evidence that a process of transition had commenced whereby residents had visited the new accommodation and further visits were planned. Improvements, however, were required in relation to supporting residents develop life-skills to enable them to live as independently as possible due to the absence of an adequate training programme.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents.
- the premises was not in a good state of repair, for example:
 - there was ingrained dirt in the corners of work surfaces, rust and stains on electrical appliances in the kitchenette, such as the cooker, dishwasher
 - a number of bathrooms did not have extractor fans and there was evidence of mould on walls and ceilings
 - there were no suitable sluicing facilities resulting in commode pans being cleaned in the shower room, which was not good infection prevention and control practice and could contribute to cross contamination
 - many bathrooms and toilets did not have a functioning locking mechanism
 - a coffee table was damaged leaving a sharp edged corner on the table
- the centre was not suitably clean and decorated, for example:
 - there was dust, dirt and cobwebs behind a wire mesh in the treatment room
 - there were no signs on bathroom and toilet doors

cobwebs were visible on walls and ceilings

- excessive dust was noted on extractor fans, fire extinguishers and in the "soft play area"
- walls and chairs were stained
- the fabric on a number of chairs was damaged
- paintwork was chipped in many areas
- the floor surface was torn and stained in one of the sunrooms

Issues identified for improvement on the previous inspection were not satisfactorily addressed.

This was a two-storey premises that comprised a male and female wing and residents were free to move between both wings. Resident accommodation comprised 30 single bedrooms, 13 of which were unoccupied and unfurnished on the day of inspection. The centre was in the process of closing and four residents had moved to alternative accommodation since the most recent inspection in October 2015. Inspectors were informed that there would be no further admissions to the centre and a notification of closure had been submitted to the Chief Inspector indicating that the centre would close by 31 December 2015 when all residents would be accommodated in more suitable settings.

On the day of the inspection four female and four male residents' bedrooms were accommodated on the first floor and all other residents' bedrooms were on the ground floor. There were wash-hand basins in some, but not all, of the bedrooms.

Sanitary facilities comprised cubicle style toilets with wash-hand basins, assisted shower rooms and assisted bathrooms. On the most recent inspection it was identified that locking mechanism on the doors of bathrooms and toilets needed to be addressed to support the provision of privacy and dignity for residents during personal hygiene activities. On this inspection it was noted that new locking mechanisms had been installed, however, many of the locks were disabled due to screws being "jammed" into the locks to prevent them from closing. It was not known exactly when this had been done, by whom or for what purpose.

There were two prefabricated buildings at the rear of the centre, one of which was used for activities and the other contained offices for medical, nursing and administrative staff.

Due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents. This was partly due to the large number of residents being accommodated in the centre, which did not support privacy and dignity and contributed to a noisy environment. This in turn posed challenges for staff to provide person-centred care and contributed to episodes of behaviours that challenge by residents.

Housekeeping staff had been redeployed two days prior to this inspection as part of the staff changeover however, new cleaning staff had not yet been sourced. Similar to the findings of the previous inspection in October 2014, the centre was not suitably clean and decorated and there was minimal evidence of improvements. For example:

- there continued to be ingrained dirt in the corners of work surfaces, rust and stains on electrical appliances in the kitchenette, such as the cooker, dishwasher
- a number of bathrooms continued to not have extractor fans and there was evidence of mould remained on walls and ceilings
- there continued to be foul smells in showers and toilets
- there continued to be no suitable sluicing facilities
- there continued to be no signs on bathroom and toilet doors
- there continued to be cobwebs visible on walls and ceilings
- there continued to be excessive dust on extractor fans and fire extinguishers
- the fabric on one of the couches was badly damaged
- paintwork remained chipped in many areas

An immediate action plan was issued in relation to the above issues.

Records were available demonstrating the preventive maintenance of equipment such as hoists, beds and baths.

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:

Actions required from the previous inspection included:

- there was no overall risk management policy outlining the arrangements in place for identifying, recording, investigating and learning from serious incidents.
- a number of improvements were required in relation to the management of risk:
 - there was no evidence of an overall review of accidents and incidents to identify trends to support learning and minimise the reoccurrence of such events
 - some risk assessments did not adequately identify the controls in place or additional measures required to minimise the risks identified
 - a number of risks that were not addressed in the risk register or individually for residents, such as access to the kitchen where sharp utensils and hot water boilers were readily accessible
 - unlabelled cleaning chemicals, used for cleaning baths and wash-hand basins, were stored in toilets and bathrooms but there was no risk assessment to identify the risk of ingestion by residents or whether they should be stored securely and inaccessible to residents

- the personal alarm panel identifying the location of the staff member requiring assistance was located in a locked nurses office and did not support staff to come to the aid of their colleague in a timely manner.
- inspectors noted personal hygiene items, such as skin barrier creams, that were available in communal bathrooms and were not labelled for individual use. One of these creams had been opened and was visibly unclean and posed a risk of cross contamination.
- there were no suitable sluicing facilities, resulting in commode pans being cleaned in the shower room, which potentially compromised the prevention of cross contamination
- each resident had a personal emergency evacuation plan outlining what to do in the event of a fire, however, these plans were identical for most residents and did not address each residents requirements in relation to evacuation, such as level of mobility and planned mode of evacuation.
- there were arrangements for reviewing fire precautions including the inspection of fire doors and ensuring fire exits were unobstructed, however this was not always completed.
- inspectors observed a number of fire safety hazards, including;
 - there were door ledges on fire doors that were potential trip hazards
 - one of the fire doors opened inwards
 - there were no records available of testing emergency lighting and staff were unable to confirm that suitable emergency lighting was available.
 - fire exits could only be opened with a key
 - the fire and safety officer indicated that one of the identified fire exits was unsuitable.
- the fire alarm panel, used to identify the location of a fire, was located in the nurses office, which was usually locked and not easily accessible by staff and inaccessible by residents and visitors in the event of a fire.
- not all staff members spoken with were knowledgeable of the evacuation process in the event of a fire, including the assembly point, and not all staff were familiar with the location of the fire alarm panel.

