

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005313
Centre county:	Sligo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Teresa Dykes
Lead inspector:	Thelma O'Neill
Support inspector(s):	Marie Matthews
Type of inspection	Announced
Number of residents on the date of inspection:	31
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 5 day(s).

The inspection took place over the following dates and times

From:	To:
10 November 2015 09:00	10 November 2015 19:00
11 November 2015 09:00	11 November 2015 20:30
12 November 2015 06:30	12 November 2015 18:30
25 November 2015 08:30	25 November 2015 19:00
26 November 2015 09:00	26 November 2015 21:30

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

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

Summary of findings from this inspection

This inspection was the eighth inspection of this residential campus carried out by the Health Information and Quality Authority (HIQA). This inspection was to assess this residential service for registration under the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The findings of this inspection identified major non-compliances with the regulations which impacted on the safety and welfare of the residents in this centre. These included Health and Safety and Risk Management, Safeguarding and Safety, and Premises issues. Following the initial findings of the first three days of inspection, the provider and Director of Services were advised that the governance and management of the centre was not sufficiently responding to the risks or protecting some residents at risk in the centre.

In response to the concerns raised the provider took immediate action to address some of the issues identified and the registration inspection was extended for a further two days two weeks later. However, similar failings were found again in other houses on the last two days of the inspection and the findings on this inspection were escalated to the inspector manager.

This service is managed by the Health Service Executive (HSE). It is located outside the town of Sligo. This service was part of a congregated setting accommodating 107 residents. The provider had recently reconfigured the service into four designated centres each with their own management structure.

This designated centre provided residential accommodation and day services in seven houses to 31 residents with mild to severe intellectual disability. The purpose of the inspection was to inform a registration decision and to follow-up on actions from the last inspection carried out by HIQA in July 2015.

As part of the inspection, the inspectors met with residents, staff members, the provider nominee and director of services/person in charge, and Clinical Nurse Managers. In addition; inspectors observed care practices and reviewed documentation such as personal plans, risk management documentation, complaints records, staff records, medical records, as well as policies and procedures as a process of reviewing service provided. Moderate non-compliances were identified including the need for better management of complaints, promoting resident's rights and access to their finances, social activities, transport, managing documentation and better use and access of assistive technology.

Inspectors also reviewed questionnaires returned by residents and their families. They were generally positive in their feedback and expressed satisfaction about the facilities and services and care provided. However, a number of families stated that more staff support was needed to care for residents and one family said their complaints were not management to their satisfaction.

At the last inspection of these houses on 27 July 2015, eight core outcomes were inspected. Inspectors found that all of the eight outcomes inspected were non-compliant. Sixteen actions were issued in response to the non-compliances identified. On review of the actions taken to address the non-compliances, the inspectors found that 10 actions were complete and six actions were partially complete.

On this inspection inspectors found that the accommodation provided was overcrowded and inadequate to meet resident's individualised needs. There was a lack of both communal and private space that was impacting on residents' rights and

dignity.

In addition; the management of risks and the protection of vulnerable adults was inadequate and staff required training in risk management. For example; staff did not recognise the procedures to follow in the event of residents experiencing frequent falls or displaying behaviours that challenge. This was negatively impacting on their peers. The inspectors found that the impact of these behaviours on the other residents living in their house were not adequately identified or managed. In addition; staff had not completed all mandatory training as required by the Regulations and the majority of the staff required training in the management of behaviour that challenge, safe moving and handling of residents, or fire safety management.

The director of services was also the person in charge for this centre. A clinical nurse manager level 2 (CNM2) managed the seven houses in this centre on a day-to-day basis. The person in charge told inspectors that she was advertising for an additional CNM level 3 post to take on the role of person in charge. This would relieve her in her post to manage the overall campus and community services. In the interim, an external quality officer was reassigned to this service from 30 November 2015 to support and supervise staff working in the service three days a week.

Although staffing levels had been reviewed and additional resource hours had been allocated to ensure that residents' social and healthcare needs were met, there continued to be a difficulty with the consistency of regular staffing working in the centre as many of the relief staff continued to be agency staff, which resulted in inconsistent and unfamiliar staff caring for residents on a day-to-day basis.

The inspectors found other areas that required attention and these are described under the relevant outcomes and identified for attention in the action plan at the end of this report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors reviewed the actions from the last inspection relating to residents' rights and the management of complaints and found that they had not been adequately addressed.

Inspectors saw that resident's privacy and dignity was respected by staff. The staff interviewed had a good knowledge of the residents' personal preferences, such as; meal choices, social activities and clothing.

Residents were consulted with regarding their daily routines and preferences. The manner in which residents were addressed by staff and in which their needs were discussed was observed by inspectors to be courteous and respectful. However, the overcrowding and the poor standard of the premises greatly impacted on some resident's rights and dignity. For example; in two chalets, four of the seven residents shared bedrooms. This limited each resident's privacy when attending to their personal care; as there were no screening provided in the bedrooms.

In addition; there was very limited space to walk between beds and two people would have difficulty in accessing the sleeping area at the same time, particularly for residents with mobility difficulties. Some residents' bedrooms were decorated to their individualised tastes and preferences; however, many residents did not have sufficient space to store additional personal belongings. For example; some residents sharing bedrooms only had half a wardrobe others only had a single wardrobe to store their personal belongings.

