Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0004090
Centre county:	Westmeath
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Muiríosa Foundation
Provider Nominee:	Josephine Glackin
Lead inspector:	Jillian Connolly
Support inspector(s):	Paul Pearson
Type of inspection	Unannounced
Number of residents on the date of inspection:	7
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 August 2015 10:00	19 August 2015 18:00
20 August 2015 09:30	20 August 2015 16:00

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 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

The designated centre consists of two community houses located in Co. Westmeath. The designated centre is operated by the Muiríosa Foundation. This inspection was conducted following an application by the provider to register the designated centre under the Health Act 2007. The application was to provide services for eight residents.

This was the first inspection conducted in the designated centre. The inspection was facilitated by the person in charge. Feedback was provided to the person in charge and area manager at the close of inspection. Inspectors met with residents, relatives

and staff during the course of the two days. Inspectors also observed practice and reviewed documentation.

Compliance was identified in seven of the 18 outcomes inspected. The Statement of Purpose was found to be substantially compliant. Moderate non-compliance was identified in eight of the outcomes. This was due to management of risk and fire procedures. Improvements were also required in the consistency of residents' opportunities for learning. Medication records and the support provided to residents who exhibit behaviours that challenge required review. Major non-compliance was identified in two outcomes. Primarily this was as evidence did not support that healthcare was provided to residents due to an absence of assessment and subsequent plans of care.

There were 20 failings of regulation identified on this inspection.

The action plan at the end of this report identifies the failings and the actions the provider/person in charge is required to take 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, which will assist with informing the decision regarding the registration of the designated centre.

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

Findings:
The organisation has a policy and procedures in place regarding the management of complaints. The procedure and the nominated person responsible for the receipt of complaints were displayed in an accessible format in both community houses of the designated centre. There was a record of complaints maintained. Of the complaints recorded, improvement was required to ensure compliance with Regulation 34 (2) (f) is achieved. This was due to an absence of the nominated person maintaining a record of the outcome of the complaint, action taken on the foot of the complaint and whether or not the complainant was satisfied.

Inspectors reviewed the minutes maintained following weekly meetings with residents and ascertained that residents were consulted in regards to the day-to-day operation of the designated centre. There was access to advocacy services for residents and evidence of referral by the person in charge. However this was not consistent. As evidenced in Outcome 11, improvements were required to the decision making process for decisions about the care and support provided to residents. In some instances, decisions made regarding the care or absence of care provided to residents did not demonstrate that the decision making process included an assessment of the risk to the resident and that it was in line with the wishes, age and nature of the resident's disability.

Each of the residents in the designated centre had their own bedroom which facilitated the undertaking of personal activities in private. Inspectors further determined that there was adequate space available for the storage of residents' personal belongings. There was also a record of residents' personal belongings maintained. Inspectors

reviewed the systems in place for supporting residents to maintain control over their own finances and were assured that they promoted same. Inspectors observed staff to engage with residents in a dignified and respectful manner. This was further confirmed by family members who met with the inspectors during the course of the inspection.

The majority of residents participated in a formal day service. Residents were also supported to engage in activities with the support of residential staff. This was informed by a person-centred plan which was created in consultation with the resident and their circle of support, if applicable. However, in some instances there was an absence of evidence to support that efforts had been made for residents to engage in all activities documented as part of the goal planning process.

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

Findings:
Residents had an assessment of their communication needs in place in their personal plan. There was a policy in place to guide practice for staff communicating with residents. Efforts had been made to facilitate information being communicated to residents in an appropriate forum such as choices for mealtime or their person-centred plan. Inspectors observed staff communicating with residents and to have an understanding of their individual needs. There was access to a variety of media forums such as television and radio.

