

**Health Information and Quality Authority
Regulation Directorate**

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



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|---|---|
| Centre name: | A designated centre for people with disabilities operated by Health Service Executive |
| Centre ID: | OSV-0003368 |
| Centre county: | Sligo |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Health Service Executive |
| Provider Nominee: | Teresa Dykes |
| Lead inspector: | Thelma O'Neill |
| Support inspector(s): | Damien Woods; |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 34 |
| Number of vacancies on the date of inspection: | 1 |

About monitoring of compliance

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

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|-----------------------|-----------------------|
| From: | To: |
| 21 October 2015 09:30 | 21 October 2015 19:00 |
| 22 October 2015 09:30 | 22 October 2015 17:30 |

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

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

Summary of findings from this inspection

This inspection was the eight inspection of this residential service carried out by the Health Information and Quality Authority. This registration inspection was an announced two-day inspection.

This designated centre provided residential and day services to thirty three residents (four males and twenty nine females) with mild to severe intellectual disability, in six separate units in the main campus building. In late 2013 this service was taken over by the Health Service Executive (HSE). This service was originally established in Sligo in 1955, where up to 200 people with an intellectual disability lived. However, this

number has since reduced to 107 residents.

At the last inspection, on the 21/7/15 eight core outcomes were inspected and inspectors found that all of the outcomes inspected were non compliant. Three outcomes were non compliant major. These related to residents rights, dignity and consultation, safeguarding and protection, and the governance and management of the centre. In addition; five outcomes were found to be non compliant moderate, they were under outcomes 5, 7, 11 ,12 and 17. Sixteen actions were issued following the last inspection which related to this designated centre and on review of the actions taken to address the non compliances, the inspectors found that ten actions were complete and six actions were partially complete.

Since the last inspection, the provider nominee had re-organised the campus into three designated centre's and new management structures were in place and their roles and responsibilities were clearly defined. All of the management team were present during the inspection and provided an overview of the new management structure in the centre and the actions taken since the new Acting Director of Services was appointed to this Service in June 2015. The managers were now aware of their responsibilities under the Health Act 2007 (Care and Support of Residents in Designated Centre's for Persons (Children and Adults with Disabilities) Regulations 2013 and was actively implementing these regulations in this centre.

As part of the inspection, inspectors met with residents, staff members, the person in charge (PIC) and the Director of Services, Provider nominee, and Clinical Nurse Managers. Inspectors observed care practices and reviewed documentation such as personal plans, risk management documentation, medical records, as well as policies and Procedures and found a significant improvement in the quality of the service provided to residents.

The management of risks, protection of vulnerable adults and healthcare issues had all improved. Staff interacted with residents in a warm and friendly manner and displayed an in-depth understanding of individual residents' needs, wishes and preferences. Although resident's living in this centre were living in a congregated setting and the premises was not suitable and did not meet the needs of the resident's needs. The provider had agreed a process of de-congregation to relocate and integrate the residents into the community and the managers told the inspectors they were actively looking for suitable accommodation to achieve this goal.

The findings of the inspection are identified under each outcome and the actions required to address non-compliances are documented at the end of this Report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Following the last inspection, two actions were issued under this Outcome. Inspectors reviewed the two actions relating to this designated centre and found that one action was complete and one not complete. These actions related to the limited size of the bedrooms and inadequate showering and toileting facilities in some of these units. The second action related to inadequate response and management of complaints.

On this inspection; resident's bedrooms were found to be individualised, person centred and decorated to resident's tastes with sufficient space for their personal belongings. All residents except two siblings had their own bedroom and they shared a bedroom by choice. Their individual privacy was assured by the use of bed screens. Since the last inspection, all resident's personal needs and bedroom accommodation requirements had been reviewed and actions were taken to meet resident's individual needs. For example; on previous inspections, inspectors found one resident had to reverse their wheelchair when entering their bedroom, as they could not turn their wheelchair in the room, due to lack of space. This resident had been relocated to a newly refurbished en-suite bedroom, which the resident was extremely happy with and had pleasure in showing the inspector their new bedroom.

Inspectors found that resident's privacy and dignity was maintained. Residents' personal and intimate care was attended to. However; in one unit, there continued to be limited toileting and showering facilities. This is actioned under outcome 6 premises.

Staff also ensured residents had privacy when communicating with relatives and friends either by phone or in person. There was private space available in the centre for resident to meet family or friends in private. Residents were offered the services of an advocate to act on their behalf and to support family members at meetings. This had greatly supported residents' choice and rights issues and was a positive step in developing and maintaining an individualised and person centred service.

The centre had a complaints policy and complaints log in place. Inspectors reviewed a sample of complaints and found that the complaints policy had been fully implemented on the complaints reviewed. Complaints from residents family members had been reported to the complaints officer by residents/ their family member or staff and the complaints officer had followed up as per stated policy and procedure. Complaints reviewed by the inspectors were fully complete to the satisfaction of the complainant.

Visiting times were unrestricted and family and friends were welcome to visit the centre as per residents and family wishes.

