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 Health Service Executive
Centre ID:	OSV-0004645
Centre county:	Cork
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Angela O'Neill
Lead inspector:	Mary O'Mahony
Support inspector(s):	John Greaney; Liam Strahan; Noelle Neville; Vincent Kearns; Aoife Fleming
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
09 September 2015 08:00	09 September 2015 20:00

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

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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Inspectors found a significant level of non compliance in this centre, which impacted on the quality of life of residents. Following the inspection, the provider was required to attend a meeting with HIQA and required to engage in a regulatory plan to bring the centre into compliance with the Regulations and National Standards. HIQA (the Authority) are continuing to monitor this centre to ensure that the provider is implementing the actions that they have committed to.

This was the first inspection of this centre for people with disabilities by the Authority. It was an unannounced inspection and took place over one day. The centre consisted or three houses. Six residents resided in each house. There were no vacancies on the day of inspection. The design and layout of each house was identical and consisted of three twin bedrooms for use by residents and a single bedroom for night staff sleepover. Each house had two bathrooms, one of which contained a shower, toilet and wash-hand basin and the second which contained a bath, a toilet and wash-hand basin. Communal facilities in each house consisted of a kitchen/dining room area and a comfortable sitting room.

The houses were situated in a quiet estate within walking distance from an activation centre of a related service. Many of the residents worked in, or attended, this activation centre daily. Residents, who were retired, were facilitated to attend the activation centre for meals. During the inspection, inspectors met with residents, day duty and night duty staff members, the person in charge and the management team. Inspectors observed practices and reviewed records such as personal care plans (PCPs), accident and incident logs and personnel files.

Residents expressed their satisfaction with the care and support in the centre and indicated to inspectors that their rights and autonomy were respected. They explained their daily routine and spoke about the activities, holidays and outings which they had engaged in. They were familiar with each other's visitors and were aware of how to raise issues of concern. Staff members had been afforded training and were knowledgeable of residents' life stories and the individual goals. Residents were assigned key workers and they had personal plans drawn up which set out their social, medical and psychological needs, with plans of care in place, to support these needs.

However, inspectors' findings indicated that significant improvements were required in the area of governance and management and health and safety and risk management. Additional improvements were required in the areas of social care needs, safeguarding and safety, contracts, medication management, health care needs, notifications and fire safety. The provider was issued with two immediate action plans on inspection. One immediate action plan concerned fire safety management issues and the second immediate action plan was issued in the area of risk management systems, both of which are discussed in more detail under Outcome 7: Health and safety and risk management. A response to these immediate action plans was received within the time frame set out by the Authority. However, further assurances and clarification were required from the provider in the area of fire safety management in the centre. These assurances were submitted following the inspection.

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 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:
Residents had not been provided with a written agreement of the terms on which they resided in the centre. This was not in compliance with Regulations.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
The person in charge informed inspectors that the health, personal and social care and support needs of each resident were assessed prior to admission. Records reviewed indicated that these assessments were multidisciplinary.

Personal care plans (PCPs) were kept under review annually and more frequently where required. However, inspectors noted that not all PCPs were reviewed annually as required by Regulations. Residents' participation in planning their goals was recorded within their personal plans. Documentation was seen by inspectors which indicated that residents' representatives were involved in PCP reviews. If representatives were unable to attend the meetings, this was recorded. Where residents were transferred between places of residence transition plans were implemented to support this. A sample of personal plans, reviewed by inspectors, included the names of those responsible for supporting residents to achieve their goals, within agreed timescales. Residents discussed their goal achievements with inspectors. However, when reviewing one PCP, inspectors found that one resident had not been facilitated to achieve a frequently expressed goal and there was no identified person responsible for supporting him in achieving the goal.

Personal plans indicated that residents were actively engaged in education and activities that were meaningful and appropriate to their interests and preferences. These included day services, as well as employment experience, use of public transport, drama groups, singing, church involvement, self-management of medication, life skills, participation in sports and holiday travel. Residents who were retired were engaged in activities such as painting in a personalised painting studio, maintenance jobs and tending to the hens which were kept in the garden. Affiliated support groups organised holidays for residents and trips to garden centres and other areas of interest. Staff and residents also outlined the arrangements for activities and relaxation within the house, such as a weekly relaxation time, art and crafts, baking, watching DVDs and listening to music. Residents informed inspectors that they voted when this was required. They also spoke with inspectors regarding how they had been supported to personalise their bedrooms and other areas in the house. These bedrooms were seen to be colourful, nicely painted and decorated with personal items such as pictures, photographs and certificates of achievement.

However, not all documents in the PCPs had the date of the creation of the record included and in one instance the personal hygiene record for one resident was last documented on 18 August 2015. In addition, a person centred care plan for one resident was not signed by that resident even though the resident had signed the medical care plan. Furthermore, the 'hobbies and interest' admission checklist recorded in residents' care plans did not always correlate with the daily activity sheet entries recorded for each resident. Evaluation sheets, which were used to record ongoing evaluation of residents' assessed needs, were not sufficiently detailed. These sheets were inadequately stored as inspectors observed a number of evaluation sheets as being stored loose and not attached to the relevant care plan. Not all plans of care were accurately recorded or updated in line with changes that occurred. For example, a resident who had a plan of care for his unsteady gait did not have the fall and subsequent x-ray which occurred in July 2015, documented in the plan of care. The last entry recorded was 19 June 2015 when he attended the physiotherapist. In addition, this resident had a mobility plan, which had been used to record his mobility level, discontinued on 14 November 2014. Furthermore, inspectors noted that there were no care plans in place for some medical issues, such as dermatitis and diabetic dietary needs, which will be addressed under Outcome 11: Healthcare needs.