Some, but not all, of the issues identified on the most recent inspection were addressed satisfactorily.

There was a risk management policy that provided detailed guidance for managing incidents including the identification and investigation of incidents and actions to be take to minimise reoccurrence, however, it was not always implemented in practice. For example, a recent incident of a resident absconding had not been adequately investigated to identify how the resident had absconded. Measures had been put in place to minimise the risk of reoccurrence that included repairing the locking mechanism on the front door and one-to-one staffing for the resident concerned. However, even though the resident stated that he had absconded via the perimeter fence, this was not properly investigated and remediated to prevent other residents from absconding. In accordance with the policy on missing persons/service users, the resident's risk assessment for absconding was reviewed following the incident, however, inspectors were not satisfied that the review was adequate. For example, even though the resident had absconded twice, the likelihood score remained at "unlikely" and the residual risk remained at green (low risk).

The risk management policy did not address the risks and measures in place to control

the unexpected absence of a resident; accidental injury to residents, visitors, or staff; aggression and violence; or self-harm.

Additional improvements were also required in relation to incident and risk management. There was an inadequate system in place for reviewing and learning from incidents. For example, even though incidents were recorded and each incident was reviewed individually there was an inadequate system for reviewing incidents to identify trends to support learning and minimise reoccurrence.

Personal hygiene items such as shampoo and skin barrier cream continued to be available in communal bathrooms/showers and were not labelled to identify use by individual residents.

A sample of personal emergency plans were reviewed and contained adequate information to identify the supports necessary to evacuate residents in the event of an emergency. However, the plans were contained in residents' personal plans and were not easily accessible to staff in the event of an emergency. There were arrangements in place for reviewing fire precautions, including daily checks of means of escape, fire safety equipment, the fire alarm panel and break glass units. Fire exits were seen to be unobstructed on the day of inspection.

There continued to be some fire safety hazards, including a door wedge on a fire door that was a potential trip hazard, a fire door opened inwards and was identified as unsuitable by the fire safety officer and fire exits could only be opened with a key. The fire alarm panel remained in an office, however, the door was unlocked and the fire alarm panel was accessible to all.

Due to a change in staffing skill mix, a number of new staff, predominantly social care workers/healthcare assistants, had started working in the centre on the day prior to this inspection and existing staff had returned to mental health services. All of the new staff had not received centre-specific fire safety training. Even though such training had been scheduled to take place as part of staff induction before they commenced working in the centre, this had not happened. Inspectors were informed by management, and minutes of meetings viewed by inspectors confirmed, that union representatives had informed management that members of the union would not work alongside the new staff. Inspectors were also informed by management that a union representative had objected to the new staff being on the premises before the date they were due to commence employment in the centre. Therefore fire safety training in respect of building layout, escape routes, location of fire alarm call points and location of first aid fire fighting equipment could not take place. Inspectors considered that the absence of suitable fire safety training posed a risk to the safety of residents and an immediate action plan was issued to address staff training in fire safety.

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:

Improvements required from the previous inspection included:

- inspectors were not satisfied that there was clarity in relation to the use of the soft play/time out room regarding:
 - the evidence base to support the use of the room
 - the therapeutic use of the room or the benefits to be obtained by residents spending time in the room
 - when it could be used
 - for what type of behaviour
 - the length of time that residents should spend there
 - the level of supervision required when residents were in the room
- there was no policy or procedure available for the management of locked/secured doors or residents access or egress from the centre
- two members of staff were overheard speaking to residents in a disrespectful/inappropriate manner; one staff member was heard repeatedly telling a resident to leave a room in a non-respectful and forceful tone of voice and a second staff member talked about a resident as though the resident was not present in the room at the time of the conversation
- most, but not all staff, had received up-to-date training on the recognition and response to abuse.

Some of the above actions were satisfactorily addressed since the most recent inspection.

The soft play/time out room was no longer in use and was no longer accessible by residents. There was a policy in place addressing the management of locked/secured external doors.

There was a policy in place identifying what to do in the event of suspicions or allegations of abuse. There was a policy on the management of behaviour that challenges and a policy on the use of restraint. Other than locked external doors, there was no restraint in use in the centre on the days of inspection. Staff members were seen to interact with residents in a courteous and respectful manner. A number of residents presented with behaviour that challenges. A small number of staff were

familiar with residents and the triggers that could precipitate behaviour that challenges, however, as many of the staff were new, they were not all familiar with residents' behaviours.

Inspectors were informed that the new team of staff engaged by the centre the previous day had all received training in responding to allegations or suspicions of abuse as a component of their induction, as well as from the agency that employed them. However, training records were not available in the centre on the day of inspection to verify this. In addition, inspectors were informed that not all members of staff had undergone training in positive behaviour support and as already stated adequate training records were not available to ascertain what members of staff had received up-to-date training in the management of behaviour that challenges or physical intervention techniques.

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):

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

Findings:

The previous inspection found that notifications required to be submitted to the Chief Inspector on a quarterly basis had not been submitted. This inspection found that a written record of incident/accidents occurring in the centre was maintained and the Chief Inspector had been notified as required by the regulations.

Judgment:

Compliant

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):

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

Findings:

Improvements required from the previous inspection included:

- there was insufficient evidence to demonstrate that residents are supported to attain educational goals outlined in personal plans.

The above action was not satisfactorily addressed.