There was good documentation records maintained of all items of income and expenditure for the residents. Inspectors reviewed daily recording of resident's money and no discrepancies were noted in records checked. However, residents personal monies continued to be managed by the organisations finance department and residents did not have free access to their personal money or weekly Disability Allowances. Changes to this practice was included as part of the residents transitioning to the community, where each resident will have their own personal account in a financial institution where they can access freely.

Previously, the lack of accessible transport had limited resident's rights to socialise or have active lives. Inspectors found that the HSE Services had addressed this issue by supplying additional transport services to residents via wheelchair taxis to residents for social activities, if their own transport was not available. A number of residents and staff told inspectors that this has greatly improved their opportunity to leave the campus and access community services.

Although the staff had taken all possible measures to meet resident's individual needs, the size and layout of this building was institutional in design. The building's design promoted institutional routines and practices that impacted on some resident's rights. For example; meals continued to be provided from a central kitchen and the dinner times continued to be at a set time each day, e.g. Dinner at 12.30 pm and this limited choice and variety to resident's meals and schedules. However, there was some progress made in this area and this is discussed further under outcome 6 and 11.

Judgment:
Substantially Compliant

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents were supported to communicate at all times in the centre. Systems were in place that ensured their individual needs were met.

The organisation had a communication policy. The policy sets out to address the total communication needs of residents. Residents that required specific communication supports had an individualised communication profile in their personal plan. Some residents were supported through the use of pictures to show them what activities were planned for the day. Other residents used communication books which were used between the resident's residential and day service. These communication books were in picture format and helped the resident in understanding their planned day.

Some policies were in an 'easy read' format for residents and were made available in the centre. For example the safeguarding and safety policy. Pictures were used to directed residents to specific areas such as the kitchen's, dining rooms and sitting rooms. In some units, there were signs to identify and locate toileting and bathing facilities.

In most units residents had access to televisions and stereos in their bedrooms and also in communal areas.

All residents had hospital communication passports, which contained vital information for hospital personnel to care for the resident in hospital. It had been used on a number of occasions and staff told inspectors it had improved the residents experience in hospital as the staff caring for them understood their communication and medical needs better.

Although there was good evidence of residents communication needs being met, some residents could benefited from developing their communication skills even more through the use of electronic communication aids or with the use of alternative communication techniques. These could be assessed and taught by a Speech and language Therapists, which would improve residents' communication skills in preparation for transiting to community living.

Judgment:

Substantially Compliant

Outcome 03: Family and personal relationships and links with the community

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Residents living in the residential unit of the centre were supported to maintain links and to have positive relationships with their families and friends. Some residents living in this centre had a good relationship with family and friends and other residents have lived in the centre for over 50 years, and have limited contact with their family. Some residents went home regularly for a night/ weekend others for Christmas or festive occasions throughout the year. Staff told the inspectors, that families and residents attended personal plan meetings and reviews and there was documented evidence of their attendance and involvement in residents' visiting records.

The person in charge indicated that there was no issue with residents having visitors to the centre. The organisation had a visitors policy on to guide best practice.

Staff told inspectors residents had participated in community living, significantly more since they received the procurement card. Residents were able to purchase food and personal items for residents, and residents were interacting with the local community more through shopping for these items. Residents were also attending more social events in the community, since the staffing and transport issues had been resolved. Residents are developing their shopping skills with staff support as part of the transitioning to community. Some residents told inspectors they enjoy accessing the community facilities.

Judgment:

Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

This centre was a seven day service residential service for residents. All residents/families had received the contract of care pertaining to the residential placement, however not all contracts were signed.

This centre was closed for admissions and is in the process of de- congregating residents to the community. All residents files examined had provisional transitional plans in place for moving to the community. The plans described the residents accommodation wishes which were used by management to plan for residents individualised housing needs as part of the transition to community services.

An action under outcome 5 from the last inspection was not complete. It relates to discharge planning of a child living in one of the units with adults that had been delayed. On this inspection, inspectors were told that although efforts were being made to source an appropriate residential placement, the date of discharge for this child had been delayed further and would be implemented in the near future. However, the provider could not give an exact date of discharge. Inspectors were informed that the child had been reviewed by social workers from the Child and Family Agency and although they found the placement was unsuitable for the child, they found that the child was provided with individualised staff support and they were safe in the interim until appropriate arrangements were in place for the child's discharge to the community services.

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):

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

Findings:

There were two actions issued under social care needs following the last inspection. These related to social activities being resource led, rather than following resident's social care needs or desires. The second action related to the unsuitable placement of a

16 year old child in a dementia unit for adults. One of the actions was complete and the second action was not complete.

Since the last inspection significant improvements were noted in the assessment of resident's personal and social care plans. All residents had health and social care assessments completed. Each resident had set personal goals they wished to achieved and many of the goals had already been achieved.

Inspectors also found residents' social assessments and social activities were kept in a pictorial format that aided the resident's ability to access the information in a user friendly manner.