Judgment:
Compliant

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

Theme:
Individualised Supports and Care

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

Findings:
Family members were regularly present in the designated centre. Over the course of the inspection, inspectors observed relatives to be comfortable within the environment and familiar with all residents and staff. Family members reported that they were welcome in the designated centre at all times, with some family members being involved in the maintenance of the garden. Fundraising events had been facilitated in the designated centre to develop the garden which involved members of the local community being invited to the centre. There was a record of family contact maintained. There was also a record of visitors maintained in the designated centre. Each of the community houses had areas in which residents could meet with family members in private.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
There had been one admission to the designated centre since the commencement of regulation in November 2013. Inspectors reviewed documentation in respect of the admission and found that a comprehensive assessment had not been completed on the resident's admission to the designated centre. Inspectors determined that as a result specific needs of resident had not been assessed. Therefore there was no plan of care in place to address same which is addressed in Outcome 5. At the time of admission, practice was guided by the organisation's policy on admissions and discharges which was dated July 2013. This policy did not adequately guide practice. However, following on from the admission, a local operating procedure had been implemented in June 2015. The procedure adequately addresses the actions to be taken in line with Regulation 24 and 5.

Each resident had been issued with a written agreement which outlined the services to be provided to residents and the fees to be charged. However, there was one contract which had not been agreed between the resident and the service provider due to representatives disagreeing with the terms and conditions of care. There was an

absence of evidence to demonstrate that action had occurred to resolve this.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Each resident had a personal plan in place which was informed by an assessment of their health and social care needs. From this, there were plans of care and risk management plans created which aimed to outline the supports residents required to meet that need. In conjunction with this there was also a person-centred plan in place which identified a resident's vision for how they wish to live their life and the goals in place to assist with achieving that vision. Of the sample of personal plans reviewed, inspectors found that improvements were required to ensure that they were informative and met the needs of residents, particularly in respect of healthcare needs. This is evidenced in Outcome 11.

As stated in Outcome 1, improvements were required to ensure that action was initiated to assist in supporting residents to engage in activities which correlated with their vision as documented in the person-centred plans of residents.

Residents in the designated centre had access to a range of allied healthcare professionals who were employed directly by the registered provider. Inspectors found that when a need was identified that residents were referred to the allied healthcare professionals. However there was an absence of referral if the registered provider did not directly employ or had a vacancy in a particular field. Referrals were not consistently occurring to community based services for residents in this instance.

Relatives stated that they were involved and consulted in the care provided to their loved one.

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

Findings:
The designated centre consists of two community houses located on the outskirts of a town in Co. Westmeath. Each house is described as a bungalow in the Statement of Purpose of the designated centre. One of which is a dormer bungalow as it provides living space on an upper level. Each house provides services to four individuals, each with their own bedroom. One of the bedrooms also has the provision of an en suite. There is also a communal bathroom, shower room and utility room in each house. There is a kitchen/dining area with appropriate facilities for the preparation of food in each house and a separate sitting room. While the second house has the provision of a second living space on an upper floor, inspectors determined that it was not fit for use by residents due to the risk associated with accessing it via a spiral stair case.

The designated centre was clean and suitably decorated. Residents' bedrooms were personalised and reflective of their needs. Inspectors also found that there were suitable furnishings throughout the centre. There was adequate heating and lighting in place on the day of inspection. There were also adequate facilities in place for the disposal of waste.

Each area had external grounds which were well maintained.

Judgment:
Compliant

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

Findings:
The designated centre had policies and procedures in place regarding the health and safety of residents, staff and visitors. There was a specific risk management policy which contained all of the particulars of Regulation 26 (1). There was a system in place for the assessment, management and ongoing review of risk including a system for responding to emergencies. However, inspectors identified communal and individual hazards within the designated centre which had not been identified. This resulted in the system not being effective in practice.

For example, in one of the community houses the radiators were protected as a result of residents' risk of falling. However, in another area of the same house there was a fire place which was quite prominent and could potentially cause injury if a resident fell in that locality. This had not been assessed to identify the likelihood of this occurring and the potential impact to residents if this occurred.

There were also numerous exits in one of the community houses and there had been an incident of a visiting resident from another designated centre leaving the centre without the knowledge of staff. There had been no assessment of risk conducted following on from this.

As stated in Outcome 6, there was an upper room in one of the community houses. Inspectors were informed that it was not used by residents and only for the purposes of storage. However, on accessing the room via the stairs, inspectors determined that a robust risk assessment was required to identify specific control measures to minimise the risk not only to residents but to staff. A review was required of the individual risk assessments in place, to ensure that they adequately reduced the risk to individual residents.