Personal care plans identified goals of developing budgeting and money management skills, and reading and writing skills. However, similar to the findings of the previous inspection there was insufficient evidence to identify how residents were supported in achieving many of the goals identified in their plans. There was no evidence that the programme of activities was developed based on an assessment of residents in order to provide activities to support residents achieve their potential.

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):

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

Findings:

Improvements required from the previous inspection included:

- records indicated that residents had access to the services of a GP and there was evidence of regular assessment and review, however, there were no records available to indicate that residents were consulted in relation to whether or not the GP was acceptable to them
- improvements were required in relation choice of food for all residents:
 - there was no evidence of consultation with residents in relation to the menu options available
 - residents on modified diets were not offered a choice of food at mealtimes, as there was only one option of modified texture food available for each meal
 - tea was served from large pots with milk already added.
- the records of one resident indicated that the resident had been given free fluids when the resident had been prescribed thickened fluids. Even though a subsequent assessment of the resident recommended that the resident could have free fluids, this

was being done in the absence of an updated review by a SALT.

- inspectors observed residents that were prescribed a modified diet having their food served with the potato, vegetable, meat and gravy/sauce all mashed together by staff before being served.

Some, but not all, of the above actions were not satisfactorily addressed.

Records indicated that residents had access to the services of a General Practitioner (GP) and there was evidence of regular assessment and medical review. All residents were under the care of one GP but inspectors were informed that should a resident request the services of another GP, this would be facilitated; this was included in the statement of purpose. Residents had access to out-of-hours GP and urgent care services. The service provided in the centre was led by a consultant psychiatrist and there was evidence of regular review. Records indicated referral and review by services such as psychology, dietetics, speech and language therapy, chiropody and physiotherapy.

Records indicated that residents had a nutritional assessment, including monthly weights. Inspectors observed the provision of meals within the centre and found that residents could exercise choice in respect of what they ate. Residents spoken with by inspectors stated that they were happy with food at mealtimes. There were two dining rooms and even though inspectors were informed that residents could eat in either dining room, in practice, male residents had their meals in one and females ate in the other dining room. Food was delivered in heated food trolleys to the centre from a separate facility within the same campus. Residents were offered a choice of foods, including residents who were on modified diets. Food appeared to be nutritious and was presented appropriately. Inspectors observed the breakfast, dinner and tea sittings in the centre. Residents requiring assistance were assisted by staff in a dignified and respectful manner. There were a variety of foods available at breakfast and tea. Residents who requested snacks throughout the day were facilitated and some residents were given access to the kitchenette area to avail of snacks/drinks. Residents were observed to be given food and fluids based on that prescribed by a speech and language therapist.

Each resident had a comprehensive nursing assessment however, some improvements were required. For example, the nursing assessment for one resident stated that the resident did not have any problems with their thyroid, while in another section of the record it was stated that the resident had an underactive thyroid gland (hypothyroidism). The section dealing with epilepsy for one resident was not adequately completed, even though records indicated that the resident had a previous history of epilepsy. This action is addressed under Outcome 5.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- improvements were required in relation to medication management practices, as:
 - there was a large stack of "stock" medications, however, there was no stock control system in place
 - some medicines were disposed of in sharps boxes, which is not in compliance with best practice
- there was no process in place to ascertain if the available pharmacist was acceptable to the residents.

The above actions were satisfactorily addressed.

There was a policy on medication management dated September 2013 and due for review in September 2014 however, it was not clear that this had taken place. Medications were supplied to the centre from a single pharmacy and inspectors were informed that should residents wish to have their medications supplied from another pharmacy, then this would be facilitated.

Based on a review of a sample of prescription and medication administration records, all appropriate information was available on the records to support the safe administration of medicines. Residents' prescriptions were regularly reviewed.

Inspectors observed medication administration practices and were satisfied that they were in compliance with relevant professional guidance. There was no longer a large stock of medications in the centre and there was an adequate system in place for the disposal and return of unused medication to the pharmacy.

There were no controlled drugs in the centre on the days of inspection.

Judgment:

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):

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

Findings:

Improvements required from the previous inspection included:

- there was a written statement of purpose, however, it did not accurately describe the services provided in the centre and did not contain all of the information required in Schedule 1 of the regulations.
- the statement of purpose was not available in a format accessible to the residents.

One of the above actions was addressed, however, the other remained outstanding.

The Statement of Purpose was reviewed in March 2015. Nevertheless, at the time of this inspection, it did not meet the requirements of the regulations. Shortcomings included that it did not set out the specific care needs that the service was designed to meet, it did not adequately outline the complaints procedures, it did not contain an adequate description of room sizes, and it did not outline current staffing arrangements.

While an accessible version of the Statement of Purpose had been made available to residents by way of the Resident's Guide, the content of it was insufficient. This was further discussed under Outcome 18.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- improvements were required in relation to the system for monitoring and reviewing the quality and safety of care:
 - a number of audits had been completed in the weeks prior to the inspection, however, there was minimal evidence of a systematic process to review the quality and safety of care prior to these audits. As the audits had only recently been completed there was minimal evidence of improvements in response to the audits
 - an infection prevention and control audit completed by an infection control nurse in July 2014 identified a number of issues for improvement, however, the findings of this inspection indicate that many of the issues identified were not satisfactorily addressed. These included the inappropriate storage and communal use of personal hygiene items and deficits in environmental cleaning.
- the process of audit did not incorporate consultation with residents and/or their representative/relatives.
- inspectors were not satisfied that the system in place for identifying the person responsible for supervising care delivery at evenings and weekends provided adequate oversight of the centre to support the consistent delivery of safe, effective care.

Some actions remained outstanding since the last inspection, however, additional issues were also identified for improvement on this inspection.