A sample of residents health care plans were also examined by inspectors and found the plans were regularly reviewed by staff and healthcare goals were comprehensive and most had achieved the targets set.

Every resident in this designated centre was now attending a full- time or sessional day service, or least was offered the opportunity to attend. Some residents with Dementia chose not to attend every day. However, the opportunity is available to them to attend, should they so choose to do so.

Judgment:
Compliant

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:

This centre was located in a congregated setting and it was situated in the main campus building and divided into six separate units. There were six residents residing in four units and five residents in two units. The premise was completely inadequate and institutional in design. Its appearance and the facilities did not meet the individualised needs of the residents, or the philosophy of care identified in the centres Statement of Purpose.

The action identified under outcome one from the last inspection related to residents rights and dignity, such as the lack of showering facilities in the unit and the inspectors found that some residents continued to share one shower and toilet between six residents in their unit. This issue had not been addressed.

The inspectors had found that some actions were addressed. In one incident a residents that required a wheelchair friendly bedroom was now accommodated in a purpose built wheelchair accessible en-suite bedroom. The resident told the inspectors that her new bedroom had greatly improved their quality of life.

Twelve residents living in two of the units could only access their kitchen/ dining area by leaving their unit and accessing their kitchen/dining room via a long corridor. These two units shared kitchen among the twelve residents and recently they had received a cooker, to cook residents some evening meals. They also shared a dining room and meals were served to the residents through a serving hatch from the kitchen into the dining room. The four other units in this centre were equally as institutional in layout and design. For example; there were two units located on each of the two long corridors and only a door dividing the units. In addition; these four units did not have an operational kitchen; they had no cookers or hotplates to cook residents' meals or evening teas, and residents' food was supplied from the main kitchen area. Inspectors found that this limited residents accessing their kitchen to view or smell the food being offered to them daily.

Some living rooms were comfortable and tastefully decorated while other sitting rooms had the appearance of large institutional rooms that lacked character and decoration.

Records were available to indicate that equipment in the centre had been serviced as required. General waste was disposed of safely; however, Inspectors found that sluice facilities were completely inadequate. In two units there were no hand washing facilities for the staff to use in the sluicing areas; staff had to use hand washing facilities in the nearby toilet areas on the units. This created an infection control risk and needs to be addressed swiftly. In addition some units only had one shower and one toilet for six residents and this was impacting on their access to toileting and showering facilities.

A central Laundry service was available to residents, and some units had a washing machine and dryer available for residents to use. Most residents' had adequate storage options in their bedrooms, and wardrobes were spacious with bedside lockers available and chests of drawers to maintain personal belongings. However, some bedrooms had only standing room available and limited space for a chair or storage of personal items.

The Health Service Executive (HSE) has tenancy agreement with the owner, which expires in four years time, and the provider nominee is actively looking for suitable accommodation to de-congregate this centre.

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):

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

Findings:

There were three actions issued following the last inspection. They were: inadequate management of risks, inadequate fire evacuation equipment and lack of implementation of the recommendations of a fire consultants report. The fire escape route was found to be blocked and evacuation plans were inadequate. Two of the actions were complete and one was partially complete.

At the last inspection, inspectors found that the systems in place to identify, access and manage risks were neither responsive nor effective with residents placed at risk due to poor oversight. Inspectors found on this occasion that incident and accidents were appropriately reviewed, and details were recorded about each incident. Furthermore, there was clear documentation and learning from incidents that were recorded on the incidents review forms to prevent further incidents of a similar nature.

In addition; since the last inspection, the risk review group (which comprised of managers and multidisciplinary team members) had met weekly instead of monthly to review accidents and incidents in the centre. The actions taken by the risk review group were also recorded on the system as a response to the risks identified. This had improved the response times to accidents and incidents and a greater cohesive response from management.

The provider had also implemented a new computerised national incident management system for recording accidents/incidents and near misses. This supported managers to review accidents/ incidents and provide an analysis of patterns emerging in the centre. The centres risk register had been reviewed and was a live document and contained risks that had been identified in each unit. The individual and environmental risk assessments completed on each unit were used to maintain the risk register as a live document.

On review of the residents' individual risk assessments, inspectors found staff and managers were much clearer in the procedure to follow and the control measures required for managing individual risks. Staff told inspectors they had received training in risk management and it was clear from discussing residents risks with staff, that they were more confident in completing risk assessments and managing and preventing risks/incidents in the centre.

The new acting Director of Services had also implemented a range of auditing tools to manage risks and this was assisting staff and managers in identifying gaps in knowledge or processes. Inspectors found that there was evidence that risk management had

significantly improved since the last inspection and that managers and staff had reviewed accidents/ incidents and ensure that any learning or patterns that emerged from the analysis were immediately addressed and the risks were mitigated or managed.