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:
As outlined in the introduction to this report the centre consisted of three single storey houses. These were situated in quiet estates and were within walking distance of the activation centre of a related service. Each house was similar in design and layout and they were comfortable and homely. Residents stated that they were happy with their accommodation. They explained how they cleaned the house weekly and did their own washing. They had decorated the houses with lamps, photographs, pictures of family and outings and their personal items. There were two bathrooms in each house, one had a shower installed and one had a bath, which afforded choice to residents. However, the houses were located at the top of a hill and this presented accessibility problems for some of the older residents. Some houses had a steep driveway and issues of risk and accessibility were addressed under Outcome 7: Health and safety and risk management.

Each house had one large sitting room and a combined, well equipped kitchen/dining room. However, there was lack of communal space for residents to afford residents private visiting time if required. In addition, in one house inspectors noted that the covering on the couch was torn and required repair. In some bedrooms there was mould-like staining on the ceiling which was quiet extensive in one bedroom. Furthermore, the bedrooms were twin bedrooms and were inadequate for storage of personal belongings and privacy reasons. Inspectors observed that there was very little space between the beds and there was no privacy screen available for residents who wished to stay on in bed or when getting dressed. Staff informed inspectors that residents dressed in the bathrooms.

The doors of all bedrooms were wedged open. This presented a potential fire safety risk where fire doors had been installed and they were rendered ineffective by the presence of the door wedges. This arrangement had not been risk assessed. This issue was addressed under Outcome 7: Health and Safety and risk management. Residents had personalised their bedrooms however, inspectors noted that they had very little space in which to store their belongings, despite having large double wardrobes and bedside

lockers. As there were no extra rooms available in which to keep personal belongings in the house, therefore residents had a large amount of belongings to store in their bedrooms. Inspectors noted that suitcases were stored by the wall in some bedrooms. In addition, the wardrobes were full and clothes were seen hanging on the wardrobe doors in a number of bedrooms. Furthermore, there was no space in the bedrooms if a resident wished to have a chair to spend time watching their individual TVs.

Staff used a hall cupboard to store residents' files. This accumulation of paper in a hall cupboard presented a potential fire risk, as discussed under Outcome 7: Health and Safety and risk management and had not been risk assessed. In addition, the lack of office space required that files were also stored on kitchen worktop. Staff informed inspectors that they had asked for office space in the staff bedroom. However, as there were two beds in this room there was not sufficient space. Staff informed inspectors that these staff bedrooms will no longer be in use in the future, as there will be a waking staff member assigned to each house at night. The clinical nurse manager (CNM) stated that this extra bedroom would be used to alleviate the lack of bedroom space for residents.

There were large garden areas available to residents. There were washing lines, sheds and smoking areas in place. One resident tended to the hen coop in one garden and he also had the use of a painting studio for his art work. There was garden furniture available for residents' use.

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

Findings:
Fire evacuation drills were carried out during the day and records of these were seen by inspectors. However, as these were led by an external person, staff informed inspectors that they were not familiar with leading a fire drill. The provider was issued with two immediate action plans (IAP) in response to findings of non compliance with Regulations on fire management and risk assessment. Responses were received from the provider in a timely manner. However, some issues in fire safety management required follow up, for example, fire door provision on the hot press in the hall, the provision of emergency lighting in the kitchen and utility room and the provision of fire extinguishers in the lower hallway near to residents' bedrooms. Assurance were submitted by the provider that these issues had been addressed following the inspection.

The first immediate action plan concerned Regulation 28 (3) (d) on fire safety management. The serious and significant concerns were as follows:
-the design and layout of the houses was such that the staff bedroom and the residents' three double bedrooms were situated down a long narrow hallway away from the exit doors.
-the hot press, a storage cupboard containing paper files, the kitchen and utility/laundry room were situated between the exit doors and the bedrooms. This was significant in that these areas were possible locations for fires and were not risk assessed as such. There were other related fire safety management systems of concern in the house, which were known to the senior management team.

For example:
-the was no fire extinguisher in the vicinity of the bedrooms
-all bedrooms doors which were designated fire doors, were wedged open, with wooden wedges, all day
-no staff member was trained to lead fire drills with residents: therefore no night time drills had been carried out and staff were not familiar with leading a fire evacuation drill, by day or night
-residents, including a resident who smoked in the house, spent time alone in the houses during the day unsupervised, as staff went off duty officially at 09.00 and returned at 17.00: while this had been risk assessed there were no suitable controls to mitigate the identified potential fire risk associate with the elderly resident smoking unsupervised in the house
-a fire evacuation panel in one house had some buttons damaged. While this had been identified as requiring replacement in 2014, inspectors found, however, that this replacement had not been done. This fire panel was located in the house where the resident, who smoked indoors, resided. This had been replaced since the inspection.

The person in charge stated that she had asked on numerous occasions if a staff member could be trained to lead fire drills and be trained as a fire warden. However, she stated that she had been informed that this was not allowed. There were no fire exit signs on the exit doors and no emergency lighting in the kitchen and utility room, considering that one of the fire exits was located in the utility room. In addition, the 'generic' risk assessment for fire in the centre was inadequate in that it did not consider all hazards and it did not have sufficient controls in place or did not set out additional controls required. There were no specific health and safety meetings. Health and safety issues were discussed at staff meetings, according to the CNM2. Minutes of meetings, reviewed by inspectors, indicated that incidents and accidents were discussed at these meetings. Staff did not carry out audit in the area of health and safety, to include fire safety. In addition, the procedure to be followed in the event of a fire was not displayed in a prominent space. However, it was available in an accessible folder in the sitting room.

The provider's response to the first IAP was received by the authority within the specified time frame. This response was inadequate, in view of the other identified related fire risks, and an email was sent to the provider to provide assurances that all risks were assessed and controls put in place. A satisfactory response was received by the Authority.