The centre had previously been staffed by nurses from health service executive (HSE) mental health services however, a decision had been taken to transition to a social care model from a nursing model with the introduction of social care workers/healthcare assistants. The Authority had been informed of this proposal in advance and the changeover had occurred on the day before this inspection. Nursing staff had returned to mental health services and the centre was now staffed by nurses and social care workers/healthcare assistants employed through an agency. In order to ensure residents were adequately supported during the changeover, a number of staff that had previously worked in the centre through an agency continued to work in the centre. These included two clinical nurse managers and some staff nurses. The person in charge and the clinical nurse manager 3 remained working in the centre and were familiar with the residents.

Even though staff had undergone an induction process in the week prior to the changeover, inspectors were not satisfied that there were adequate management systems in place to ensure the service was safe, appropriate to residents' needs, consistent and effectively monitored. For example, not all staff members spoken with were adequately knowledgeable of residents' individual needs due to the absence of a transition period whereby new staff would receive a handover from staff that previously worked in the centre. Due to the absence of an adequate system of delegation staff were unclear of their responsibilities, such as, for example, which members of staff were responsible for ensuring that the needs of individual residents were met. Additionally, as already discussed under Outcome 7, staff had not received suitable centre-specific fire safety training as a result of not being permitted to be on site prior to the scheduled changeover on 01 July 2015. This training had been scheduled to take place in the centre on the Friday before the changeover occurred. An immediate action plan was issued to address this issue. One of the clinical nurse managers was on annual leave

and the other was scheduled to commence work in another HSE service in the week following this inspection. This arrangement had the potential to disrupt the continuity of care provided to residents. This was allayed somewhat by the presence of the person in charge and/or the clinical nurse manager in the centre each day, including weekends.

Inspectors were satisfied that there were adequate numbers of staff on duty, however, based on a review of staff rosters, the roster did not identify who was responsible for supervising care delivery and to oversee the delivery of safe, effective care.

The provider had not carried out an unannounced visit to the centre at least every six months, as required by the regulations, to report on the quality and safety of care and support provided in the centre.

There was evidence of a review of the quality and safety of care as evidenced by audits on medication management and communication, however, improvements were required. For example, some audits were undated and there were no records to demonstrate that actions identified were addressed or who was responsible for implementing the recommendations. The last inspection noted that the findings of the Infection Control Audit in July 2014 had not been adequately addressed. This inspection found that some recommendations had been implemented, however, there remained deficits in implementation for example, environmental cleaning still required significant improvement. There was evidence of consultation with residents through residents meetings and with relatives through a relative's forum.

There was a person in charge worked full time and was a suitably skilled, qualified and experienced manager. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

Judgment:

Non Compliant - Major

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There was no period when the person in charge was absent for a period in excess of 28 days.

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

Findings:
Improvements required from the previous inspection included:
• the facilities and services available do not reflect the statement of purpose or support residents to achieve maximum independence and quality of life.

The above action was not satisfactorily addressed.

There was evidence to support the provision of resources, for example, by the improvements made to the centre since the last inspection in areas such as new dining room and some sitting room furniture. However, the facilities and services available did not reflect the statement of purpose or support residents to achieve maximum independence and quality of life.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

implemented.

Findings:

Improvements required from the previous inspection included:

- there was an over reliance on staff working overtime and on agency staff that did not support the continuity of care
- staff did not have the required training to meet the needs of all residents, particularly in relation to communicating with residents with communication difficulties
- there were inadequate arrangements in place for the supervision of care delivery at all times
- there was not an adequate programme of induction for new staff, particularly in relation to the specific profile of residents living in the centre.

The above actions were not satisfactorily addressed.

There were seventeen residents living in the centre on the day of inspection. Daytime staffing on that day comprised the person in charge, a clinical nurse manager 3, a clinical nurse manager 2, four staff nurses and seven social care workers/health care assistants. Based on a review of the roster, night-time staffing comprised three nurses and two social care workers/healthcare assistants. Based on the observations of inspectors on the day of inspection there were adequate numbers of staff on duty to meet the needs of residents. However, as already discussed under Outcome 14 improvements were required in relation to the supervision of staff and the delegation of roles to ensure the needs of residents were met.

Other than the person in charge and the clinical nurse manager 3, the service was now completely reliant on agency staff. Based on a review of staff rosters efforts had been made to ensure there were consistent staff on duty to support the continuity of care. However, even though there was an induction process for staff, the process was not adequate as all staff members were not familiar with residents individual needs due to the absence of an adequate handover or induction. As already discussed under Outcome 14, the staff roster did not identify who was responsible for supervising care delivery and to oversee the delivery of safe, effective care. Additionally the person in charge or the clinical nurse manager 3 were not identified on the roster.

Training records were not available in the centre and it was not possible to determine if all staff had received training in relevant issues, such as adult protection, behaviour that challenges, manual handling or communication. As already stated, many of the staff were employed through an agency. Records were not available in the centre on the day of inspection demonstrating that information and documents as specified in Schedule 2 were obtained for all staff.

Judgment:

Non Compliant - Major

Outcome 18: Records and documentation

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

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Improvements required from the previous inspection included:

- some policies were not centre-specific, such as the medication management policy and others were not available, such as provision of behavioural support; creation, access and destruction of records; and access to education training and development.
- there was no directory of residents containing all of the information specified in paragraph 3 of Schedule 3 of the regulations.
- there was a residents' guide in an accessible format, however, it did not include all of the information required by the regulations, such as the terms and conditions relating to residency, arrangements for resident involvement in the running of the centre, how to access any inspection reports on the centre or sufficient detail of the complaints process.

Some, but not all, of the above actions were satisfactorily addressed.