An action partially addressed since the last inspection, was the allocation of an additional night staff to the children's unit to support the children when the nursing staff had to leave the unit at night to provide clinical or medication support in other units. This action had reduced the risk to the children, being left supervised by unfamiliar staff. In addition; the General Practitioner had reviewed night time medication charts and changed some medication administration times to 8 pm instead of 10pm, reducing the need for medication to be administered by night staff. However, nursing staff in other units continued to leave their units to administer medication in other units. This actioned under staffing in outcome 17.

Inspectors found that fire evacuation procedures were compliant. Inspectors found that regular fire drills and evacuation procedures were completed in each unit; staff were familiar with emergency exits and residents personal evacuation procedures and the number to ring in the event of an emergency. The majority of staff, over 90% as of 19/10/15 had up to date fire training and an on-going training programme was in place. All fire equipment checked had been serviced as required. All emergency exits were clear. The fire register was complete.

However, the action plans issues on previous inspections in relation to fire safety risks showed that structural repair works were required to comply with National Fire Safety Standards. The provider nominee informed inspectors that the provider (HSE) had arranged for remedial fire works to commence early in Quarter one of 2016. This was in response to concerns raised by their own fire consultant's report of March 2015. These works included the provision of additional compartmentalisation to units to contain and prevent the spread of fire, the upgrading of fire doors throughout the units requiring replacement. A new fire panel had already been installed and the provision of supplementary fire panels will be completed in 2016.

In addition; since the last inspection, officers from the Sligo Fire service had visited the centre and familiarised themselves with the number and design and layout buildings, as well as the organisations emergency evacuation procedures. They provided feedback to the management on safety procedures and fire prevention to the provider following their visit to the centre.

Inspectors reviewed the centres policy on falls management and reviewed one serious incident where a resident had fallen and received a serious injury. The inspector found that the falls management policy had been followed and the residents falls risk assessment and care plan was reviewed and updated. The resident had also been regularly reviewed by the general practitioner GP and Physiotherapist and a treatments plan put in place. A post falls review had been completed and additional support staff was allocated to this resident during their recovery.

Judgment:
Substantially Compliant

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):

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

Findings:

Inspectors were told that there were no allegations of abuse reported in this centre and no Trust in Care investigations on-going in the centre.

There were five actions relating to safeguarding and safety issued following the last inspection, however, only two of these actions related to this designated centre and they were complete. The two actions relate to inadequate staff training on child protection policies and procedures and restrictive practices in the centre that were not regularly reviewed, risk assessed and appropriately monitored.

Inspectors found that child specific safe guarding and protection training for staff had been complete for all staff working with the child. This action was complete.

Previously, inspector had found there were restrictive practices in operation in this centre, in particular, the use of restrictive clothing for one resident at night as part of a behaviour management strategy, this practice had now ceased and the resident displayed no signs of adverse behaviours by removing this restriction. There were also restrictions on some of the unit's internal and external doors; some of these restrictions had been removed from the internal doors into the kitchen, and restrictions that remained were risk assessed and restrictive logs were maintained to monitor all restrictions.

Most staff (94%) had completed training in protection and safeguarding of residents and an ongoing training schedule was in place. The centres policy on safeguarding and protection had been reviewed and staff members interviewed were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse.

Staff identified the PIC as the new acting designated person as the person to whom they would report a concern. The policy contained a form for reporting any suspicious of abuse. In discussion with inspectors those residents who spoke with the inspector said they felt safe and during the inspection inspectors observed that the staff were patient and respectful towards residents.

On a previous inspection one resident had received chemical restraint on a regular basis as a behaviour management strategy and this was actioned on a previous inspection. However, inspectors found on this occasion that the residents had been relocated to a new environment that was quieter and more suitable for their individual needs and their personal health and social goals were reviewed in co-operation with the resident. Following this assessment, one to one staff supports were allocated to ensure that all of the residents needs were being met. This has resulted in the resident not having had any behavioural outbursts that required chemical restraint since moving to this new unit and the staff told the inspector the resident was much happier and more settled in her new environment.

Judgment:
Compliant

Outcome 09: Notification of Incidents

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

Theme:
Safe Services

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the centre was maintained using a computerised system and where necessary notified to the Chief Inspector.

The inspector reviewed incidents and accidents and found that incidents requiring notification had been submitted to the Authority as per the regulations. The person in charge demonstrated knowledge of their regulatory responsibility in regard to notifiable events.

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):

No actions were required from the previous inspection.

Findings:

Inspectors found that resident’s general welfare and development needs were supported in the centre. A review meeting of the person’s personal goals were reviewed regularly. The establishment of residents' educational, employment and training goals were discussed at transitional planning meetings.

There was on-going review meetings of resident’s personal goals that were recorded in their “listen to me document”. Residents were consulted during this process to ensure they were receiving the support they needed to achieve identified goals.

Some residents spoke with told inspectors what activities they pursued at their daily activities programme. They discussed the positive experiences and benefits their work and meeting new people daily.

There was evidence to show residents skills and talents were encouraged and supported. Residents living in the residential units and with a flair for the arts and crafts were actively involved in the arts and craft group. Residents also had opportunities to engage in hobbies and engaging past times within the centre for example, baking and cookery in the day centres kitchen.