The second immediate action plan was issued in relation to Regulation 26 (2): there were inadequate systems in place for the assessment, management and ongoing review of risks, in particular in regards to residents who smoked, including,
-residents had a smoking assessment as to their suitability to smoke however, they did not have an individualised quantitative risk assessment carried out into the level of risk involved and suitable controls put in place in response to this
- one resident smoked indoors in one house, however, he had no individual quantitative risk assessment completed. This risk assessment did not consider the full risk potential associated with this elderly resident spending the majority of the day alone in the house, as an unsupervised smoker: In addition, this resident had not been provided with a external smoking area, even though the generic risk assessment stated that all alternatives to smoking indoors would be offered to him
- three residents smoked in one house: these residents retained their cigarettes and matches on their person: inspectors noted at least four empty cigarette packets on a resident's dressing table and two electronic cigarettes also:
-there was another smoker in a third house: the person in charge stated she never smoked indoors: however, she did not have a quantitative risk assessment completed
- the residents from one house had been provided with an unsuitable outdoor smoking shed: This timber shed was unsuitable as there was a large plastic bin in the shed that was provided to empty the ashtrays: Inspectors noted that the ashtray in the shed was full, at the time of inspection
-the fire extinguisher in the timber shed did not have any service record
-it was unclear if fire drills had been conducted to include the potential of a fire occurring in the timber smoking shed
-there was an old worn cushion in the shed, which the person in charge confirmed was not flame retardant
-on wet days and in the winter the area in front of the shed became muddy and slippery, staff informed inspectors that they had requested on numerous occasions that this area be made safe for the ageing residents. However, this had not been done. This issue was significant in that, if residents were unable to gain safe access to the smoking shed, they may smoke elsewhere, particularly in the winter
-the aforementioned hazards had not all been addressed or identified in the risk assessments.

Inspectors noted that the risk management policy for the centre did not include the requirements of Regulation 26 (1)(c) that the control measures and actions in place for the following four specified risks: self harm, accidental injury, the unexpected absence of a resident and aggression and violence, be set out in the risk management policy. In addition, inspectors noted that there was no risk management policy or risk assessment on self harm of residents, in the centre. Furthermore, there was no risk register available in relation to the risks in each individual house. This risk register was stored centrally. The emergency plan was not centre specific and referenced a staff member who had retired from the service.

In addition to the aforementioned risks, the following risks were identified by inspectors:
-there were unsafe outdoor surfaces that had been identified as a potential hazard by staff however, there were inadequate controls in place to mitigate this risk
-there was no suitable outdoor assistive railing provided on the steep driveway to assist residents' access to the houses, particularly in the wintertime: staff informed inspectors

that they had requested, on numerous occasions, that such a railing be installed -at times residents were required to walk home, via a steep hill, in the evening time when they were tired.

While there was a system in place for checking medications in the monitored dosage systems, when received from the pharmacy, however, there were still on-going incidents of medication dispensing errors. Some of these errors were only detected at the time of medication administration. It was not clear what action or controls were in place to reduce the occurrence of this on-going risk to residents' safety. This issue was addressed under Outcome 9: Medication Management.

There was a colour coded cleaning system in place in the centre and residents and staff cleaned the houses at weekends. However, there were areas of the house that required deep cleaning and these were identified to the clinical nurse manager. Inspectors were informed that the houses were deep cleaned on an annual basis while residents were on their holidays. However, staff stated that deep cleaning had not been done this year. This issue was of was significant as there had been an episode of a vomiting bug and carpets and soft furnishings in the house had not been deep cleaned since this outbreak. Furthermore, staff informed inspectors that they were required to move between the houses during the outbreak, thereby presenting a risk of cross contamination.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

Findings:
Residents informed inspectors that they felt safe in the centre and this was attributed to the fact that they were familiar with the staff. Inspectors observed that staff and residents were very comfortable in each other's company.

There was a policy on the management of allegations of abuse. However, this policy was inadequate as it did not reference the Safeguarding Vulnerable Persons at Risk of Abuse which was developed in December 2014 by the health services executive (HSE). In addition, the policy did not outline the regulatory obligation to notify the Authority of

any allegation of alleged or suspected abuse, within three days. Furthermore, the policy did not define verbal abuse. Training records indicated that the majority of staff had received training on the prevention and detection of abuse. Staff spoken with by inspectors were knowledgeable of what constituted abuse and were aware of the reporting responsibility in the event of witnessing any abusive interactions. However, not all staff had received this mandatory training. In addition, some staff members were overdue refresher training. Furthermore, all residents did not have intimate care plans in place. There was a policy on the prevention and use of restrictive interventions which outlined measures to promote a restraint free environment. However, the policy was not centre specific as required by Regulations. Residents in the centre were independently mobile and did not require any form of physical restraint. One resident had received sedative medication on a PRN (when necessary) basis. However, this use of chemical restraint was not notified to the Authority and was addressed under Outcome 9: Notifications.

There was a policy in place for the management of residents' finances. Residents generally managed their finances independently and some receipts were retained from shopping events and outings. However, the oversight system in place for residents' who required support with their finances was not robust. For example, residents added money to their purses on receipt of their weekly payments. These purses were retained by staff at the residents' request. However, the balance was not counted, verified and recorded by the resident and staff member when money was being added or taken out, for various purchases. In addition, staff who were on night duty kept possession of the key for the locker where some residents' finances were held. Therefore, these residents would be unable to access their money, if required, during the day. Not all receipts were maintained and it was not clear if the balance of residents' money was correct or not in the absence of complete records. Furthermore, where residents had agreed to an independent audit of their finances this had yet to be arranged.

The person in charge explained to inspectors that residents had been trained on protection issues. Residents spoke with inspectors and indicated that they found the programme very helpful in their daily lives.

The centre had a policy on behaviours that challenge. However, this was not a centre specific policy as required by Regulation. In addition, staff had not been afforded mandatory training in behaviours that challenge.

Judgment:
Non Compliant - Major

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

Theme:
Safe Services

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

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

Findings:
Inspectors were not assured that the centre was submitting all notifications as required to the Authority in line with the requirements of Regulation 31.