Not all residents had the opportunity to meet visitors in private; as there was no room available separate from the sitting room for residents to meet family and friends in private. The layout of the houses is discussed further under outcome 6.

Residents were supported to attend religious celebrations as requested. At the time of the inspection all residents admitted to the centre were Roman Catholic and there was a chapel on the grounds of the campus and residents were supported to attend religious ceremonies if they so wished. Also some residents were registered voters and were supported to vote during local and general elections.

There were policies and procedures in place on managing personal property and finances in the centre. Inspectors viewed some of the residents' petty cash in the centre and found that there were written records of all items of income and expenditure for the residents. There were no discrepancies noted in records checked in the chalets. However, the finance system in operation was not individualised or person centred. For example; there was no evidence of assessments being completed of the residents' competencies to manage their money, or the different levels of supports required to promote residents' financial independence.

In addition, residents' money was managed by the finance department in the campus and residents had to request their money in advance prior to a social activity to ensure they had sufficient funds available in their petty cash purse. Therefore, the inspectors found that residents living in this centre did not have the same opportunities or freedom offered to them to access and manage their money as other individuals living in the community.

Some houses had weekly residents' meetings and residents were consulted about their daily routines. Residents had access to advocacy services and information about their rights. Inspectors viewed evidence of advocates supporting residents and their families achieve their right to an individualised service in the centre which had resulted in positive outcomes for some residents.

There were policies and procedures in place for the management of complaints. The complaints process was user-friendly, accessible to all residents and displayed in communal areas in the chalets. Residents and their families were made aware of the complaints process and were supported to make complaints. There was a nominated person to deal with all complaints. However, not all complaints were promptly investigated and in some incidents the complainant was not advised of the outcome of their complaint in a timely manner or of the appeals process if they were not satisfied with the outcome of the complaint.

In two incidents inspectors found that a family member had complained that their family member was not accessing day services due to transport issues. Despite assurances being given to the family that this issue was resolved, inspectors found on the day of inspection a staff member had to transport the resident's wheelchair to day services in their own car as the transport bus could not facilitate the resident's wheelchair. Therefore, the inspector found that this issue had not been fully resolved due to inadequate transport facilities to meet the resident's needs.

A number of restrictive practices were in place in some houses, such as: locked doors, locked kitchen bedroom cupboards, window restrictions and physical restraints such as restrictive nightwear to prevent behavioural issues. In most cases, there was evidence available that other less restrictive options had been considered before instigating these restrictions and the restrictions were included on the centres restraint register. However, regular reviews of these restrictions were required as they were impacting on other residents' rights on a daily basis. This issue is discussed in more detail under outcome 8 safeguarding and protection.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

The organisation had a communication policy. The policy aimed to address the communication needs of residents. Some policies were in an 'easy read' format for residents and were easily available in the centre for example; the safeguarding and safety policy and the complaints policy. Pictures were used to direct residents to specific areas in the houses such as, the kitchens, dining rooms and sitting rooms. In some units, there were signs to identify and locate toileting and bathing facilities.

In most units residents had access to televisions and stereos in their bedrooms and also in communal areas. Most residents had hospital communication passports, which contained vital information for hospital personnel to care for the resident in hospital.

Some residents were supported to communicate by non-verbal means of communication to ensure their individual needs were met. Also, residents that required specific communication support had individualised communication profiles in their personal plan. In addition; some residents were supported through the use of a picture timetable to show them what activities were planned for the day. Other residents used communication books which were used between the residents' residential and day service. These communication books were in written and picture format and helped the residents and staff members understand their planned day.

Although there was evidence of residents' communication needs generally being met, some residents with communication deficits and behavioural issues were not reviewed by a Speech and Language Therapist (SALT) to assess their communication needs. A

SALT assessment would identify each resident's ability to communicate their choices in their daily lives and the supports required to promote the resident's communication skills, for example; through the use of alternative non-verbal communication techniques or electronic communication aids. This would also enhance each resident's preparation for transiting to community living.

Judgment:

Substantially Compliant

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

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

The organisation had a visitors policy to guide best practice. Staff told inspectors that there were no restrictions to residents having visitors in the centre. However, houses did not have a spare sitting/ visiting room for residents to meet with their visitors in private.

Staff told inspectors that residents had participated in community activities significantly more since they received additional staffing and a procurement card to purchase food and personal items for the residents. This had increased resident interaction with the local community through shopping locally. Residents were also attending more social events in the community since the staffing and transport issues had been increased. Residents were developing their shopping skills with staff support as part of the transitioning to community plan. Some residents told inspectors they enjoy accessing the community facilities more frequently.

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There were policies and procedures in place for admitting residents, including transfers, discharges and the temporary absence of residents. This service was a seven day residential and day service for 31 residents within the organisation. The director of services advised inspectors that the centre was closed to new admissions and was in the process of de-congregating residents to the community. Most residents had provisional transitional plans in place for moving to the community.