However, other residents daily activities required development to ensure individualised personal activities were available to suited their interests and capabilities. For example, the development of computer classes and social and community integration classes for residents transitioning to community services.

Judgment:

Substantially Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

There were two actions relating to the last inspection that were not fully addressed. These relate to institutional practices around meals and meal times and the opening

hours around the canteen.

Inspectors found that management had taken steps to improve some aspects of residents' nutritional experiences. Some residents' were involvement in preparing the occasional evening meals and others now had the opportunity to eat their dinner in the main canteen with their work peers as part of their daily routine. There were also changes in the choice and delivery of food to residents. Residents were observed to be offered a choice of two main meals at dinner time and efforts had been made to improve the choice of meals and the mealtime experience for some residents.

A banking procurement card had also been provided in all units to enable residents, supported by staff, to purchase groceries and snacks from the local shops. This was reported to be a positive step towards promoting alternative food choices for residents, particularly for resident that had medical conditions such as Coeliac or Diabetes. However; the central kitchen continued to provide all of the meals for the residents and supplied meals via a hot storage box to each individual unit. Access to cooking facilities were not freely available in all units and some residents had to leave their units to gain access to a cooker, as there were no cooking facilities in their unit. The canteen was observed to be used by several residents during the inspection; however, it continued only to operated during the hours of 9 am to 5pm and closed at 3 pm at weekends. This was an action from the last inspection that was not adequately addressed.

There were other issues identified in the findings of the recent Quality and Nutritional Audit completed by residents and staff in the centre and the Person in Charge was addressing issues raised in this survey. Although a lot of positive steps had occurred to promote residents access and choice to food, inspectors found that training in food preparation, and hygiene was required for residents and staff as part of the transitional process, to ensure they are prepared to live and support residents to cook their own meals when living in the community settings.

Resident's healthcare needs were well met. Residents were individually assessed and monitored by the GP. A new GP was in post and he attended the centre twice a week to attend to residents medical needs. Resident had received an annual medical review and this was on-going. Inspectors observed care plans and saw they were person specific and provided very clear guidance to staff on how to make residents' comfortable. There was good evidence that residents were referred to and reviewed by specialists where appropriate. Progress notes were completed for each resident which reported on the care provided.

Management and staff assured inspectors the organisations intimate care policy was appropriately implemented. This was achieved through the use of personal and intimate care plans for each individual resident. Inspectors found these to be complete.

Inspectors reviewed wound care and management in the centre and found that there were adequate assessments and reviews of residents wounds and appropriate input from the MDT team, such as; the GP, tissue viability nurse specialists, dieticians, and physiotherapists.

Judgment:

Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

There was one action from the last inspection, however, did not relate to this designated centre.

The prescription/administration charts for some residents were reviewed and inspectors noted that all medications were individually prescribed and regularly reviewed by the GP. Inspectors reviewed medication charts and found that medications were administered as prescribed to the resident for whom it was prescribed. Medication prescriptions were transcribed by two nurses from prescription charts with a copy of the original prescription kept on file. There was a policy to guide staff in relation to transcribing medication.

Only nurses administered medication to residents in this centre, however, in preparation for transitioning to community services, some non nursing staff have been trained in safe administration of medication.

A system of recording medication in stock on a monthly basis was now in place and this assured managers and staff that medication stock was well monitored. Medication that was out of date was appropriately managed in line with organisational policy and procedures.

The local pharmacist visited the units monthly to review medications stocks and discuss medication issues with the nurses. In addition; medication audits were conducted in some areas by the Clinical Nurse Managers (CNM's) and these were tools used to evaluate medication management within the units.

Controlled medication was kept in a secure locked press and the controlled medication register was maintained as per An Bord Altranais guidelines. However, in one case a resident that was prescribed controlled medication via a syringe driver, as part of their palliative care treatment, did not received their medication all night due to a faulty pump. The equipment failure was not identified until the nurses on day duty the following morning found the error. The patient was reviewed by the palliative care team the following morning and was found not to have been adversely affected by the error. An incident report was completed and a new pump was provided by the palliative care

team the following day. In future, where residents are receiving palliative care treatment via a medication pump, the palliative care team have agreed to provide training on managing controlled medication and syringe driver equipment for all staff (Day and Night staff) that are caring for the resident receiving palliative treatment.

Systems were in place to record medication errors and although medication errors had occurred in some units; staff had taken appropriate steps to protect the residents and to ensure that the errors would not reoccur.

Medication that required refrigeration was kept securely and daily recordings of the fridge temperature were maintained.

Medications were securely stored in a locked cabinet and security measures had been implemented. A log was maintained and updated as residents were prescribed or received prescriptions. Staff had received training in administration of medication used for treating seizures and a protocol was in place regarding the procedure to follow in the event of an epileptic seizure for each individual resident that was signed by the General Practitioner.

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):
No actions were required from the previous inspection.

Findings:
There was a written statement of purpose that accurately described the service that was provided in the centre.

The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided was reflected on the two days of inspection.