However, a documented incident of a resident sustaining a fall and attending hospital for x-rays was not notified to the Authority; this was required within 3 days of the event as a serious injury to a resident which required hospital treatment.

A documented incident of the use of chemical restraint for a resident, to control their behaviour in an acute situation in March 2014, was not notified to the Authority in the quarterly notifications as required.

Judgment:
Non Compliant - Major

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

Theme:
Health and Development

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

Findings:
Residents had access to the services of a general practitioner (GP) and there was evidence of regular review. Residents also had access to allied health and specialist services such as psychiatry, dietetics, physiotherapy, dental and chiropody.

Care plans were in place for some identified health issues such as hearing impairment and low iron levels, however, improvements were required. For example, there was not always an updated care plan in place for residents with diabetes or for residents with skin conditions requiring on-going treatment. A record of the weight of a resident with diabetes was maintained. However, in two care plans reviewed by inspectors the malnutrition universal screening tool (MUST) and body mass index (BM1) had not been recorded for those residents, in line with best practice, to interpret the residents' risk of malnutrition. Where care plans were in place, it was sometimes difficult to ascertain the current recommended care due to the manner in which the care plan was updated. For example, changes to recommended care were recorded in the narrative section of the document and the section detailing the care plan to be provided was not always updated. As a further example, a resident with diabetes had a care plan dated 13/11/13. In addition, residents who had communication challenges did not have communication care plans in place. Furthermore, staff were not trained in augmented communication

strategies. This issue was addressed under Outcome 17: Workforce.

Staff with whom inspectors spoke were knowledgeable about residents' health and social care needs and were observed to provide care as outlined in the personal plans. Staff members spoken with by inspectors were knowledgeable of each resident's medical and social needs. However, as will be further discussed under Outcome 17, there were not always adequate numbers of staff available to support residents at times of illness. For example, a resident that had recently been ill was left alone in the house for periods of time during the day, as there were inadequate numbers of staff available. While a CNM spent some time in the house during the day when the resident was unwell, there were no designated staff to stay in the house, to care for the resident between 09:00hrs and 17:00hrs. On another occasion, inspectors noted that a planned outing for residents had to be cancelled as there was no staff member available to care for a sick resident. This issue was addressed under Outcome: 17.

Residents had their breakfast meal and tea prepared in the houses each day and attended the dining hall in a nearby residential centre for their lunch, from Monday to Friday. Many of the residents also attended this centre each day for activities. A small number of residents, who had retired, continued to attend the dining hall for their lunch. Residents usually went out for lunch on Sundays to restaurants in neighbouring towns and villages and the venue was usually decided by residents at their Friday meeting. Residents had access to fresh fruit and snacks and were seen to help themselves to hot and cold beverages throughout the day.

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

Findings:
The arrangements for storing medication in the centre were reviewed. There were no designated medication fridges in place in the centre. As a consequence, staff informed inspectors that medications that required refrigeration were stored in the kitchen fridge. In addition, a daily record of the fridge temperature was not maintained. Some medications were seen stored in a plastic box in the kitchen fridge. This was not in line with best practice guidelines issued by of Bord Altranais agus Cnáimhseachais na hEireann, 2007, Guidance on Medication Management.

Inspectors reviewed the records of medication errors and incidents. Medications were

supplied to the centre from the pharmacy in monitored dosage systems (MDS). However, a significant number of dispensing errors were recorded in the MDS over recent months. For example, one resident's MDS did not contain one of their diabetic medications; another resident's MDS did not have an alternative daily dosing regimen for one medication dispensed correctly. In some cases these errors were detected by the staff nurse when checking the MDS on receipt from the pharmacy. However, in other cases the errors were only detected at the time of administration. It was highlighted at the feedback meeting at the close of the inspection that, according to Regulation 29 (4) (b) 'the person in charge shall ensure that appropriate practices are in place to ensure that medicines which are prescribed are administered as prescribed to the resident'. Medication audits had been conducted in the centre, however these incidents of medication dispensing errors in the MDS were not listed in the audit findings. The audits were not sufficient to adequately address these errors and to implement learning. This was also addressed under Outcome 7: Health and Safety and Risk Management.

Staff in one house outlined to inspectors that residents were self-medicating; however, the practices in place did not demonstrate that residents were taking responsibility for their medications. On review, inspectors found that medications were stored in the medication storage press in the kitchen by staff. Staff were administering medications to residents and supervising them while taking the medications. The centre had implemented a form for assessing residents' ability to self-administer their medications. However, this assessment was not comprehensive and did not outline how a decision was made in relation to the resident self medicating or not, at the end of the form. The form consisted mainly of yes or no check-box questions with no open or narrative space to outline resident's individual routine or practices around the administration of medication. Inspectors formed the view that the self-medication assessment form in use, was not an appropriate risk assessment or assessment of capacity, as required by Regulation 29 (5).

Residents' medication prescription sheets were reviewed and were found to contain the required information regarding the resident and medications prescribed. However, maximum daily doses of PRN (as necessary) medications were not always documented by the prescriber.

There were residents with a diagnosis of epilepsy residing in the centre. However, inspectors were informed that not all staff were trained in the administration of buccal midazolam, which was prescribed for rapid treatment to stop seizures, that may occur for those residents with epilepsy There was an instruction sheet on the inside of the medication storage press to guide staff on the administration of this emergency medication. However, it was not adequate and did not outline in the detail the steps to be taken when administering this medication.

Judgment:
Non Compliant - Major

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:
The statement of purpose did not contain all of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. For example, it was not centre specific and did not contain a description of the rooms.