There were policies and procedures in place regarding infection control. As stated previously, the centre was observed to be clean on the two days of inspection. There was a colour coded system in place for the preparation of food and for the cleaning of the designated centre. Inspectors observed staff to demonstrate appropriate hand hygiene practices in the preparation of food and in the administration of medication.

Inspectors reviewed the fire management systems in place and identified that there were some improvements required to ensure that they are safe and effective. There was suitable fire fighting equipment provided which were maintained at the appropriate intervals, such as extinguishers, a fire alarm and emergency lighting. There were also clear instructions in place to be followed in the event of a fire.

Fire drills were undertaken on a regular basis and evidenced that the highest number of residents could be safely evacuated with the lowest staffing compliment in an appropriate time period.

Staff had received training in the prevention, detection and management of fire and residents demonstrated to inspectors that they were familiar with the procedure to be followed in the event of a fire. However, there were inconsistencies noted by inspectors in the procedure to be followed. For example, inspectors were informed that the exit in the kitchen would not be used in the event of a fire as it had a step and residents were documented as being a high-risk of falls. In some instances a wheelchair was required to safely evacuate residents. However, the record of fire drills were recorded as regularly utilising that exit. There was also a review required to ensure that fire doors were effective, as inspectors found that some did not fully close.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The designated centre has policies and procedures in place for the protection of vulnerable adults which had been reviewed in July 2015 and reflected the National Policy which became active in December 2014. Staff had received training in the protection of vulnerable adults and were aware of what constitutes abuse. Relatives informed inspectors that they felt that their loved ones were safe. There had been no incidents or allegations of abuse reported.

Residents in receipt of services were assessed as experiencing behaviours that challenge. Inspectors reviewed a sample of personal plans to ascertain the supports that residents require. While efforts had been made to alleviate and identify the causes of the behaviour, improvements were required to ensure that the strategies documented were effective and reviewed by the appropriate allied healthcare professional on a regular basis. Staff were documenting incidents which occurred as a result of a resident exhibiting behaviours that challenge, however the information did not inform of the actions taken by staff to attempt to alleviate the behaviour or the effectiveness of said actions. One resident had been formally discharged by the positive behaviour support team of the organisation, 16 months prior to the inspection. Since that time, the resident had continued to display socially inappropriate behaviour. A meeting had been

held in the interim in which it was stated that staff should continue to implement the strategies for the resident and records of incidents be forwarded on to the relevant allied healthcare professional. However, there was no evidence that this had occurred.

A record of restrictive practice was maintained in the designated centre. Improvements were required in the assessment and implementation of some practices to ensure that all alternative measures are considered and that the least restrictive procedure, for the shortest duration, is used. For example, a resident was assessed as requiring personal protective equipment. Inspectors were informed that the resident also utilises the equipment at night, however on review of the assessment by the appropriate allied healthcare professionals, there was no reference to the resident wearing the equipment whilst sleeping. In conjunction with this, the resident was documented as having a disrupted sleep pattern, however; the effect of the equipment had not been assessed as a potential contributing factor or if there was an alternative option.

Judgment:
Non Compliant - Moderate

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

Findings:
The designated centre maintained an accident and incident log. Prior to completing the inspection, inspectors also reviewed the notifications submitted to the Chief Inspector. Inspectors identified that the unexpected death of a resident following transfer to hospital from the designated centre had been notified to inspectors in the written report provided at the end of a quarter as opposed to within three working days as required by regulation 31 (1).

Judgment:
Non Compliant - Major

Outcome 10. General Welfare and Development
Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:
Health and Development

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

Findings:
There was a policy in place in respect of residents' access to training, education and employment which was implemented in April 2014. As stated previously, the majority of residents had access to a formal day service and engaged in recreational activities in the evenings and weekends which were facilitated by residential staff. However, improvements were required to ensure that the activities of residents who did not engage in a formal day service were person-centred and promoted lifelong learning. For one resident their weekly activities included, aromatherapy, going for a walk, shopping, bowling and art.

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

Findings:
Inspectors reviewed a sample of the records of appointments for residents and found that residents had access to their general practitioner. As stated in Outcome 5, residents had plans of care or risk management plans in place once a need was identified.

Inspectors found that a review was required of the assessments completed in respect of some residents. This was as they did not identify all of the healthcare needs of residents. As a result there was an absence of subsequent plans of care or risk management plans in place. Inspectors further found that the information within the plans of care or risk management plans did not consistently inform the supports that residents required to meet that need. Therefore it was challenging to ascertain if the healthcare needs of residents were being adequately met.