Policies and procedures were in the process of being updated, however, all policies specified in Schedule 5 of the Regulations were not available such as provision of intimate care; staff training and development; and the creation, retention and destruction of records. Furthermore, the policy for the recognition, prevention and response to abuse and incident management referenced the requirement of statutory notifications, however, they failed to include the legal duty to notify the Authority, where relevant. The available policies had a signature sheet for staff to sign once they read and understood the policy however, none of these had been signed.

The directory of residents did not contain all of the information required by Schedule 3(3) of the Regulations. Information missing included marital status, next of kin details, address of the General Practitioner and sources of admission.

There was a residents' guide that contained most of the information from the Statement of Purpose in an accessible format. However, not all of the information required by the regulations was included. For example the guide did not contain the terms and conditions of residency, it did not identify the arrangements for resident's involvement in

the running of the centre, it did not identify how residents could access inspection reports, and there was insufficient detail on the complaints and appeals process.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0002459
Date of Inspection:	02 July 2015
Date of response:	08 September 2015

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The design and layout of the centre did not support the privacy and dignity of residents or support residents to make choices about their lives in a manner that reflected their individual preferences and diverse needs. For example:

- the provision of care to residents with an intellectual disability in an institutional type

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

setting such as this, is not in compliance with evidence-based practice and does not support residents make choices about how they live

- the locking mechanism on the doors of bathrooms and toilets were disabled by the insertion of screws into the locking mechanism and therefore could not be locked to maintain the privacy of residents during personal hygiene

1. Action Required:

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

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

- Due to the structure/layout of the building and, since the HIQA inspection of October 2014 and in the light of the Congregated Settings recommendations, all current service users are in the process of transitioning to new service providers in community-based settings and once all are re-settled, the Centre is under Notification of Closure to HIQA with a planned closure date of December 2015.
- All locks on bathrooms/toilets were checked by the locksmith and made operative as of Friday 3rd July.

Proposed Timescale: 31/12/2015

Theme: Individualised Supports and Care

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

Plans were in place for all residents to have access to an advocate on an individual basis, but this was not yet in place.

2. Action Required:

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

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

- All service users have access to Advocacy services with representatives from Cork Advocacy Service, who visit the Centre on a fortnightly basis to provide support as required.
- The National Advocacy Service is to begin working with service users from 10th August 2015, in collaboration with Cork Advocacy Service. Each service user will be enabled to have one-to-one support.

Proposed Timescale: 10/08/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

There was no evidence that the programme of activities was developed or adapted following consultation with residents to ensure they were in accordance with residents' interests, capacities and developmental needs.

3. Action Required:

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

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

- From July 2015, each service user is provided with a 'Daily Journal' facility, whereby all discussions relevant to their interests, wishes and needs can be recorded as they are developed during interactions between staff and service users.
- Case Reviews, Transition Reviews and informal meetings held with the service users are all recorded and where possible, new experiences are arranged locally based on requests and recommendations therein.
- Following on from the recent assessment conducted by the SALT, each service user has been provided with a visual calendar using pictures to depict regular events and activities happening on a daily basis.
- New Service Providers will be given information about future options for each resident along with Care Plans during transition planning.

Proposed Timescale: 31/07/2015

Theme: Individualised Supports and Care

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

The complaints log did not record whether or not the complainant was satisfied with the outcome.

4. Action Required:

Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

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

- The currently ongoing revision of the Complaints Management Policy will include recording the complainant's level of satisfaction with the outcome of their complaint.

Proposed Timescale: 31/07/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Experienced staff were capable of communicating with residents and were familiar with their differing communication techniques. However, the new staff within the centre had limited knowledge of the communication needs of residents and relied on the experienced staff to assist in interactions.

5. Action Required:

Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.

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

- All new staff will familiarise themselves with the Care Plans for each service user in their care. Specific attention will be given to understanding how the service users communicate which is detailed in the Assisted Communication assessments which were recently undertaken by the SALT.
- All new staff will have their picture taken which will then be displayed on the notice-board to aid service users' recognition of staff members.
- Pictorial Menu Cards have been produced to facilitate choice-making at meal times.
- Visual Calendars with pictorial prompts for activities, interests and planning daily living processes have been personalised for each service user.
- Each member of staff will be assigned as a key worker for individual service users in order to develop specific in-depth knowledge relating to their abilities and needs.
- Options for extension of Lámh training will be investigated and funding sought if required.

Proposed Timescale: 31/08/2015

Theme: Individualised Supports and Care

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

Pictorial menus were not used consistently. In addition, there was a blackboard in each dining room which staff advised was where they wrote the menu options. There was nothing written on the blackboards on the day of inspection. The fire evacuation procedure was not displayed in an easy-to-read format.

6. Action Required:

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

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

- All staff are to use the pictorial aids when communicating with service users about choices for menus.
- Daily handover will specify that the blackboard is to be updated daily with menu

options.

- The Fire Safety Policy is currently under review [with assistance from Quality and Safety Team] and will be displayed in easy read format on completion of review [30th September 2015

Proposed Timescale: 31/07/2015

Outcome 05: Social Care Needs

Theme: Effective Services

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

The centre remained unsuitable to meet the individual needs of residents due to the institutional design and layout of the centre. For example, there were periods when there was excessive noise due to one of the residents shouting making it difficult to comfortably hold a conversation.

7. 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:

- No feasible modifications are possible to the design/layout of the building. –Following on from the Time to Move on from Congregated Settings report and the HIQA inspection in October 2014, this centre is under HIQA Notification of Closure. This is scheduled for December 2015 once service users have been transitioned to new community-based service providers.

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

There was evidence that personal plans were reviewed, however, there was minimal evidence that the review took into consideration the effectiveness of the plan for all residents.