Each resident had a written agreement of the terms and conditions agreed with them and the agreement sets out the services to be provided and all fees are included in the contract. However, the details of additional charges were not always included. All residents/ families had received the contract of care pertaining to the residential placement; however, at the time of the inspection, not all contracts were signed by the resident or their next of kin at the time of the inspection.

Judgment:

Substantially Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

There were two actions following the last inspection. One action was partially achieved and related to social care assessments, and the other action did not relate to this designated centre and was not reviewed.

The inspectors met with the majority of residents in each house and reviewed a selection of their personal plans. Initial findings of some residents' care plans found that resident's health, intimate and personal care needs were being met; however, there were a number of files where care plans and risk assessments were not updated following changes to residents' physical or psychological health. Inspectors found on the second part of the inspection these residents' files had been reviewed and the residents referred to the appropriate multidisciplinary team members.

Improvements were observed by inspectors in the assessment of resident's social care needs since the initial inspections of the service in 2014. Each resident had a health and social care assessment completed and personal goals were identified. Many of the goals had been achieved and inspectors saw that goals included weekend breaks, day trips and concerts.

Copies of residents' personal plans were available in a pictorial format to aid the resident's ability to access their information. However, in some cases, individual social goals were observed to be continuously repeated year-on-year despite having been achieved.

It was also unclear in some plans viewed who was responsible for supporting residents to achieve their goals and in some incidents residents' personal goals appeared limited. For example; the choices available or offered to residents were the same opportunities for most residents. Such as; shopping, horse riding, concerts.

It was also unclear how the residents' preferences or aspirations had been sought as part of the assessment process. For example; in some incidents where residents were non-verbal, unfamiliar or agency staff had attended the meetings with the resident and/or family members and it was unclear if the goals set were suitable or acceptable to the resident.

There was better use of accessible taxis to transport residents to attend social events outside of the campus since the last inspection. However, from discussions with staff and through observations during the inspection the availability of appropriate accessible transport in the centre was still an issue and this was impacting on the social activities residents could attend. This is discussed further under outcome 16.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

The structure and layout of the houses where residents resided were not inspected on the previous inspections; however, it was reviewed as part of this registration inspection.

Since the last inspection, the provider had completed some external work to install wheelchair access to most of the houses and most of this work was complete. In addition; one house had a safe accessible sensory area developed in the outside garden for residents to access. This house also had received new furniture, such as a dining room table and chairs and blackout blinds for resident's bedrooms.

Inspectors were advised that the seven houses in this designated centre were originally designed to accommodate children and were not intended to accommodate adults. Inspectors found that the layout and facilities provided in the houses were inadequate and did not meet the individual or collective needs of the adult residents. The premises had inadequate communal space, toileting/showering facilities and accommodation facilities for the number of adult residents residing in this centre.

Inspectors also saw that there was a large variance between the houses in relation to the decoration and furnishing in the houses and the individualised personalised bedrooms of residents. Most houses had adequate furnishings, fixtures and fittings and the centre was clean; however, other houses communal rooms were bare and institutional in appearance.

There were suitable kitchens and appliances in each house. However, most residents did not fully utilise the kitchen facilities due to the central kitchen on the campus providing most of the meals for the residents. Most houses had access to a part-time house keeper each day for cleaning and laundry support, however, they were not involved in preparing or cooking residents' meals.

In all of the houses access to the bedrooms and bathrooms was via long corridors which were narrow and residents were restricted in their movements due to the poor design of the building. These created difficulties for residents with walking aids and inspectors saw that staff had identified risks where other residents would push past residents and they could fall if they were not supervised.

Of the seven chalets in this centre, two chalets accommodated seven residents and four of these residents shared bedrooms. Another two houses accommodated five residents and one house accommodated four residents. Another two chalets accommodated one resident each. In the multi-occupancy bedrooms there were no screens provided between beds to ensure privacy. However, the manager advised inspectors they were in the process of ordering screening for the residents' bedrooms, but the space between beds was limited, particularly for access between the beds and may not be suitable for screening. Furthermore, screening could create a hazard due to the size of the bedrooms.

Some residents had personalised their bedrooms and new beds and wardrobes had been provided in some bedrooms. However, in many houses the wardrobes were small and lacked storage space. In the shared bedrooms, residents only had access to half of a wardrobe to store their clothes; others only had single occupancy wardrobes. In some instances residents had their bedrooms decorated beautifully and had chosen their own bedding and furnishings and paint for their bedroom walls. However, other residents' bedrooms had very limited individualised or personal possessions displayed and the fixtures and furnishings were old and institutional in appearance. For example; in one chalet, one resident had no curtains or blinds on their bedroom window and the drawers in their bedroom were locked. Some bedrooms were used to store mobility equipment, such as; wheelchairs and shower chairs, this was due to the lack of adequate storage space in some houses.

Appropriate accessible shower facilities were not available in each house and the facilities provided did not meet the assessed needs of residents. In some houses the residents had to step down into the shower area and this was difficult for some residents with mobility issues. In 2010 an Occupational Therapist had recommended adapted showering facilities for three residents, but these adaptations had not been completed to meet residents' needs. This limited residents' access, rights and choice to suitable personal hygiene facilities.