There were also instances where residents were documented as requiring a specific intervention to assess or address a need. The decision had been made not to access the intervention based on the needs of residents. However, there was an absence of

evidence to support that a robust risk assessment had been conducted following consultation with pertinent members of allied healthcare professionals regarding this decision. There was also an absence of evidence to ascertain if alternative measures had been considered to assist with supporting the resident to access the intervention prior to the decision being made.

Residents residing in the designated centre were documented as having specific dietary requirements such as a high fibre or high calorie diet. As stated previously, improvements were required in the referral to allied healthcare professionals who were not directly employed by the registered provider. Inspectors identified this as a priority need for residents' dietary intake. While information had been provided to staff in regards to the types of food that would constitute that diet, the evidence to support residents' nutritional intake was in line with that guidance was absent.

As stated previously, the menu options for the week were done in consultation with residents utilising pictures as a forum of communication. While this is a positive practice, the evidence did not support how the meals were modified to meet the individual dietary intake of residents. Inspectors discussed this with staff and found that their knowledge did not adequately demonstrate that diets were appropriately modified to meet the needs of residents.

Residents' nutritional status was monitored utilising an evidenced based tool. Inspectors found that residents were not consistently supported to have their weight monitored in line with plans of care. Inspectors observed staff preparing food and noted that some of the ingredients were sourced directly from the vegetable garden of the designated centre. Inspectors further observed mealtimes to be a social experience with sufficient staff available to support residents in an appropriate manner.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
The designated centre had organisational policies and procedures in place for medication management. Inspectors reviewed the storage of medication and were assured that medication was stored in a secure location. Inspectors also observed staff administering medication to residents and observed that it was done in a dignified and

respectful manner, in line with appropriate practice.

Of the sample of prescription and administration sheets reviewed, inspectors were assured that they contained the pertinent information. The name, date of birth, name of medication and dose were clearly stated. There was also a signature from the prescriber in place if medication was discontinued.

There was additional information to guide staff in the event of p.r.n. medicine (a medicine only taken as the need arises) being administered. However, a review was required as the information contained conflicted with the prescription. For example, a resident was prescribed medication in the event of a seizure. The dosage to be administered on the guidance for staff was double of that prescribed therefore presenting an unnecessary risk.

Whilst there was a system in place for the monitoring of safe medication management practices improvements were required, as it did not identify the conflicting information.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
As part of the application to register the provider is required to submit a Statement of Purpose to the Chief Inspector. Inspectors reviewed the Statement of Purpose based on the findings of the inspection and found that it contained all of the information as required by Schedule 1 of the regulations.

However, as evidenced throughout this report improvements were required in the service provision to ensure sure that the practice of the designated centre is as stated in the Statement of Purpose and that it is in line with the application to register.

For example, as previously stated there was inconsistent referral to community based services which is a service documented as being provided in the Statement of Purpose. A review was also required of the criteria of admissions for the designated centre as the Statement of Purpose refers to the organisational policy; however, as stated in Outcome 4, this policy did not accurately guide the practice of the designated centre.

Judgment:
Substantially Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The organisation has clear line management structures in place which outline the roles and responsibilities. The provider nominee is the regional manager. There is an area manager who reports to the regional manager. The person in charge is the local manager who reports to the area manager. The person in charge commenced their role in July 2014. The person in charge is full-time and meets the requirements of regulation 14. The person in charge was formally interviewed by HIQA on the 24 July 2015 and demonstrated sufficient knowledge of the regulations and their statutory responsibilities.

There was evidence that there were regular staff meetings within the designated centre, with a standing agenda, that reviewed practices such as person centred planning and support and restrictive practices. There was also evidence that the provider nominee meets with the person in charge at appropriate intervals. A review of the quality and safety of care provided had been conducted by the regional manager in December 2014. There was evidence that actions identified had been addressed.

While the systems in place promote a robust management system and review of the quality of care provided, evidence within this report demonstrates that a review was required in respect of the clinical governance of the centre considering the findings of Outcome 11.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge had not been absent from the centre for more than 28 days since they commenced their post in July 2014. The provider demonstrated their awareness of the requirement to notify the Chief Inspector as required by regulation 32 if this were to occur. As part of the application to register, the provider had nominated another manager within the service to deputise in the event of the person in charge being absent.