The statement of purpose met all the matters as set out in Schedule 1 of the Care and Welfare Regulations.

Judgment:
Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

Previously, Inspectors had identified significant deficiencies with the governance and management arrangements in place in this centre. Since the last inspection, the governance of the centre had improved by re-configuring the Governance structures of the campus into three designated centres. The Area Manager was allocated person in charge of this designated centre and now they were specifically responsible as person in charge for six units. The person in charge will be supported by two Clinical Nurse Managers. There were two other managers being appointed as persons in charge for the other designated centres, that would report to the Area Manager and Acting Director of Services. This restructuring of management roles was to allow the person in charge to have an active role in the day to day management of this centre.

Although the findings on inspection were more positive than on previous inspections, inspectors found the person in charge role greatly extended past role as person in charge for these six units. For example; In addition to managing services for thirty three residents and managing staff support for these residents, the person in charge was also the nominated designated person to contact in the event of an allegation of abuse being reported in the campus, they were also the nominated Complaints person for the service and Area manager for the campus, Chairperson for the Health and Safety Committee, member of the Quality and Safety Committee, incident review group and nutritional review group. The number of extended roles of responsibility allocated to the person in charge in attrition to their role as PIC could deflect from the full time post allocated to the person in charge in this centre and may need to be reviewed in the future.

Prior to the inspection, the provider nominee and managers had completed a number of unannounced inspections of individual units to update themselves with current risks and ongoing issues in each unit and to actively manage these issues. Their findings were reported back weekly to the risk review meetings as part of the new process of managing risks.

Inspectors reviewed minutes of weekly management meetings and these recorded the management team responding to specific non compliances identified by the Authority in previous inspections. Improvements were noted in areas including; annual medical reviews and social assessments, quality and safety protection issues, a reduction of

accidents /incidents in each unit, accurately completed individual risk assessments, the management of complaints and critical staffing issues.

The PIC had devised a quality and safety template for unannounced inspections and had visited all but one area. Completed forms were available.

Judgment:

Compliant

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:

The person in charge of the centre had not been on leave for more than 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):

No actions were required from the previous inspection.

Findings:

A significant amount of resources had been input into this centre in recent months. This was noted in the allocation of staffing in the centre, the provision for staff training, the introduction of procurement cards for residents individualised purchases, maintenance works and transport provision. The provider also advised inspectors that a capital funding had been sanctioned to purchase/rent suitable accommodation for residents transitioning to the community. Staffing resources and skill mix were now based on the

assessed needs of residents.

Judgment:

Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

There were two actions issued following the last inspection. These related to staffing levels and skill mix and the second related to mandatory staff training. One action was complete and the second action was partially complete. Inspectors found that there was adequate staff on duty in each unit on the day of inspection. Additional staffing had been allocated to some units and in some incidents residents assessed as requiring additional staff supports were receiving same.

Staff told inspectors that the additional resources have had a very positive effect on resident's personal and social care. Additional staffing had been provided to some units which ensured that resident social care opportunities were being met. Some residents were assessed as requiring one to one staffing 24/7 and this was provided daily.

On previous inspections inspectors found that the staffing levels and the deployment model in use were not sufficient to meet the needs of the residents and there was a heavy reliance on agency staff. However, inspectors were told that the staffing agency that provided replacement nursing staff did not have the capacity to fill these vacancies. Improvements were noted, where there was regular and consistent staff working with residents on a one to one basis, where previously, there were continuously different agency staff attending these residents. This had impacted on residents care and welfare. Since staffing in the centre had stabilised, staff told inspectors residents were much happier and there were less incidents of behavioural outbursts and aggression reported in the centre. There was evidence available that seventy three whole time equivalents (WTE) had been allocated to the HSE campus and community services since January 2015.

The rate of staff sick leave in this centre has gradually decreased and there was more HSE staff on duty than on previous inspections. However, there were nine agency staff on duty in this centre over the week of the inspection, these agency staff were used to replace regular HSE staff on leave or to provide 1; 1 staff support to residents.

On previous inspections the Authority identified that staff did not have up to date training in fire safety, adult protection, managing behaviour that challenges and in manual handling. Inspectors found that some improvements had occurred. A training matrix was reviewed which conveyed that an ongoing schedule of training was now in place to ensure staff completed mandatory training required by the Regulations. 94% of staff had completed training in Safeguarding and Protection, 90% of staff had completed fire training. 88% of staff had completed training in manual handling, however only 29% of staff in this designated centre had completed training in the management of behaviours that challenge.

The inspectors observed that most staff had now completed performance appraisals and there were good supervision arrangements evident.

Inspectors observed good staff interactions with residents and nursing staff interviewed had a good knowledge of residents' medical needs and advocated for residents to ensure they medical appointments were attended and appropriately followed up on. Residents appeared comfortable in the company of staff. Those on duty during the inspection demonstrated a good knowledge and understanding of each resident's needs wishes and preferences.