Communal rooms were generally comfortable and some were tastefully decorated while others were small and lacked character and decoration. The lack of adequate communal space was particularly evident when all the residents and staff were present in the house together. Also; the inspector found that in one house, the full glass panel in the front door was broken and replaced with a wood panel, which was very unsightly and had not been replaced by a suitable and safe alternative. The couches and chairs in some houses were worn and damaged and not replaced. This created a risk of injury or infection control issues to the residents or staff.

Storage facilities were inadequate and mops and cleaning equipment were left outside the front door of some houses. This was very unsightly and a hazard to residents, staff and visitors in the centre. Records were available to indicate that equipment in the centre had been serviced as required. A central laundry service was available to residents, and some houses had a washing machine and dryer available for residents to use. The heating system was a centralised heating system and staff told inspectors that it was not reliable and regularly broke down. However, it was working sufficiently at the time of the inspection. The provider has been requested to submit an engineer's report as to the efficiency of the heating system in this centre.

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

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

There were three actions issued following the last inspection in July 2015. These related to risk management and fire and evacuation procedures and practices. One action was complete, one was partially complete and one was not complete.

Inspectors observed that the management of risk had improved since the last inspection; however, areas of improvement were still required. The inspectors found that although accidents and incident were recorded and reviewed by a risk review group; risk management arrangements did not manage all risks as required in Regulation 26. For example; the inspectors found that one resident had fallen from a bath chair hoist, due to unfamiliar staff supporting the resident during their intimate care procedure. Another resident had fallen in the centre on 10 occasions and no review of the residents falls risk assessment had been completed to prevent further falls. This had since been reviewed.

A risk register was available for the centre which was a live document and contained risks identified in each unit. However, it was evident that some staff members were not clear on the procedure of managing risks. Staff members had not received training in risk management and were not fully competent in completing risk assessments and managing and preventing risks/incidents in the centre. For example; an oxygen cylinder and a large tub of chemicals were stored in a resident's bedroom, which could have caused a risk to the resident using the bedroom if they had used these items. In addition; wheelchairs and shower chairs were stored in the residents' bedrooms due to a lack of storage space in the chalets. In one bedroom the inspector had difficulty accessing the resident's wardrobe drawers due to a wheelchair blocking access. This created an access issue and a risk of falls for some residents in their bedroom.

There were precautions in place against the risk of fire. Staff demonstrated knowledge of what to do in the event of a fire and fire equipment was available. Inspectors saw that fire safety equipment was serviced on an annual basis. A personal emergency evacuation plan (PEEP) was documented in each resident's personal plan which described the assistance that residents would require in the event of an emergency evacuation. A procedure for the safe evacuation of residents in the event of fire was also displayed. Evidence of monthly fire drills completed in each house was reviewed by the inspectors which included both day and night time evacuations. The time taken to evacuate all residents was recorded in the centres fire register.

Fire alarms were fitted in every house; however, risks identified by a fire safety expert in an external fire risk assessment had not been addressed in a timely manner and fire doors were not fitted with self closing devices and were kept open with wooden wedges, which could create a risk in the event of a fire. In addition, there was no emergency lightening in one of the houses inspected. 83% of staff had completed fire safety training. Inspectors were told that a training schedule was in place to ensure the remaining 17 % of staff who had not yet completed the training were schedule to attend shortly.

Mobility assessments had been completed for those residents at risk of falling; however over 65% of staff were overdue training in safe moving and handling of residents. An emergency management policy with procedures was in place to direct staff in such an event as power outages, flooding and gas leaks. Details of local hotels where residents could be evacuated in an emergency were included in the plan.

Judgment:

Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

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

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

Findings:

There were five actions issued under this outcome on the last inspection. These actions related to restrictive practices, inadequate management of behaviours that challenge, unaccounted bruising on a resident, failure to protect residents from assault by other residents and inadequate training for staff on protecting vulnerable adults. Three actions were complete, one was partially complete and one was not complete. These related to managing behaviours that challenge, managing restrictive practices and protecting residents from assault.

On this inspection, inspectors were told that there were no allegations of abuse reported to management and there were no 'Trust in Care' investigations ongoing at present in the centre. All staff had completed training in the protection and safeguarding of residents and an ongoing training schedule was in place. The centre's policy on safeguarding and protection had been reviewed and staff members interviewed were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse.

On this inspection, and the previous inspection in July 2015, the inspectors found evidence in the centre's risk management logs of frequent incidents of peer-on-peer abuse, some of which resulted in two residents being moved to alternative accommodation for their and their peers' protection. On this occasion inspectors met with one of these residents and were told that the incidents of aggressive behaviour had significantly reduced since the resident had one-to-one staffing and was living alone in a house which was having a positive effect on their wellbeing.

Inspectors reviewed the incident forms for some residents over a six to nine month period and found that similar incidents of peer-on-peer abuse were frequently repeated; some on a daily or weekly basis by the same residents.

Inspectors also saw records where members of the multidisciplinary team had stated that inconsistent staffing; overcrowding and inappropriate environments were key issues to residents displaying behaviours that challenge.