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:
Inspectors formed the opinion that the governance and management system in place in the centre was inadequate. The management structure in the centre was not clearly defined. The person in charge, as notified to the Authority, was qualified and suitably experienced. However, she expressed to inspectors that her role and responsibilities in other related designated centres resulted in a lack of capacity on her behalf, to ensure the effective governance, operational management and administration of the three houses centre, as required under Regulation 14 (4). She stated that she had requested to be replaced in the role of person in charge over the three houses in March 2015 and this request had not been granted. Both staff and the person in charge stated that she rarely visited the houses and relied on the clinical nurse managers to fulfil the duties of managing staff and supervising the care, welfare and safety of residents.

Inspectors undertook a review of audits. However, audits were undertaken sporadically and there was no evidence of learning outcomes or any resultant actions taken for

improvement. For example, there was no audit of the health and safety management arrangements. In addition, there was no audit of infection control measures despite an outbreak of vomiting which had affected residents and staff.

The annual review of the quality and safety of care and support in the centre, as required under Regulation 23 (1) (f), had not been made available to inspectors. Unannounced visits by, or on behalf of the registered provider, to review the quality of care and support had not been conducted in all houses, as required by Regulation 23 (2).

Staff performance management and supervision had not taken place, as required by the Regulations.

There were no records of staff meetings available for inspectors' review. Staff informed inspectors that such meetings did not take place. Staff, who spoke with inspectors, stated that they were not facilitated to raise concerns with management on the quality and safety of care and support for residents, as required under Regulation 23 (3) b. For example, staff informed inspectors that they had requested handrails on the driveway to facilitate residents' safety and access. In addition, this issue had also been reported as a complaint by a resident in February 2015. However, no action had been taken in response to either the complaint or the staff members' concerns. Furthermore, staff informed inspectors that they had raised concerns regarding staffing levels and residents' supervision, with managers. However, they informed inspectors that these concerns were not addressed. Staffing issues were discussed under Outcome 17: Workforce.

Judgment:
Non Compliant - Major

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

Theme:
Responsive Workforce

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

Findings:
During the inspection inspectors observed that the skill mix of staff on duty was appropriate to meet the needs of residents. Staff displayed knowledge of residents' needs, of relevant policies and of Regulations and Standards for the sector. However, the policies were not available in all houses and one staff member, spoken with by

inspectors, did not know where the copy of the Standards and Regulations were filed. The person in charge informed inspectors that there were no volunteers involved in the centre. However, a review of duty rosters and interviews with staff indicated that staff were not always replaced when on annual leave or if absence occurred as a result of illness.

Residents were encouraged to be as independent as possible. Residents had access to staff by using the phone in the centre or their personal mobiles where possible. A staff member carried an 'on call phone' and was accessible to residents. Staff were seen to facilitate independence and were seen to remind residents if tasks were to be done in the house, for example doing their washing and tidying their bedrooms. However, lack of sufficient staffing particularly at times of illness of residents was apparent. A care plan reviewed by inspectors indicated that a sick resident had been left alone in the centre for unspecified periods of time following his return from hospital for treatment of a serious condition. This was confirmed by a staff member who was assigned her usual duties to attend to all the houses as was the norm. While he was in hospital he had been prescribed a new medication for this condition. However, staff informed inspectors that no specific staff members was assigned to care for him during his recuperation when he returned to his house. In addition, staff informed inspectors that during an outbreak of vomiting staff were still required to move between all three houses, even though residents in one house were 'in isolation' for infection control reasons. Furthermore, staff stated that a resident, who was in bed sick at that time and was vomiting, was alone for unspecified periods of time during the day, while staff attended the other houses. He, also, had not been assigned a specific staff member to attend to his needs. Staff expressed concern for residents' welfare at times of illness due to lack of staff assigned to remain on duty in the houses throughout the illness period. There was no evidence that learning or review had occurred as a result of these incidents or that provision had been made to ensure that this would not happen in the future. Risks associated with these occurrences had not been assessed. This was addressed under Outcome 7: Health and safety and risk management.

Records indicated that all staff did not have access to appropriate training for their role. However, the majority of staff had received certain training including; fire safety training, manual handling, safeguarding vulnerable adults, non-violent crisis intervention and the safe administration of medication. Further training undertaken by some members of staff included epilepsy awareness training. Management staff stated that they regularly reviewed training records to ensure staff had received all mandatory training and that refresher training was delivered when necessary. However, some staff required communication training, food hygiene training, fire evacuation training, fire safety training, buccal midazolam and manual handling training. For example, some residents were non verbal and staff had not received training in communication skills. In addition, inspectors noted a discrepancy in the training matrix maintained in the centre. For example, a staff member who had not attended manual handling training was entered as having completed the training. This member of staff was ill at that time. For this reason inspectors could not be assured that training records were kept up to date and accurately recorded.

A sample of staff files were seen by inspectors. Documentation required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for

Persons with Disabilities) Regulations 2013 was maintained. However, there was no evidence that staff had undergone appropriate supervision or appraisals. In addition, in the sample of files reviewed one staff member had a gap in employment history and a staff member's qualification certification was not present in a second file. Furthermore, there was no start date on file for a staff member who had taking up a new post.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0004645
Date of Inspection:	09 September 2015
Date of response:	30 November 2015

Requirements

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

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

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed, on admission, to agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

1. Action Required:

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

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
A contract of care is currently being developed for these houses. This will be discussed and distributed to all residents.

Proposed Timescale: 18/12/2015

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that all the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) were met. These are outlined in detail under the Outcome findings, for example, storage, room size, office availability, communal and private space, privacy and dignity issues.

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

Please state the actions you have taken or are planning to take:
These houses which are situated in the community are three bedroomed units. As each house currently provides accommodation for six residents all are sharing rooms. Residents dress / undress in the bathrooms.
All residents have indicated that they are happy with the current sharing arrangements. This will be discussed with residents again.
At this time there is no opportunity to provide single bedrooms for residents in these houses. If opportunities arise, residents will be afforded the opportunity to have a single bedroom.
Residents have been consulted regarding the use of privacy screens and shown examples of these screens; however, have declined to have them permanently installed in their rooms. Privacy screens will be made available within the units; however, if residents choose to use these in their bedrooms when they want to.
Additional shelving is being sourced for installation adjacent to the hot press to provide increased storage. A filing cabinet may also be installed, dependent on available space once shelving is completed.