There was also a system in place to ensure that there was always an appropriate member of management available to support staff in the event of the person in charge being absent for less 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):
This was the centre's first inspection by the Authority.

Findings:
The designated centre had resources in place such as transportation to support residents to access the local community. However, from a review of the staffing levels in conjunction with the assessed needs of residents, inspectors were not assured that one of the community houses was sufficiently resourced from 8 pm to 8 am. The standard staffing level for the designated centre is two staff during the day and one staff at night. However, inspectors found that one resident preferred to shower at night and required support from one member of staff with this task. In addition, there was one resident who was a high-risk of falls and another resident at risk of being absent without leave.

Both residents were documented as requiring supervision. Staff confirmed that residents would be unsupervised for periods of time after 8 pm. Inspectors requested at the feedback meeting that the provider conduct an internal review to ascertain the risk associated with the reduction in staffing levels and submit the outcome including actions to be taken to the Chief Inspector. A report was received by HIQA and the action taken by the provider is stated in the action plan at the end of his report.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors reviewed a sample of rosters, inclusive of those for the week of inspection, and confirmed that there was an actual and planned roster in place. The staffing levels on the day of inspection correlated with the standard staffing levels in the Statement of Purpose and the rosters reviewed. Inspectors observed staff to engage with residents in a dignified and respectful manner. However a review of staffing levels was required in one of the community houses post 8 pm as stated in Outcome 16.

There was evidence that staff had received the appropriate training pertinent to their role inclusive of the statutory requirements of manual handling, fire management, protection of vulnerable adults and management of behaviours that challenge. There was also additional training in place for the safe administration of medication, inclusive of rescue medication in the event of a resident experiencing a seizure.

Inspectors reviewed evidence of staff supervision and planned dates to ensure that it was standard practice.

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

Findings:
Inspectors confirmed that all of the policies as required by Schedule 5 were maintained in the designated centre. There was also a directory of residents maintained in the designated centre which included the name, date of birth, date of admission and other pertinent information as required by Schedule 3. However, inspectors determined that not all of the information as required by Schedule 3 (g) and (i) was maintained in the designated centre as there was an absence of records in respect of medical and nursing care provided to residents. There was also an absence of documentation maintained regarding the decision of a resident to refuse medical treatment.

Improvements were also required to ensure that the records, as required by Schedule 4 (5), evidence that the food provided is in line with the nutritional needs of residents.

Inspectors completed an additional fieldwork day and confirmed that the items as required by Schedule 2 were maintained in respect of staff employed in the designated centre.

Inspectors confirmed that the centre was adequately insured against injury to residents, staff and visitors.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Jillian Connolly
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 report[1]

Centre name:	A designated centre for people with disabilities operated by Muiríosa Foundation
Centre ID:	OSV-0004090
Date of Inspection:	19 August 2015
Date of response:	22 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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of evidence to support that the decision making process regarding the care provided to residents.

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

1. Action Required:
Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

Please state the actions you have taken or are planning to take:
Actions Completed: 15/12/2015
The decision making framework is being used by the family, keyworker and the person in charge regarding care issues, particularly if there is a consent issue for the individual being supported.

Actions planned:
The person in charge will discuss with the local staff team the decision making framework tool.

Additional support will also be sought from the independent advocacy service when required.

Proposed Timescale: 30/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents were not consistently supported to engage in activities in line with their personal goals.

2. 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:
Action Completed: 08/12/2015
Two new templates the Monthly Key Worker Report and Monthly Person Centred Plan Review were introduced to all team members to facilitate the person in charge tracking the progress of each individual's goals.

Actions planned:
Where an individual is not having the opportunity to engage in activities that are in line with their personal goals, this will be discussed at the local team meeting.

This will be escalated to the area director if the staff team are unable to support the individual in the activity.

Monthly Key Worker reports will be submitted to the person in charge who will review the report to ensure that there is evidence of achievement of goals and/or actions

completed working towards achievement of goals.

Supervision will be undertaken by the person in charge with the staff members as required.