In addition; a lack of quiet space, lack of familiar staff and the loud noise in the houses were impacting on residents' behavioural issues. The consequences of these inappropriate environments resulted in some residents assaulting other residents or displaying incidents of self injury; such as, head banging, biting, and removing their clothing.

Some residents living with peers that displayed behaviours that challenge displayed episodes of anxiety or fear from living with these residents. Inspectors found that there were not sufficient proactive measures being taken to reduce or eliminate the risks of self-injury or aggressive behaviours towards residents in this centre. This was an action from the last inspection that was not adequately addressed.

The role of the positive behaviour support team was currently under review. Inspectors found that there was a lack of corporate and clinical governance in management of behaviours that challenge. There was no line of management responsible for all staff working in the psychology department and this required review. Some of the behaviour

support plans reviewed did not provide guidance on preventative, proactive or reactive strategies to minimise the risks to residents, their peers or staff members. For example; in one house, staff members were regularly physically assaulted by a resident and there were not adequate proactive strategies put in place to protect these staff members.

One resident had developed a fear of leaving their house and this was impacting on their physical and psychological wellbeing but there was no active behavioural support plan in place to assist this resident in planning to transition to the community or in the event of an emergency evacuation of the chalet.

Previously, it was found there were restrictive practices in operation in this centre, in particular on some of the units internal and external doors. These restrictions had been removed from the internal doors into the kitchen and restrictions that remained were risk assessed and logs were maintained. However, the impact of these restrictions on all residents living in the house had not been adequately assessed or monitored.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

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

Theme:

Safe Services

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

No actions were required from the previous inspection.

Findings:

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

The inspector reviewed incidents and accidents and found that incidents requiring notification had been submitted to HIQA as per the regulations.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Residents' social participation, education, and training had improved since previous inspections. Residents' personal goals were reviewed regularly and were recorded in their "listen to me document". Residents were consulted during this process to ensure they were receiving the support they needed to achieve identified goals.

There was evidence to show residents' skills and talents were encouraged and supported. Some residents living in the residential units participated in arts and crafts groups. Residents also had opportunities to engage in hobbies such as horse riding, baking and cookery. Some residents told inspectors what activities they pursued at their daily activities programme. They explained the positive experiences and benefits of their work and how they enjoyed meeting new people daily.

Many residents received a part-time day service Monday to Friday and some services had increased to full-time since the last inspection. A number of residents that previously only had a part-time service were now attending a full-time day service and other residents that had no service previously were attending a part-time one. However, some residents' day service involved using a day activity room in the main campus building and they were supported by their residential staff for supervision. However, there were limited activities available and residents often chose not to participate in this session due to there being no structured programme available. There was a lack of individualised personal activities that suited each resident's interests and capabilities, such as, participating social and community integration activities for transitioning to community services.

Inspectors found that day social activities were short sessions and restricted by residents having to return to their chalets for meal times. Residents attended day services at 10am and returned to their chalets at 12pm for their dinner at 12.30pm. They returned to day services again for the afternoon session at 2pm until 4.30pm after which they returned home for their evening tea. The practice of residents having to leave their day/work activity area to return back to the chalets for their meals was institutional in practice and limited the resident's choice to participate in other daily activities.

There was a hydro therapy pool in operation on site in the campus, however, due to the restricted opening times, a lot of residents that would like use the pool, could not do so as the pool usually was booked or closed early in the evening and every weekend when residents would like to avail of the facility.

Judgment:

Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

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

Findings:

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

Inspectors found that residents' food and meals continued to be provided by a central kitchen on campus, which limited food and nutritional choices and social integration for residents. This practice was found to be institutional and not person-centred. For example; the central kitchen continued to supply residents' meals twice a day in hot storage boxes to each individual unit, despite adequate cooking facilities being available in all units in the centre. Some residents were occasionally supported to cook their evening meals as part of the transitional process in preparation for moving to the community, however, this was dependent of individual staff choosing to do so or having adequate staff available to supervise all residents.

Since the last inspection, management had taken some steps to improve aspects of residents' nutritional experiences by promoting resident involvement in preparing their evening meals. Also, some residents now had the opportunity to eat their dinner in the main canteen daily. In addition; residents were offered a choice of two main meals at dinner time and efforts had been made to improve the choice of meals for some residents. A banking procurement card had also been provided to most units to enable residents to purchase groceries and snacks from the local shops. This had a positive effect on residents' choice and nutritional choices.

However, inspectors found that the food supplied from the main kitchen to one unit was not meeting the residents' health needs. One resident was recommended a low fat/low sugar diet, by a dietician due to a medical condition and the food choice supplied was limited. For example; staff told the inspector that most evenings the healthy eating option was limited to a salad.

Inspectors also found that there was no menu to advise residents or staff of the meal choices for the day and staff questioned were unsure what meals they were serving to residents when preparing to give them to the residents.

The canteen was observed to be used by several residents during the inspection; however, it continued only to provide food at set times during the day and continued to open during the hours of 9am to 5pm and close at 3pm on weekends. This was an

action from the last inspection that was not addressed.