Proposed Timescale: 31/01/2016

Theme: Effective Services

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

the following respect:
The premises required painting internally and repair to outdoor surfaces.

3. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
The requirement for internal painting in these houses has been addressed.

HSE Estates are currently evaluating the requirement for external work and will revert with a plan for same.

Proposed Timescale: 29/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The location of the houses at the top of the hill and the steep driveways up to the houses did not conform to the regulations on accessibility.

4. Action Required:
Under Regulation 17 (6) you are required to: Ensure that the designated centre adheres to best practice in achieving and promoting accessibility. Regularly review its accessibility with reference to the statement of purpose and carry out any required alterations to the premises of the designated centre to ensure it is accessible to all.

Please state the actions you have taken or are planning to take:
HSE Estates will review these properties with a view to improving the accessibility of 2 of the properties.

Proposed Timescale: 29/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deep clean of houses, undertaken annually, had not taken place.

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

Please state the actions you have taken or are planning to take:
The deep clean has taken place in 2 of the houses with the 3rd scheduled to take place on the 24/11/2015.

Proposed Timescale: 25/11/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the risk management policy includes the measures and actions in place to control all risks identified.
For example:

Each house did not have a centre specific risk register.
-it was not clear what actions or controls were in place to reduce the on-going risk to resident safety due to medication dispensing errors in the medication dispensing systems
- all smokers did not have a quantitative risk assessment in place
-one fire panel had been identified as requiring replacement
-the smoking shed was unsafe and all risks within it had not been identified
-the fire extinguisher in the smoking shed had no evidence of servicing
-residents were alone for periods of time when sick
-there were no fire extinguishers near the bedroom areas of residents
-fire doors were wedged open
-there were unsafe outdoor surfaces identified by staff as high risk, which had not been addressed
-a supportive outdoor assistive railing had not been provided on the steep driveway to support residents
- older residents were not always afforded a drive home, up the steep hill in the evenings

6. Action Required:
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
An individual risk register is now available in each house.
A meeting has taken place with the pharmacist to address medication errors in blister packs.
All residents who smoke have a smoking risk assessment in place.
The identified fire panel was replaced on 23/09/2015.
The fire extinguishers were serviced on 16/09/2015.
Door wedges have been removed.
Accessibility issues will be addressed in consultation with HSE Estates.
Taxis are available to all residents. This is highlighted at weekly meetings. These taxis are paid for by the residents and this will be highlighted in the contract of care for each resident.

Proposed Timescale: 19/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the risk management policy included the measures and actions in place to control the unexplained absence of a resident.

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

Please state the actions you have taken or are planning to take:
A stand alone policy is available in each house for the unexplained absence of a resident.
The risk management policy will be updated to reflect this issue.

Proposed Timescale: 14/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the risk management policy included the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Please state the actions you have taken or are planning to take:
The risk management policy will be up dated to reflect the measures and actions in place to control accidental injury to residents, visitors or staff.

Proposed Timescale: 14/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the risk management policy included the measures and actions in place to control aggression and violence.

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

Please state the actions you have taken or are planning to take:
The risk management policy in use since January 2015 includes information with regards to behaviours of concern including aggression & violence (Section 5 / subsection 5.1).

Proposed Timescale: 31/01/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the risk management policy included the measures and actions in place to control self-harm.

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

Please state the actions you have taken or are planning to take:
The centre's risk management policy will be updated to reflect measures and actions in place to control self-harm.
The PPPG on the Provision of Positive behaviour support does give specific guidance to all staff on how to address self injurious behaviour. This has been in use since June 2015.

Proposed Timescale: 14/12/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to put systems in place in the designated centre for the assessment, management and ongoing review of risk, for example, residents who smoked did not have quantitative risk assessments in place, fire safe doors were wedged open and there were no health and safety meetings in the centre. The emergency plan was not centre specific and had not been updated with the names of relevant personnel.

11. 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:
Individual smoking risk assessments are now in place for all residents who smoke.
A door closure system has been installed in the remaining fire doors to eliminate the use of door wedges and door hold-open devices have been ordered for the three houses.
Health and safety issues are discussed at staff meetings which occur six-weekly and these issues are recorded in the minutes for these meetings. Any issues can be brought to the attention of the line manager/nurse-on-duty between meetings also if immediate attention is required.
The emergency plan will be updated to be centre-specific and the names of relevant personnel will be included.

Proposed Timescale: 21/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had not ensured that residents who may have been at risk of a healthcare associated infection were protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. For example: the houses had not been deep cleaned following an outbreak of the 'vomiting bug' and staff were required to move between houses during the outbreak, due to staff shortages.

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

Please state the actions you have taken or are planning to take:
Following the recruitment of additional staff, the need for staff to move between areas has been lessened. In the event of any outbreak, all staff are required to adopt universal infection control precautions. Information and guidelines on these precautions are available in each area

Proposed Timescale: 01/10/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to put in place effective fire safety management systems. For example staff were not trained to direct and manage fire evacuation drills by day or night.
Staff had not been afforded fire warden training.

Fire doors were wedged open.
Fire extinguishers were not available next the bedrooms areas.

13. 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:
All staff will undergo training in fire evacuation procedures.
A door closure system has been installed in the remaining fire doors to eliminate the use of door wedges and door hold-open devices have been ordered for the three houses.
A fire extinguisher has been provided near to the residents' bedrooms.
A memo has been circulated to all areas offering staff the opportunity to undergo fire warden training.

Proposed Timescale: 29/02/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The external fire smoking area was unsafe and combustible materials were located in the fire shed, For example, a plastic cigarette disposal bin and a torn cushion were located there. The fire extinguisher in the smoking shed had no service record available. The fire panel in one house had not been replaced as recommend by suitably qualified personnel.