Proposed Timescale: 30/01/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of the nominated person maintaining a record of the outcome of the complaint, action taken on the foot of the complaint and whether or not the complainant was satisfied.

3. 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:
Actions in Place:
The person in charge is the nominated complaints officer. A record of all complaints received are maintained within the location of the designated centre.

Complaints remain an item agenda on the monthly team meetings for the person in charge and area director.

Actions Planned:
The Participation and Engagement Plan will detail actions taken to achieve resolution of a complaint received by the person in charge and key worker.

On the monthly reports to the area director, the person in charge will high light any complaints that still remain unresolved where additional actions required can be identified and discussed.

Proposed Timescale: 29/01/2016

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:
There were inconsistencies in the assessment process resulting in an absence of acknowledgment of a need.

4. Action Required:
Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The assessment for each individual has been reviewed and updated.

A monitoring Health Care template was developed for each individual specific to their relevant health conditions in consultation with the individual, their family and relevant multidisciplinary team members. Each health care condition is now listed as a life event in the individuals care plan and cross referenced.

Where a support need was identified a referral was sent to the relevant allied health care professionals. All individuals have attended appointments and reviews as of 18/12/2015.

Each individuals care plan and monitoring health care template will be reviewed at least annually by the key worker and the person in charge, or more frequently if required. To ensure that supports required are sought.

Proposed Timescale: 07/01/2016

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:
Inspectors identified communal and individual hazards within the designated centre which had not been identified which in turn resulted in an absence of control measures.

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

Please state the actions you have taken or are planning to take:
Action completed: 08/12/2015
The Local Risk Register within the designated centre was reviewed by the person in charge and area director, with input from the operations manager and the maintenance manager. Additional control measures have been identified and implemented to minimise the likelihood of harm occurring to either individuals or the staff team.

The person in charge discussed the additional identified risks, control measures and importance of adhering to these control measures were discussed at the local staff

team meeting on the 08/12/15.

Additional risks identified relate to fire safety, the use of prescribed protective equipment, trip risks and accessing the second storey of one of the locations.

Proposed Timescale: 08/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire doors did not fully close.

6. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
All fire doors were reviewed by maintenance team and fire officer to ensure that each door closes fully.

Daily monitoring of the safe and operational function of all fire doors within the designated centre is included on the daily fire monitoring checks.

The importance of staff checking the functionality of all fire doors and aware of procedure to promptly report any issues to Maintenance Department as a matter of priority was discussed at the monthly staff meeting.

Actions Planned:
Fire Safety remains on the agenda of all monthly staff team meetings.

Supervision on the fire doors checks will be completed with staff members as required by the person in charge.

Proposed Timescale: 30/01/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of fire drills were in contradiction to the procedure to be followed in the event of a fire.

7. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably

practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Actions completed: 14/12/2015
A location specific Risk Management Plan in relation to Fire Safety was developed for both community houses which identifies specific actions to be taken in an evacuation.

This includes the correct exits to be used depending on the location of the fire.

The location specific risk management plan and exits to be used in an evacuation was discussed at a local team meeting on the 08/12/2015.

An Operations Management Review on the specific exit door was undertaken.

A risk management plan was developed by the person in charge, fire officer and the area director in regard to use of the exit with steps and a directive was given to the staff team not to use the identified exit during an evacuation. This can be accommodated due to the number of existing exits.

Actions Planned:
Person in charge will review the fire evacuation forms for three months to ensure that the identified fire exits are utilised during evacuations.

The fire register remains an item agenda on the staff team monthly meetings.

Supervision will be completed with staff members as required.

Proposed Timescale: 30/03/2016

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:
Evidence did not support that all efforts were made to alleviate the cause of residents' behaviours and that equipment was utilised for the shortest duration necessary.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 11/12/2015
The individual's risk management plan in relation to prescribed protective equipment was reviewed and additional control measure were identified to reduce the duration of

the use of the restrictive practice (protective helmet).

Person in charge met with the Psychologist and staff team to discuss the individuals behavioural support plan and identify triggers and develop proactive strategies for same. ABC charts were reviewed.

Supervision meetings completed by the PIC with staff members in relation to the appropriate completion of documentation in relation to supporting individuals with behaviours of concern.