The general practitioner (GP) attended the centre twice a week to review patient's medical needs. Residents had received an annual medical review and this was ongoing. Residents were regularly monitored by the GP or as required. Inspectors found most healthcare plans were detailed and provided very clear guidance to staff on how to attend to residents' needs. There was good evidence that residents were referred to specialists where appropriate. However, in a few cases where residents had chronic medical conditions, they did not have up-to-date healthcare plans in place. Also, residents' healthcare plans were not always linked to the recommendations of the allied healthcare professionals following changes in a resident's healthcare needs. This had at times impacted on the residents' health and required review.

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):

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

Findings:

Inspectors reviewed the single action required from the previous inspection and found it was adequately addressed. This related to the guidance and management of residents with insulin dependent diabetes.

Inspectors reviewed medication charts and found that medications were administered as prescribed to the resident for whom it was prescribed. Controlled medication was kept in a secure locked press and the controlled medication register was maintained as per An Bord Altranais guidelines. Medication that required refrigeration was kept securely and daily recordings of the fridge temperature were maintained. Systems were in place to record medication errors and although medication errors had occurred in some units; staff had taken appropriate steps to protect the residents and to ensure the errors would not reoccur.

The inspectors found that a new system of recording medication in stock on a monthly basis was now in place and this assured managers that staff could identify if there were inconsistencies in residents' medicines management. The local pharmacist visited the units monthly to review medicines stocks and discuss medication issues with the nurses. In addition, medication audits were conducted in some areas by the clinical nurse managers (CNM's) and these were tools used to evaluate medicines management within

the units.

Inspectors observed and spoke with two nurses who had to administer medications in other houses as well as their own house up to four times a day. This resulted in nurses leaving their own units understaffed to administer medication in other houses. This created a risk to the nurses, for example; there was one staff nurse that was physically assaulted while entering another chalet to administer medication to a resident who was known to be a risk of assaulting visitors to their house. Although staff and management were aware of these risks, no alternative arrangements were made to prevent such an incident. This was despite the male care staff on duty telling inspectors that they would administer the medication if they had the appropriate training. This is actioned under staffing in outcome 18.

Also, one resident had a history of 10 falls over the past year. They had been prescribed a high dose of antipsychotic medication and benzodiazepine for mental health issues. However, a review of the resident's medication had not taken place to identify if the resident's medication could be a contributing factor in the increased levels of falls. Inspectors brought this to the attention of the manager and the resident was seen by the psychiatrist. The resident's medications were reviewed and the resident received a full assessment from the physiotherapist and a mobility plan was now in place.

Judgment:
Compliant

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

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

Findings:

On the first day of inspection, there was a written statement of purpose that described the 12 chalets in this designated centre, however, during the inspection, the managers advised inspectors that they wished to divide the centre again into two separate centres. Inspectors agreed and this report reflects seven houses in the service.

The revised statement of purpose has not yet been submitted to HIQA to outline the facilities and services available to residents availing of this service.

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):

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

Findings:

The director of services was also identified as the person in charge of this centre. Inspectors found the director of services/person in charge of this centre did not ensure effective governance, day-to-day operational management and administration of the centre due to the extensive responsibilities currently assigned to her.

Inspectors were informed that another person in charge was being appointed to manage the 12 chalets that accommodated up to 61 residents on the campus site. They would report to the area manager and acting director of services. However, this post was not yet filled at the time of inspection. In the interim, a clinical nurse manager level 3 (CNM3) was assigned to the centre to support and supervise the CNM2s in the day-to-day management of the centre.

The person in charge told inspectors that restructuring the management roles would ensure better day-to-day management of the centre.

There were regular quality and safety management meetings that reported on progress towards compliance on issues previously identified by HIQA. Improvements were noted in areas such as; annual medical reviews and individualised social assessments. However, improvement continued to be required in areas such as; residents' rights, protection issues, accidents, incidents and individual risk assessments, the management of complaints, premises issues and staffing issues.

There was evidence that the provider and person in charge completed unannounced inspections of the centre to assure themselves of the residents' safety and address any on-going issues. However, some areas of risks had not been identified by the management team following these unannounced inspections and required review.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

A clinical nurse manager level 2 (CNM2) was responsible for the day-to-day management of the centre and reported to the person in charge and provided cover in her absence.

The person in charge had not been absent from the centre for any period in excess of 28 days which is the notification period. There were no persons participating in the management of the centre identified on the centre's application to register.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

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

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

Findings:

A significant amount of staffing and financial resources had been input into this centre since previous inspections. For example; the provision for staff training, the introduction of procurement cards for residents to purchase food, maintenance works in the centre and taxi provision. There was evidence that resources were being deployed according to the assessed needs of residents although further improvement was still required.

The provider advised inspectors that funding had been approved to purchase/rent accommodation for residents to allow them to move from the centre into the community.

However, the limited availability of appropriate accessible vehicles had impacted negatively on residents as there were insufficient vehicles to transport residents to and from their day services and on social outings.

Judgment:

Substantially Compliant

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

On previous inspections, HIQA issued an immediate action notice to address the level and the deployment of staff in the centre and the centre's reliance on agency staff. The provider had responded by recruiting additional care staff and inspectors saw that they were deployed to support residents to attend social activities, particularly in the evening. This was confirmed by the staff rota. Staff told inspectors that this had made a significant difference to residents' lives.