8. 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:

- Quarterly Reviews will reflect the changes in circumstances, new developments and the effectiveness of the Care Plans.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

Residents at an advanced stage in the transition to alternative accommodation had access to their personal in an accessible format, but this was not the case for all residents living in the centre. Personal plans for these residents remained stored in the nurses office and were not in an accessible format.

9. Action Required:

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

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

- Personal Plans under review will include a visual summary of the transition issues raised during the consultation and planning towards the move to a new service provider.
- An Assessment Matrix is in development, to summarise the consultations with multi-disciplinary professionals undertaken for each service user, to include an Action Plan/Checklist.
- A Transition Flowchart in development will assist service users and staff in understanding the processes involved in gathering information on needs/services/locations/supports required to progress each service user into the most appropriate new service.

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

While there was evidence that some of the recommendations of psychological assessments had been implemented, this was not the case for all. For example, a psychological review of one resident contained a recommendation for the use of visual cues to communicate with the resident and to deescalate behaviour that challenges.

10. Action Required:

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

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

- Personal Plans under review will include a visual summary of the transition issues raised during the consultation and planning towards the move to a new service

provider.

- An Assessment Matrix is in development, to summarise the consultations with multi-disciplinary professionals undertaken for each service user, to include an Action Plan/Checklist.

- A Transition Flowchart in development will assist service users and staff in understanding the processes involved in gathering information on needs/services/locations/supports required to progress each service user into the most appropriate new service.

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

Improvements were required in relation to supporting residents develop life-skills to enable them to live as independently as possible.

11. Action Required:

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

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

- Transition Plans will include recommendations and take into account arrangements needed to enable service users have their needs met, or are notified onwards to their new service providers, pending transition.

Proposed Timescale: 31/08/2015

Theme: Effective Services

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

Each resident had a comprehensive nursing assessment, however, some improvements were required. For example, the nursing assessment for one resident stated that the resident did not have any problems with their thyroid, while in another section of the record it was stated that the resident had hypothyroidism. The section dealing with epilepsy for one resident was not adequately completed, even though records indicated that the resident had a previous history of epilepsy.

12. Action Required:

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

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

- Service users are routinely assessed by GP, Consultant Psychiatrist.
- Where appropriate, further assessments have been undertaken by Psychologist, Occupational Therapist, Speech and Language Therapist, Dietician.
- Routine examinations are carried out by the Optician, Dentist, and Chiropodist.
- Further advice and recommendations have been sought by the therapy staff who provide sensory day services such Aromatherapy, Horticulture training, Music Therapy, Art and Drama.
- Individual Care Plans are Audited and reviewed on a quarterly basis since the inspection in October 2014 and remain under constant monitoring during the current transition planning for service users to move to a new service provider by December 2015.
- Care Plans highlighted by the Inspection Report have been cross-checked to ensure contradictory statements are challenged/corrected by July 31st 2015
- Ongoing/Quarterly Review Programme in place until closure – 31st Dec 2015

Proposed Timescale: 30/09/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Due to the institutional design and layout of the premises, it was not suitable to meet the aims and objectives of the service and the needs of the residents.

13. Action Required:

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

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

- New service providers are being sought for each service user as appropriate based on their recommended needs outlined in their Personal Care Plans/Transition Plans.
- Options are being assessed to use and/or adapt rooms to better suit the needs of the service users where appropriate. Progress on this will depend on pricing and suitability for ongoing purpose

Proposed Timescale: 31/12/2015

Theme: Effective Services

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

On this inspection it was noted that new locking mechanisms had been installed, however, many of the locks were disabled due to screws being "jammed" into the locks to prevent them from closing.

14. 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:

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

- Locksmith checked/re-activated all locks throughout Grove House Centre during a visit on 3rd July.

Proposed Timescale: 3rd July 2015

Proposed Timescale: 03/07/2015

Theme: Effective Services

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

- there was ingrained dirt in the corners of work surfaces, rust and stains on electrical appliances in the kitchenette, such as the cooker, dishwasher
- there were no suitable sluicing facilities
- there were no signs on bathroom and toilet doors
- the fabric on one of the couches was badly damaged
- paintwork was chipped in many areas

15. 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:

- Deep clean instigated with new cleaning contractor for appliances and fittings in Kitchens and Bathrooms.
- Ongoing provision of 13 hours of daily cleaning from staff via new cleaning contractor to ensure no further issues with cleanliness of building, fixtures and fittings.
- Damaged sofa was removed.
- Signs have been ordered for Bathrooms/Toilets and Emergency Exit [to be fitted by 31st July 2015].
- An audit is to be conducted regarding the paintwork which will inform the decision-making process surrounding the level of cost/source of funding to be approved.

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

- excessive dust was noted on extractor fans and fire extinguishers
- a number of bathrooms did not have extractor fans and there was evidence of mould on walls and ceilings
- there were foul smells in showers and toilets
- cobwebs were visible on walls and ceilings

16. Action Required:

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

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

- Deep clean conducted by new cleaning contractor to ensure cleanliness of all fittings and fixtures, bathrooms and toilets was brought up to standard.
- New schedule for cleaning the building, fixtures and fittings in development for ongoing cleanliness of same with monthly audits to monitor same.