Judgment:
Substantially Compliant

Outcome 18: Records and documentation

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

Theme:
Use of Information

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

Findings:

Written operational policies were in place to inform practice and on review the inspector found that all policies set out in Schedule 5 were in use.

The statement of purpose and resident's guide were available in the centre and the most recent inspection report was available to residents, their family and visitors. The centre was insured and this was up to date.

Information relating to residents and staff were securely maintained in the office of the centre and were easily retrievable. A directory of residents was up to date and met the requirements outlined in Schedule 3.

Personal plans for residents were up to date and gave a good reflection of the care practices and interventions that were in action for each resident at the time of inspection.

Judgment:

Compliant

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:

Thelma O'Neill
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-0003368 |
| Date of Inspection: | 21 October 2015 |
| Date of response: | 11 December 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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Residents do not have free access to their personal possessions, such as their finances.

1. Action Required:

Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and

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

possessions and, where necessary, support is provided to manage their financial affairs.

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

The Capacity for a number of residents will always require a level of Guidance & Instruction in relation to their finances

Training for Service users with Head of Finance/Team in relation to Private Property Guidelines.

Training to be held with Head of Finance/Team with all staff in relation to Patients Private Property Guidelines. This is to commence by end of February 2016 & be completed by 29th April 2016. In relation to this designated centre SALT will assess service users capacity ability that require guidance in the area of Private Patient Property Guidelines by 29th April 2016.

Communication Workshop with SALT in relation to an easy read version for residents that have the ability to understand their finances will be completed by 29/4/2016. A competency assessment tool to be sourced in relation to this matter across the Administration/Finance dept.

On 22nd Jan 2016, Administration & Finance Dept HSE Cregg Services had consultation with the Bank, awaiting a date to meet with post office. The purpose of the meeting is to establish the requirements to be met to open an account in individual service user's names, with increased access to their money, how would this be compared to the current situation and what the implications are for staff in facilitating SU to access their funds in such accounts. Once we have that clarification HSE Tullamore will be contacted to see if the issue of Statutory Instrument SI367 2013 Section 12 (4) appearing to be at variance with the HSE Financial Regulations on the operation of PPP accounts has been resolved at national level. This remains a National Issue that requires further resolution.

We have been advised that there is a conflict between Statutory Instrument SI367 2013 and the HSE Financial Regulations in this regard which has been brought to the attention of both Department of Health and HIQA. Pending this conflict being resolved at a national level we have been instructed to continue to operate under the HSE Patient Private Property Guidelines with residents funds being managed within the local Patient Private Property (PPP) Account and the national Private Property Account based in Tullamore.

Currently residents can access their funds held in the local PPP account during office hours Monday to Friday via a clinical nurse manager signing a requisition form which is brought to the Accounts Office. These monies are then held in an individual purse for each resident which is held in a safe on each unit.

Inclusion Ireland met with Managers on 19th Oct 2015 - Managing of residents financial affairs Matters discussed here for Service Residents. The purpose of the meeting was discussion around self advocacy -& Financial Matters for residents - Inclusion Ireland to be contacted again for update week beginning 8/2/16 to arrange for further meeting & to look at commencement of discussion with residents in this designated centre.

Proposed Timescale: 30/06/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Some residents' communications skills could be developed further to improve their quality of lives, through the use of communication assessments by a SALT.

2. 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:

Residents in this designated centre have available a communication Profile , ie a process for consulting with residents in HSE Cregg Services.

Assessments have being carried out by SALT across this designated centre which outlines if the Individual residents require Assistive technology to augment their existing communication systems.

Assistive Technology centre will be contacted by 29/3/2016 for the residents who require assistive technology. Presently we have 2 residents who use this Technology. (Mobile Phones)

Where individual residents existing natural communication systems will be enhanced by secondary media (Assistive Technology) such as access to Skype, assessment for this will be discussed with the HSE Assistive Technology centre.

Where an Individuals quality of life will be enhanced by access to assistive technology for recreational purposes. This will be completed by 29/3/16 for same will be discussed with the Assistive Technology centre.

Assistive Technology centre will be contacted regarding assessments on the 7th January 2016 with a view to completing the process by 29/3/2016.

Proposed Timescale: 29/03/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Service level agreements were not fully in place for each resident.

3. Action Required:

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

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

All families have received a Contract of Care. Families are signing same. Contracts of Care to be looked at in more detail regarding services offered to residents

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

A child admitted to the dementia care unit as an emergency admission was not in accordance with organisations policy and procedures on admissions to the centre or in compliance with the centres Statement of Purpose.

4. Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

Local Implementation group are presently meeting in relation to decongregation. This group has representation from HSE & Families.

Meeting with assessment and placement officer is to take place on 14th January 2016

A suitable accommodation for the resident to be sought with other residents by 30th June 2016 the Resident turns 18 Years of age in April 2016. See Attached letter from Family in relation to the rationale for changes in his initial transitioning plan which was Oct 2015.

Proposed Timescale: 30/06/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

1. The layout and facilities were completely inadequate and institutional in design.
2. There were inadequate facilities for an individualised and person centred service,

such as; kitchen's, toileting and sluicing facilities.