Some residents were assessed as requiring one-to-one staffing 24/7 and this had also been resourced. However, inspectors found that staff rotas were not always available in the units and some rotas did not reflect the actual hours staff had worked in some units.

Aspects of staff deployment still required review to ensure consistent, familiar staff supervised residents at all times. For example, where residents had to attend a medical appointment the normal practice was for a nurse from another house to accompany them to the appointment rather than the care staff who normally worked with the resident.

Inspectors found that some care staff had still not been provided with training in medication administration so they could not administer medication to residents in their care. As previously discussed, this was resulting in nurses, who were less familiar with residents, having to come to the house to administer medication.

The provider nominee told inspectors that difficulties were still being encountered in recruiting staff and there was still a reliance on agency staff in the centre. Inspectors were told that improved arrangements had been put in place to help ensure agency staff were fully apprised of the residents' care needs before working with residents. An induction folder had been developed for each house which identified key clinical risks such as epilepsy, a risk of choking or behaviours that challenge and the emergency evacuation plans for each resident. A copy was available in each house.

On previous inspections, inspectors also identified that staff did not have up-to-date training in fire safety, adult protection, managing behaviours that challenge and in manual handling. A training schedule was ongoing. Inspectors found that some improvements had occurred however, some staff had still not completed all the mandatory training identified in the regulations. For example, 100% of staff had completed training in the protection of vulnerable adults, but only 83% of staff had completed fire safety training. However, only 32% of staff had completed training in manual handling. 62% of staff had completed training in the management of behaviours that challenge; this was a concern, due to the fact that most residents admitted to this centre would frequently display behaviours that challenge. Inspectors were informed that the remaining staff members who had not completed training were been prioritised and dates were confirmed for this training.

The seven houses inspected were managed by a clinical nurse manager level 2 (CNM2) who worked with a team of nurses, care staff and a multidisciplinary team made-up of a Speech and Language Therapist, Clinical Nurse Specialist (CNS) in behaviour, a CNS in mobility, a CNS in dementia, and a CNS for older person's services. Two clinical nurse managers level 3 (CNM3) provided nursing cover at night for all units on the campus. The inspector met and interviewed the night supervisor and a night staff on duty during the inspection. There is one staff nurse on duty at night in one house that provides nursing support to the staff in the other houses and the night supervisor was on call for units in the campus and the community houses at night.

Inspectors observed good staff interactions between residents and the nursing and care staff and those staff members interviewed had a good knowledge of residents' needs. Residents appeared comfortable in the company of staff.

There was evidence that arrangements had been put in place since previous inspections to ensure staff supervision was in place. The inspectors also reviewed minutes of staff meetings which took place weekly. This ensured that staff concerns and day-to-day issues were discussed with front line staff in the centre.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

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

Theme:

Use of Information

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

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

Findings:

Inspectors reviewed a sample of staff files and most documents outlined in Schedule 2 of the Regulations were available in each of the files; with the exception of Garda vetting clearance for some staff.

Inspectors found that information relating to most residents and staff members was securely maintained and easily retrievable. Personal plans for residents were up-to-date and gave a good reflection of the care practices and interventions that were in place for each resident at the time of inspection. However, in one incident a resident's care notes had been destroyed for a number of months due to not being safely secured. As a result, inspectors were unable to review this resident's care or accidents/incidents for the last six months.

The centre had all of the written operational policies required by Schedule 5 of the Regulations in place and records required were maintained to ensure completeness, accuracy and ease of retrieval. A statement of purpose and resident's guide were available in the centre and had been recently revised.

Judgment:

Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Thelma O'Neill
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0005313
Date of Inspection:	10 November 2015
Date of response:	12 February 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Residents had limited opportunities to exercise choice or control in their life due to the institutional routines of this service and the lack of space and overcrowding in many chalets.

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

1. Action Required:

Under Regulation 09 (2) (b) you are required to: Ensure that each resident has the freedom to exercise choice and control in his or her daily life.

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

Residents are supported to exercise choice in their daily lives by being provided with opportunities to shop in their local communities. Preparation of meals within their homes is facilitated following shopping outings. Food menus in pictorial format are provided in each house to provide opportunities for choice. Residents can access the restaurant while attending day services if they so wish. Choices in the restaurant have been increased to provide a better selection of snacks to residents' Social support hours facilitate opportunities for residents for community inclusion and community participation through shopping, eating in restaurants and cafes and partaking in personal interests and hobbies. Each resident has an individual Listen To Me Document, a care plan, communication passport a compatibility assessment and individualised living options in which family have been involved in the development of. Advocacy services are involved with the residents Inclusion Ireland has facilitated a family meeting to progress this self advocacy forum.

Residents are invited to MDT review meetings, regular resident feedback meetings are held in each house to gain residents preferred choices in the running of the house, meals prepared, and activities in which they would like to participate in. Evaluation of residents' goals and activities is undertaken to ensure optimum benefit for the resident. Review of procedure of gaining residents views and comments will be undertaken with the SALT to address non verbal residents Staff are familiar with the communication preference of each resident, including those who are non verbal and communicate through intentional and unintentional means, vocalisations and gestures Sheds are being provided for equipment that can be stored outside. Vacuum bags will be provided for residents to store clothing in, spring cleaning and rotation of winter/summer clothing will be undertaken to ensure maximum space for residents is available. Wheel chairs will be stored in an outside shed which is available for some houses.