14. 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:
The fire panel in one house has been replaced, as recommended.
A risk assessment has been carried out on the smoking shed and controls have been enhanced, where required.

Proposed Timescale: 13/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no emergency lighting in place in the kitchen or utility room and no fire exit sign over the utility room door, in the absence of emergency lighting.

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

Please state the actions you have taken or are planning to take:
The emergency lighting system has been upgraded in each house to include installation of this lighting in the utility room.
Discussions are ongoing with the HSE fire officer regarding the use of emergency exit signs.

Proposed Timescale: 31/01/2016

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:
The person in charge had not ensured that staff received training in the management of behaviour that was challenging including de-escalation and intervention techniques.

16. Action Required:
Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:
In the last 12 months there have been no documented reports of physical assault. There have been 9 incidents of verbal altercations across the three houses in this period. This area was not; therefore, prioritised for PMAV training. Training in PMAV is currently being provided across the service and training in de-escalation will be offered to all staff in this area who require it over the coming months. The staff members who require the training will be prioritised based on their needs; however, all staff will receive the training over the coming months. Due to the number of staff members who require this training, it will take a number of months to ensure that everyone receives this training.

Proposed Timescale: 30/04/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity. For example, not all residents had intimate care plans in their

(PCPs)

17. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
The majority of residents in this area are independent and require no assistance. Intimate care plans are now in place for those residents who require assistance.

Proposed Timescale: 12/11/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not ensured that all staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

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

Please state the actions you have taken or are planning to take:
Two staff members in this area require this training. They will be facilitated at the next training date which will be held prior to 31/01/2016. All other staff members have up to date training.

Proposed Timescale: 31/01/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to protect residents from all forms of abuse. For example, the management of residents' finances were not robust.

19. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
Weekly reports are submitted to the administrator with regards to household spending, including rent.
A review of residents' personal monies is being completed in order to mitigate all risks

of financial abuse.

Proposed Timescale: 30/11/2015

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:
A documented incident of a resident sustaining a fall and attending hospital for x-rays was not notified to the Authority; this was required within 3 days of the event as a serious injury to a resident which required hospital treatment (notification form number 3).

20. Action Required:
Under Regulation 31 (1) (d) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any serious injury to a resident which requires immediate medical or hospital treatment.

Please state the actions you have taken or are planning to take:
All hospital referrals will be notified to the Chief Inspector going forward.

Proposed Timescale: 09/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A documented incident of the use of chemical restraint for a resident, to control their behaviour in an acute situation in March 2014, was not notified to the Authority in the quarterly notifications as required.

21. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
This was an error and all subsequent quarterly notifications are up to date

Proposed Timescale: 10/10/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were not always adequate numbers of staff available to support residents at times of illness. For example, a resident that had recently been ill was left alone in the house for periods of time during the day as there were inadequate numbers of staff available. While a clinical nurse manager spent some time in the house during the day when the resident was unwell, there were no designated staff to care for the resident between 09:00hrs and 17:00hrs.

22. Action Required:
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

Please state the actions you have taken or are planning to take:
A SCW is now on day duty in one area in addition to the CNM.
An independent review of staffing in the area has indicated that appropriate staffing levels are available.

Proposed Timescale: 13/11/2015

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not always a care plan in place for residents for issues identified at assessment and with it was sometimes difficult to ascertain the current recommended care due to the manner in which the care plan was updated.

Not all residents had an appropriate interpretation of their nutritional status as the Malnutrition Universal Screening Tool (MUST) assessment was not conducted.

23. 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:
A review of all care plans is ongoing.
At the time of the inspection, the CNM1s stated that both MUST and Nualtra BMI assessments were in place in the 3 areas and for the residents in question.

Proposed Timescale: 31/01/2016

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre did not have designated fridges in place for the storage of medications.

24. Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
At the time of this inspection 1 resident in one house was taking eye drops which required refrigeration. Alternative eye drops have now been prescribed by the GP which do not require refrigeration; therefore, there is currently no requirement to install designated fridges in each house.

Proposed Timescale: 01/10/2015
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The self-medication assessment form in place was not an appropriate risk assessment or assessment of capacity.
Staff in one house outlined to inspectors that residents were self-medicating, however the practices in place did not demonstrate that residents were taking responsibility for their medications. On investigation it was found that medications were stored in the kitchen medication press, staff were administering medications to residents and supervising them while taking the medications.

25. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
A new, more comprehensive assessment is being sourced with regards to self administration of medication which will address the issues identified.

Proposed Timescale: 31/01/2016
Theme: Health and Development

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

There were a significant number of on-going medication dispensing errors, originating from the pharmacy, recorded in the centres medication error and incident records.

Not all staff had training in the administration of buccal midazolam. The administration instructions in place for buccal midazolam were not comprehensive to ensure the safe and appropriate administration of this medication in the event of a seizure.

Medication prescription sheets did not always have the maximum daily dose of PRN (as required) medications documented by the prescriber.

26. 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:
A meeting has taken place with the pharmacist and a new protocol has been implemented with regards to same these practises by the CNM1 & CNM2.
All residents who may require buccal midazolam have had the associated documentation update. Both CNM1s have received updated training in the administration of this medication.
At night-time, the night supervisor/CNM3 is available in the centre to administer this medication. A nurse is always available in the service to administer this medication during daytime also.

Training in the administration of Buccal Midazolam has not been afforded to non nursing staff in any of the centres; therefore, this will be planned and arranged over the coming months for the relevant staff members.

Medication charts now have the maximum daily dose of PRN.

Proposed Timescale: Training for staff in administration of this medication to be undertaken by 30/06/2016.

Proposed Timescale: 30/06/2016

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 did not contain some of the information required by Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

27. Action Required:

Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The statement of purpose will be updated to reflect the requirements.