3. The food and laundry services were centralised and not individualised services.

5. 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:

Local Implementation group are presently meeting in relation to decongregation for seeking suitable accommodation to meet the high support needs for the residents in this designated centre. The purpose of the meeting is to discuss requirements for Individual residents & to discuss accommodation to meet their needs. Meetings are ongoing in relation to these issues.

Meetings held with Provider on Friday 29th January & Mon 1st February in relation to a Preliminary Plan for decongregating this designated centre. Next meeting to be held on 15th February in Markievicz house.

Project Vision team with Project Officer to be set up in relation to working on Decongregation.

All sluice rooms will be relocated to separate rooms that will incorporate a wash hand basin and suitable shelving. The costing on the refurbishing of the relevant areas, St Raphael's, Hazelwood and Benbulbin view has being submitted and work completed by 31st March 2016. Costings submitted but work has not commenced in this area as of yet. Discussions with Head of Maintenance are ongoing.

The Fire Company are commencing work in February 2016 in the service. The Phase 2 & Phase 3 of this plan which incorporates this designated centre will commence in March 2016 & be complete by May 2016.

Two cookers will be installed in this area following these Fire Risk Assessment works being complete.

Proposed Timescale: 30/05/2016

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:

Structural repair works were required to comply with regulatory fire safety standards and had not been completed.

6. Action Required:

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

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

The Fire Company are commencing work in February 2016 in the service. The Phase 2 & Phase 3 of this plan which incorporates this designated centre will commence in March 2016 & be complete by May 2016.

Proposed Timescale: 30/05/2016

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:

Residents daily activities required development to ensure individualised personal employment activities were available to suited their interests and capabilities.

7. 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:

Contact to be made with VEC re training schedules for classes in relation to social & community integration for resident transitioning to the community services. This will be done no later than 30/3 /2016.

Contact to be made with St Angela's College in relation to Classes regarding social & community Integration for residents transitioning to community. This will be done no later than 30/3/2016. At present 1 Resident from this designated centre is taking part in a college course in St Angelas in relation to Self Advocacy from sept 2015 –May 2016 when graduation will take place. This is taking part in conjunction with Day services department.

Role of RNID – "Transitioning people to community" Modules to commence in 2016 with CNME for Nurses. (College Year & will be ongoing).

The residents when attending these classes will be going from their residential home initially.

New Directions – Review of HSE Day Services & Implementation Plan 2012-2016 is the proposed new approach to adult day services provision.

The decongregation will commence by 30th June 2016.

Proposed Timescale: 30/06/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The practices at mealtimes continue to be institutional for some residents and residents choice to participate in cooking was limited due to the lack of cooking facilities in their homes.

8. Action Required:

Under Regulation 18 (4) you are required to: Ensure that residents have access to meals, refreshments and snacks at all reasonable times as required.

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

Presently we have a supplied selection of foods available at all times to residents to meet their personal choice.

At present we are using the facilities in the Day Service Kitchens for the 4 areas who have currently no cooking facilities.

Regular Social outings which include Meals out are continuing across this designated centre.

Training to be sought for all staff from "HASSAP" action Plan completed in relation to the Catering department which incorporates this. This to commence by end of April 2016.

Training to be sought for individual service users who would benefit from this training also from "HASSAP" This to commence by end of April 2016.

Structural changes take place in relation to Fire Risk Assessment (to be completed by end of May 2016 Phase 1 & Phase 2).

2 cookers will be installed in 1 of these area following completion of Fire works. We have 2 areas with cooking facilities which is utilised on a daily basis to facilitate choice during mealtimes across this designated centre. Also facilities for cooking takes place in the sunset club & Day services over evenings & weekends

Procurement cards are in operation in this designated centre for residents to go shopping for their preferred choices.

Discussion to be had with Catering Department in relation to Opening Hours .this situation has to be discussed further with Industrial relations & Catering staff. The proposal will be to have staff available in Catering area for longer periods on a 7 Day roster. No finalisation date known at present. TUPE process is ongoing.

Proposed Timescale: 29/05/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Mandatory staff training was not complete

9. 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:

All Mandatory training has Schedule of Events for remainder of 2015.

We currently have 98% of staff trained in adult protection, the 1 staff remaining requiring a refresher, has been schedule to attend this training on the 5th January '16.

We currently have 96% of staff trained in fire evacuation and the remaining 2 staff are schedule to attend training on the 15th January 2016 but will not be working in a lone working situation until this training is completed.

We currently have a plan in place to ensure by mid 2016 that all staff has the mandatory manual handling training and all staff who work directly with behaviours of concern are prioritised in Qtr 1, 2016 for studio III training.

Training will continue to be a priority in 2016.

HR notify all staff in writing when their training is expired & due for renewal.

All Schedules for Mandatory Training in 2016, Fire, Manual Handling , Studio 111 , Protection & Safeguarding have being received.

Proposed Timescale: 30/03/2016