Proposed Timescale: 31/07/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Improvements were required in relation to the management of risk, such as:

- The risk management policy was not always implemented in practice such as following the absconsion of a resident

17. 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:

- Review of Risk and Safety Incident Management Policy [currently ongoing with assistance from the Quality and Safety team] will be completed, updated and put in place to include specific procedures for ensuring security and safety of all service users, including absconsion or missing service user.
- Incident Feedback to be given to all staff once an incident is signed off as reviewed, with learning outcomes implemented locally immediately, as appropriate.
- Quarterly Learning Outcomes to be reviewed and recommendations implemented timeously pending final report.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

There was an inadequate system in place for a systematic review of incidents for the purpose of learning and minimising the risk of reoccurrence

18. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

•National Risk and Safety Incident Management Policy to be adopted as local policy [undergoing review currently with assistance from Quality and Safety team],to include the arrangements for identification, recording and investigation of, and learning from, serious incidents or adverse events involving service users.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

The risk management policy did not address the risks and measures in place to control the unexpected absence of a resident.

19. Action Required:

Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

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

•As above, National Risk and Safety Incident Management Policy to be adopted as local policy[undergoing review currently with assistance from Quality and Safety team], including the arrangements for identification, recording and investigation of, and learning from, serious incidents or adverse events involving service users, including the unexplained absence of a service user.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

The risk management policy did not address the risks and measures in place to control accidental injury to residents, visitors, or staff.

20. Action Required:

Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

•As above, National Risk and Safety Incident Management Policy to be adopted as local policy [undergoing review currently with assistance from Quality and Safety team], to include the risks and measures in place to control accidental injury to residents, visitors or staff.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

The risk management policy did not address the risks and measures in place to control aggression and violence.

21. 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:

•As above, National Risk and Safety Incident Management Policy to be adopted as local policy [undergoing review currently with assistance from Quality and Safety team], to address the measured actions in place to control aggression and violence.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

The risk management policy did not address the risks and measures in place to control self-harm.

22. Action Required:

Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

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

•As above, National Risk and Safety Incident Management Policy to be adopted as local policy [undergoing review currently with assistance from Quality and Safety team] to include addressing the risks and measures in place to control self-harm.

Proposed Timescale: 30/09/2015

Theme: Effective Services

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

Personal hygiene items such as shampoo and skin barrier cream continued to be available in communal bathrooms/showers and were not labelled to identify use by individual residents.

23. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

- All toiletries and medications are labelled for the specific user and are stored in personal toiletry holders.
- Hand-washing solutions and instructions are available in all areas of the Unit, with all staff having undergone Infection Control training.

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

Personal emergency evacuation plans were contained in residents' personal plans and were not easily accessible to staff in the event of an emergency.

24. Action Required:

Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

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

Personal Evacuation Plans are in place for all service users and staff and are available in the Nursing Office.

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

There continued to be some fire safety hazards, including a door ledge on a fire door that was a potential trip hazard, a fire door opened inwards and was identified as

unsuitable by the fire safety officer and fire exits could only be opened with a key.

25. Action Required:

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

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

- Emergency Lighting has been placed to highlight the trip hazard. This is checked nightly by staff and quarterly by a contractor. Reports will include evidence of same.
- Additional Exit signage is to be fitted to one door [corridor, near room that is out of service], with sensor lighting to upgrade visibility of exit.
- A Pass-Key system is in place whereby all members of staff have a single key that opens all doors in the Unit in the event of emergencies [supported by emergency evacuation plans for all service users]. This is utilised because the Unit doors open directly onto public highways on the Health Campus and thus minimises the known risk of absconion.

Proposed Timescale: 31/07/2015

Theme: Effective Services

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

All staff had not received suitable fire safety training in respect of building layout, escape routes, location of fire alarm call points and location of first aid fire fighting equipment could not take place.

26. Action Required:

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

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

- Training has been undertaken by all staff in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Proposed Timescale: 30/09/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Some of the staff were familiar with residents and the triggers that could precipitate behaviour that challenges, however, as many of the staff were new, they were not all familiar with residents' behaviours.

27. 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:

- Mandatory Training for all staff to be audited via a Training Matrix.
- All staff to undertake training on challenging behaviour and positive behaviour management.

Proposed Timescale: 30/09/2015

Theme: Safe Services

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

Inspectors were informed that not all members of staff had undergone training in positive behaviour support or physical intervention techniques.

28. 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:

- Mandatory Training for all staff to be audited via a Training Matrix.
- All staff to undertake training on challenging behaviour and de-escalation techniques.

Proposed Timescale: 30/09/2015

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:

There was insufficient evidence to identify how residents were supported in achieving many of the goals identified in their plans.

29. 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:

- During Case Reviews/Transition Reviews and using evidence from the Daily Journal, opportunities to develop the education, training and employment prospects of service users will be developed, either locally where available, or as part of the Transition Plans for their new service providers to initiate, once same has been identified
- Assistance to be sought from SALT regarding the assessment and planning of goals, in the light of having a new staff base with a varied skill mix and social care model being implemented since 1st July.

Proposed Timescale: 30/09/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose did not contain all the information specified in the regulations.

30. 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:

- Statement of Purpose [currently under review] will include all information required as per regulations.

Proposed Timescale: 11/09/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

There were inadequate systems in place to ensure that service provided is safe, appropriate to residents' needs, consistent and effectively monitored due to inadequate induction, inadequate training, inadequate knowledge of residents' needs, inadequate staff delegation and lack of effective handover.

31. 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:

- New Daily Handover procedure implemented to ensure continuity of cover and service.

Proposed Timescale: 31/07/2015

Theme: Leadership, Governance and Management

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

One of the clinical nurse managers was on annual leave and the other was scheduled to commence work in another HSE service in the week following this inspection. This had the potential to disrupt the continuity of care provided to residents.

32. 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:

- Staffing hierarchy developed with teams identified and Lead Persons designated. This information is displayed in the Unit and communal areas to inform staff and service users of roles and responsibilities within the Service.
- Vacant CNM2 post to be filled once candidate identified and salary impact negotiated.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

While inspectors were satisfied that there were adequate numbers of staff on duty based on a review of staff rosters, the roster did not identify who was responsible for supervising care delivery and to oversee the delivery of safe, effective care.

33. Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

- Staff hierarchy [in development pending identification of new CNM2] in chart form showing roles and line management within teams to be displayed in Unit and included in updated Statement of Purpose.

Proposed Timescale: 31/07/2015

Theme: Leadership, Governance and Management

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

The provider had not carried out an unannounced visit to the centre at least every six months, as required by the regulations, to report on the quality and safety of care and support provided in the centre.

34. Action Required:

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

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

- Registered provider will undertake at least one un-announced visit by 30th September.

Proposed Timescale: 30/09/2015

Theme: Leadership, Governance and Management

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

There was evidence of a review of the quality and safety of care as evidenced by audits on medication management and communication, however, improvements were required. For example, some audits were undated and there were no records to demonstrate that actions identified were addressed or who was responsible for implementing the recommendations.

35. 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:

- All policies, procedures and guidelines to be reviewed and updated in line with best practice and regulatory controls.
- Safety Statement to be reviewed.
- Audit Matrix system to be established giving dates and evidence of implementation of changes in line with best practice for quality and safety of care.

Proposed Timescale: 30/09/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

The facilities and services available did not reflect the statement of purpose or support residents to achieve maximum independence and quality of life.

36. Action Required:

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

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

- HSE budgets and resources to be managed effectively and efficiently as per policy, procedure and guidelines.
- Facilities and services provided to the service users will be based on their choices and maximising their independence.

Proposed Timescale: 31/08/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

Even though there was an induction process for staff, the process was not adequate as all staff members were not familiar with residents' individual needs due to the absence of an adequate handover.

37. 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:

- Residents' individual needs are discussed during handover between staff.
- Higher than usual ratio of staff to service users is in place during the transition to new services. An effective team-work approach is in place to ensure all service users are cared for and supported in their needs.

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

The staff roster did not identify who was responsible for supervising care delivery and to oversee the delivery of safe, effective care. Additionally the person in charge or the clinical nurse manager 3 were not identified on the roster.

38. Action Required:

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

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

- Weekly Rotas to be planned in advance, using a rotating team system, with regular staff on duty, supplemented where appropriate to ensure activation of service users, coverage of all shifts and relevant skill mix available at all times.
- PIC/CNM3 to be identified on Rosters.

Proposed Timescale: 31/08/2015

Theme: Responsive Workforce

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

Many of the staff were employed through an agency. Records were not available in the centre on the day of inspection demonstrating that information and documents as specified in Schedule 2 were obtained for all staff.

39. Action Required:

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

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

- Schedule 2 details to be included in Statement of Purpose.
- Relevant records to be held by Centre for all staff.

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

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

Training records were not available in the centre and it was not possible to determine if all staff had received training in relevant issues, such as adult protection, behaviour that challenges, manual handling or communication.

40. Action Required:

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

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

- Management team to gather all documentation required as per Regulations for all staff and a Training Matrix developed to monitor mandatory training undertaken.

Proposed Timescale: 30/09/2015

Theme: Responsive Workforce

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

Improvements were required in relation to the supervision of staff and the delegation of roles to ensure the needs of residents were met.

41. Action Required:

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

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

- Lead Persons to be nominated for each shift/team. The Lead Person's name is to be displayed in Unit at start of each shift.

Proposed Timescale: 31/07/2015

Outcome 18: Records and documentation

Theme: Use of Information

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

Not all policies specified in Schedule 5 of the regulations were available.

42. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

- Due to recent changes in staff and skill mix, all Schedule 5 Policies, Procedures and Guidelines reviewed and updated. These will be available in Nursing Office, in the Visitor Room and with management team for reference by all staff and service users.

Proposed Timescale: 30/09/2015

Theme: Use of Information

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

The available policies had a signature sheet for staff to sign once they read and understood the policy, however, none of these had been signed.

43. Action Required:

Under Regulation 04 (2) you are required to: Make the written policies and procedures as 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 available to staff.

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

•Due to recent changes in staff and skill mix, all Schedule 5 Policies, Procedures and Guidelines reviewed and updated. These will be signed by all staff once they have been read and understood and copies will be available in Nursing Office, in the Visitor Room and with management team for reference by all staff and service users.

Proposed Timescale: 30/09/2015

Theme: Use of Information

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

The policy for the recognition, prevention and response to abuse and incident management referenced the requirement of statutory notifications, however they failed to include the legal duty to notify the Authority, where relevant.

44. Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

•All Policies, procedures and guidelines relevant to Risk and Safety Incident Management, Health and Safety, Fire Safety, Evacuation procedure reviewed and updated to include legal duty to notify HIQA where relevant.

Proposed Timescale: 30/09/2015

Theme: Use of Information

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

The directory of residents did not contain all of the information required by Schedule 3(3) of the Regulations. Information missing included marital status, next of kin details, address of the General Practitioner and sources of admission.

45. Action Required:

Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 .

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

- Directory of Residents to be reviewed and updated to include all relevant information as per Regulations/Schedule 3.

Proposed Timescale: 11/09/2015**Theme:** Use of Information**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

There was a residents' guide that contained most of the information from the Statement of Purpose in an accessible format. However, not all of the information required by the regulations was included. For example the guide did not contain the terms and conditions of residency, it did not identify the arrangements for residents involvement in the running of the centre, it did not identify how residents could access inspection reports, and there was insufficient detail on the complaints and appeals process.

46. Action Required:

Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident.

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

- Residents' Guide to be updated to include:
 - o terms and conditions of residency;
 - o arrangements for residents' involvement in running the centre;
 - o residents' access to inspection reports;
 - o details of complaints and appeals process.

Proposed Timescale: 11/09/2015