Discussion has been held at the monthly Staff Team Meeting in relation to appropriate documentation.

Actions planned:
Record Keeping and Report Writing refresher training for staff commenced on 04/11/2015. Additional refresher training organised.

Training in relation to documentation of behavioural incidents and Positive Behaviour Support interventions will be organised through the Psychology Department

The Restrictive Practice Register and Risk Management Plan will be reviewed on installation of alternative equipment by the person in charge

MAPA training to include the individuals identified proactive strategies behaviour supports is scheduled for January 2016.

Proposed Timescale: 30/03/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Chief Inspector was not informed of the unexpected death of a resident within a three day period.

9. Action Required:
Under Regulation 31 (1) (a) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of the unexpected death of any resident, including the death of any resident following transfer to hospital from the designated centre.

Please state the actions you have taken or are planning to take:
Actions Completed: 10/11/2015
At the quarterly regional director and person in charge meetings, the above notification was discussed.

All future incidences of an unexpected death will be notified to the Chief Inspector within the specified timeframe.

Management and staff have been reminded of the importance of prompt reporting and adherence to regulations.

Proposed Timescale: 10/11/2015

Outcome 10. General Welfare and Development

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Activities residents were offered did not consistently promote skill building and/or lifelong learning.

10. 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:
Action Completed: 08/12/2015
Two new templates the Monthly Key Worker Report and Monthly Person Centred Plan Review were introduced to all team members to facilitate the person in charge to track the progress of each individual's goals.

Actions planned:
When an individual successfully completes a goal in relation to skills building or lifelong learning, consideration will be given what is the most appropriate next step. This will involve the individual, person in charge, key worker and relevant family members. The rationale behind the next identified step will be stated in the person centred support plan.

Monthly key worker reports will be submitted to the person in charge who will review the report to ensure that there is evidence of achievement of goals and/or actions completed working towards achievement of goals.

Supervision will be undertaken by the person in charge with the staff members as required.

Proposed Timescale: 30/01/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Plans of care did not support that the appropriate health care was provided to residents.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 18/12/2015
Each individual's care plan has been reviewed by the person in charge.

A new Monitoring Health Care template has been developed and introduced to the team with training on same provided by the person in charge and the area director.

A monitoring Health Care template was developed for each individual specific to their relevant health conditions in consultation with the individual, their family and relevant multidisciplinary team members. Each health care condition has now been listed as a life event in the individuals care plan and cross referenced.

Referrals for individuals were sent to the dietician as per each individual's specific care needs. All individuals have since attended appointments and reviews as of 18/12/2015.

Action Planned:

An individual monitoring health care template will be discussed at the monthly staff team meetings for the next 3 months to ascertain that health care needs of an individual have been appropriately identified and the appropriate support sought.

Proposed Timescale: 28/03/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Refusal of access to medical treatment was not clearly documented.

12. Action Required:
Under Regulation 06 (2) (c) you are required to: Respect and document each resident's right to refuse treatment and bring the matter to the attention of the resident's medical practitioner.

Please state the actions you have taken or are planning to take:
Actions planned:
The Independent Advocate will support the individual in question with all future medical decisions.

In future the decision making frame work of the organisation will be utilised to support the individual and document the process as appropriate.

Proposed Timescale: 27/01/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Referrals to Allied Health Professionals were not consistent.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 18/12/2015
Referrals sent to the dietician as per each individual's specific care needs. All individuals have since attended the dietician and a review was completed.

Each individual has an Annual Health Checklist in place to monitor appointments and reviews.

The importance of supporting individuals with all of their health needs and monitoring of same was discussed with staff.

Organisational Policy entitled "Involvement of Multidisciplinary Practitioners – An Overarching Framework" is also in place to guide referrals.

A Monthly Key Worker Care Plan report has been developed and introduced which captures the care plan status and additional requirements for allied health professional input.

Proposed Timescale: 18/12/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Evidence did not support that the food provided for residents was in line with their dietary requirements.

14. Action Required:
Under Regulation 18 (2) (d) you are required to: Provide each resident with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.

Please state the actions you have taken or are planning to take:
Actions Completed: 18/12/2015
All individuals with specific dietary requirements have been supported to access a Dietician and attend a review. The dietician reviewed the proposed food menus and food diaries and recommended that current dietary practice were meeting the individual's needs.