Proposed Timescale: 11/01/2016

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:
The registered provider failed to satisfy the chief inspector that the person in charge, who was appointed as the person in charge of more than one designated centre, could ensure the effective governance, operational management and administration of all the designated centres concerned, in particular this designated centre.

28. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
A new PIC/CNM3 will take up this role with effect from 14/12/2015, working part time the week of 14/12/2015 &21/12/2015 assuming the role in full with effect from the 02/01/2016

Proposed Timescale: 02/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that there were management systems in place in the designated centre to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. For example, there was no consistent system of audits in place and no system for staff to raise concerns about the quality and safety of care.

29. 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:
There is a complaints' policy in place in the centre so that residents and staff members can raise any issues of concern. Systems are also in place to allow staff to raise concerns at staff meetings which occur on a monthly basis. Each resident's PCP is reviewed yearly, or more frequently if required, to ensure that the service they receive is appropriate to their needs.

An audit system for complaints will be in place by 31/01/2016. Regular staff meetings take place every month with a memo being issued to all staff with dates for the next calendar year. These regular meetings commenced on 01/10/2015.

Proposed Timescale: Regular audit of complaints to be in place by 31/01/2016

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to make available to the chief inspector and to residents, a copy of the annual review of the quality and safety of care and support in the designated centre.

30. Action Required:
Under Regulation 23 (1) (f) you are required to: Ensure that a copy of the annual review of the quality and safety of care and support in the designated centre is made available to residents and, if requested, to the chief inspector.

Please state the actions you have taken or are planning to take:
A review of the quality and safety of care and support in this centre will be arranged and undertaken in the coming months.

Proposed Timescale: 31/01/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider, or a designated person failed to carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and failed to prepare a written report on the safety and quality of care and support provided in the centre. In addition, the registered provider failed to put a plan in place as a result of this unannounced visit to address any concerns regarding the standard of care and support.

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

Please state the actions you have taken or are planning to take:
An unannounced visit will be undertaken by the registered provider or a designated person in the coming weeks.

Proposed Timescale: 31/12/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider had failed to put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering. For examples, there was no evidence of staff appraisals, staff meetings or effective and timely responses to concerns raised by staff.

32. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Staff can report any issues of concern regarding residents or operational issues to their immediate line manager.
Staff can also raise issues of concern through the centre's complaints policy
A document has been circulated to all areas with regards to the reporting structure
Staff meetings occur on a 6 weekly basis
CNM1s hand over to the SCW on duty in each house on a daily basis. The CNM2 links with staff on a daily basis.
A supervision sheet has been issued to the CNM2 so that the CNM2 links with staff in all areas on a daily basis. This supervision includes unannounced visits to all units to discuss any issues of concern with staff.

Proposed Timescale: 29/02/2016

Theme: Leadership, Governance and Management

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

Staff were not facilitated to raise concerns about the quality and safety of the care and support provided to residents.

33. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
Staff can report any issues of concern regarding residents or operational issues to their immediate line manager.
Staff can also raise issues of concern through the centre's complaints policy
A document has been circulated to all areas with regards to the reporting structure
Staff meetings occur on a monthly basis. Dates for meetings for the next calendar year have been issued. A staff meeting last took place on 12/11/2015.
CNM1s hand over to the SCW on duty in each house on a daily basis. The CNM2 links with staff on a daily basis.

Proposed Timescale: 01/10/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The registered provider failed to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre. For example, at times of illness of residents and where older residents wanted to spend time in the house during the day and required supervision.

34. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
SCWs have been recruited and are now on duty during the day.

Proposed Timescale: 21/10/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that information and documents as specified in Schedule 2 were obtained for all staff.

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

Please state the actions you have taken or are planning to take:
The issues regarding gaps in employment history, qualification certification and start date for employees will be reviewed, verified and updated as required.

Proposed Timescale: 31/01/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure that staff had access to appropriate training, including refresher training, as part of a continuous professional development programme. For example, communication training, food hygiene training, fire safety training and manual handling training.

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

Please state the actions you have taken or are planning to take:
Training is ongoing in this centre. Currently, PMAV training is being offered. Communication training is being facilitated in centre by the SLT. Fire safety training and manual handling training will be arranged for all staff members who require this. Fire training is held every six months with the most recent fire training held on 26/11/2015. PMAV training is dependent on the availability of trainers and will be offered over the coming months. The staff members who require the training will be prioritised based on their needs; however, all staff will receive the training over the coming months. Due to the number of staff members who require this training, it will take a number of months to ensure that everyone receives this training.

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge failed to ensure staff were appropriately supervised. For example, there was no staff appraisal system in place and there was no supervision arrangements in place. Staff meetings were not held on a regular basis with the provider nominee and person in charge.

37. Action Required:

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

Please state the actions you have taken or are planning to take:
A system of staff appraisal is currently being considered for implementation.
Supervision of staff in this area is overseen by the CNM2 on duty. A CNM1 is on duty Mon-Fri between the 3 houses.
At night-time, the social care workers can report any issues of concern to the CNM3 Night Supervisor who provides cover to all areas.

Proposed Timescale: 29/02/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of where or how to access copies of the Regulations.

38. Action Required:
Under Regulation 16 (2) (a) you are required to: Make available to staff copies of the Act and any regulations made under it.

Please state the actions you have taken or are planning to take:
At the time of this inspection, copies of the standards were available in each house.
The CNM2/CNM1s in this service have spoken to all staff with regards to the location of the standards and all staff are now aware of how to access these.

Proposed Timescale: 13/11/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of how to access copies of the Standards set by the Authority for the disability sector.

39. Action Required:
Under Regulation 16 (2) (b) you are required to: Make available to staff copies of standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
At the time of this inspection, copies of the standards were available in each house.
The CNM2/CNM1s in this service have spoken to all staff with regards to the location of the standards and all staff are now aware of how to access these.

Proposed Timescale: 13/11/2015