Individuals receiving a prescribed diet will have same monitored through the use of Food Diaries which are monitored by the person in charge monthly.

Actions Planned:
Spot checks are undertaken by the person in charge to ensure that meals are nutritious and are in line with the Dietician's and Speech and Language Therapist recommendation.

Proposed Timescale: 18/12/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was conflicting information between the prescription for a resident and the guidance in place to support same.

15. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Actions Completed: 22/08/2015
The PRN Protocol was reviewed by the individual's GP.

The person in charge reviewed all PRN Protocols to ensure they corroborated with the individual's drug kardex. Nil additional discrepancies identified.

Actions Planned:
On completion of a PRN protocol, the GP, key worker and person in charge will ensure that the drug prescription is reflected correctly in the PRN protocol to minimise risk of

error and to promote safe and effective medication management.

This will be discussed at the next local staff team meeting.

Proposed Timescale: 22/01/2016

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 had not been revised in line with the standard operating procedure for the admission of residents.

16. Action Required:
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
Action Taken:
The Statement of Purpose and Function was reviewed by the Provider Nominee, area Director and Person in Charge and submitted to the Authority by the Provider Nominee.

Proposed Timescale: 16/10/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review was required of the systems in place to ensure effective clinical governance.

17. 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:
Actions Completed: 08/12/2015
A meeting was held with area director and person in charge to review the clinical governance within the designated centre. The following forms part of the ongoing governance locally.

Person in charge visits the designated centre weekly.

Area director visits designated centre monthly.

There is a set agenda for monthly house meetings which are chaired by person in charge.

Ongoing staff supervision is completed as required.

A new template the Monthly Key Worker Report and Monthly Person Centred Plan Review was introduce to all team members to facilitate the person in charge to track the progress of each individuals' goals. This report will form part of the monthly returns.

A new monitoring Health Care template was developed. This is specific for each individual's relevant health conditions and is cross referenced in each individual's care plan.

Proposed Timescale: 08/12/2015

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 centre was insufficiently resourced to ensure appropriate supervision for residents.

18. 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:
Actions Completed: 11/11/2015
A review of the staffing levels between the hours of 7.00hrs and 8.00 hrs and the hours of 20.00 hrs and 23.00 hrs in one house within the designated centre was completed by the area director.

The review concluded:
An additional hour on a Sunday would benefit the individuals and the roster was amended to meet this need.

The presence of an active on call arrangement and the contingency plan provides the additional support and advice to staff when required.

Proposed Timescale: 11/11/2015

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was an absence of records maintained in respect of medical and nursing care provided to residents. There was also an absence of documentation maintained regarding the decision of a resident to refuse medical treatment.

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

Please state the actions you have taken or are planning to take:
Actions Completed: 08/12/2015
All staff received an information session on Management of Service Users files Muiriosa Foundation Standard Operation Procedure.

A record of the individual's condition and any treatment or other interventions will be maintained in their personal care plan.

A record will be maintained in regard to all medical treatments and where the individual refuses treatment within the individual's personal records.

Each individual's care plan has been reviewed to ensure that all records are maintained in respect of their medical and nursing care needs.

Record Keeping and Report Writing Training completed by staff.

Actions Planned:
Additional report and record keeping training and care plan training scheduled.

Each individuals care plan and monitoring health care template will be reviewed at least annually by each key worker and the person in charge, or more frequently if required.

Proposed Timescale: 28/02/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were also required to ensure that the records as required by Schedule 4 (5) to evidence that the food provided is in line with the nutritional needs of residents.

20. Action Required:
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:
Actions Completed: 11/12/2015
All individuals with specific dietary requirements have been supported to access a Dietician and to attend a review.

All individuals who now have a prescribed diet will have same monitored through the use of Food Diaries which are reviewed by the person in charge monthly.

Information on nutrition intake will be recorded in progress notes daily for individuals who do not require a prescribed diet.

Actions Planned:
Ongoing spot checks will be undertaken by the person in charge to ensure that meals are nutritious and as per Dietician's and Speech and Language Therapist recommendations.

Any actions required following the spot checks will be communicated to the staff team by the person in charge.

Proposed Timescale: 11/12/2015