A day service in close proximity to this service is available for residents use in the evening and at weekends if they so wish; visitors can also be facilitated here. A decongregation plan will be submitted to the Authority by March 31st 2016. Following the initial transition of 1 house to the community a review will take place within the service to address the overcrowding and lack of space through a reassessment of the service.

Proposed Timescale: 31/03/2016**Theme:** Individualised Supports and Care**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The management of residents' money was not individualised or person centred and limited resident's rights to financial independence and free access to their money.

There were no financial competency assessments completed for each resident to ensure the appropriate supports were available to the residents.

2. Action Required:

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

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

Financial competency assessments have been sourced and will be undertaken for each resident to access supports required. Opening of Post Office accounts will commence following this process

Proposed Timescale: 31/03/2016

Theme: Individualised Supports and Care

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

Some residents did not have adequate space to store and maintain their clothes and personal property and possessions.

3. Action Required:

Under Regulation 12 (3) (d) you are required to: Ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.

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

New suitable accommodation is currently being sourced for residents in the service. In the interim residents will be provided with vacuum bags which will permit additional storage space. Storage sheds will be provided for all houses to ease storage problems for cleaning utensils and other items.

A decongregation plan is being developed which will be based on compatibility and capacity. Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus will have their own bedrooms and will be afforded more space to store their clothing and personal belongings.

A monthly transition/decongregation meeting has commenced to ensure smooth transition of overall plan. Project Officer to be appointed to support decongregation process.

Proposed Timescale: 30/06/2016

Theme: Individualised Supports and Care

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

In some cases the complainant was not informed promptly of the outcome of their complaint or the appeals process available to them.

4. Action Required:

Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

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

Complaint/appeal procedure sent to all families/NOK. Complaints and appeal process in easy to read format is displayed in prominent area in all houses. As per the complaints procedure all complainants will be contacted by letter and informed of the status of their complaint within 5 days of lodging a complaint.

A complaint log with a monthly summary sheet is in place in all houses. Complaints are reviewed as part of the Quality and Safety Workarounds.

Complaints are formally reviewed and submitted to the HSE complaints officer on a monthly basis by the Cregg Services complaints officer.

Proposed Timescale: 17/02/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Some residents with communication deficits and behavioural issues were not reviewed by a Speech and Language Therapist to assess their communication needs.

5. Action Required:

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

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

Residents with communication deficits and behavioural issues have been referred to the SALT, CNS in behaviours and Psychology for assessment.

A communication passport and an individual communication preference profile is in place for all individuals as appropriate. Referrals regarding assistive technology devices will be made for residents who would benefit from this.

If a resident does not have an individual communication profile a referral will be made to the Speech and Language Therapist to have their communication profile administered.

The residents' individual communication profiles will be reviewed by their key workers: where this profile identifies a need for assistive technology to support an individuals' communication system, a referral will be made to the Speech and Language Therapist.

Access to social media through the use of assistive technology for residents can be explored via staff awareness training with the HSE Assistive Technology Department.

HSE Assistive Technology representative to meet with staff to discuss how social media can be used to improve residents' contact with their natural network and enhance their life experience

Proposed Timescale: 31/03/2016

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

Theme: Individualised Supports and Care

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

There were no suitable private facilities available to receive visitors in private in the chalets.

6. Action Required:

Under Regulation 11 (3) (a) you are required to: Provide suitable communal facilities for each resident to receive visitors.

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

A decongregation plan is being developed. Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus will be afforded more room to facilitate accommodating visitors in a communal area.

In the interim on Saturdays and Sundays and evenings during the week visitors will be accommodated in day services which are in a convenient location to the Service

Proposed Timescale: 17/02/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

Not all contracts were signed. The details of additional charges were not always included in contracts of care.

7. Action Required:

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

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

Review of the agreement for the provision of services will be undertaken so that it includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged. The reviewed agreement for the provision of services will be issued to all families/NOK.

Cregg Services apply long stay charges to residents in line with the HSE 'Charges for In-Patient Services' National Guidelines. The main requirements for the charge to apply are 'inpatient services' (residential care) and nursing care. Where 24 hour nursing care is provided at the residential facility Class 1 charges apply. Where less than 24 hour nursing care is provided at the residential facility class 2 charges apply. Currently where there is no nursing care at a residential facility no charges apply. At the time of the introduction of the charges we were advised that Class 1 charges should apply to all residents on Cregg Campus as 24 hour nursing care is provided on the campus.

In calculating the applicable charge for each service user there are certain 'allowable expenses' provided for in the Guidelines. In addition for 'community type residences' the guidelines provide for 'socialisation/care plan expenses' which relate to 'additional expenses incurred as a result of greater independence and integration into the community'. We have been advised that a reasonable interpretation of this would be that socialisation allowance is granted where the personal allowance is not enough to cover the costs incurred by "greater independence and integration into the community". We are currently reviewing each service user's expenditure to determine if they are spending all of their personal allowance on an ongoing basis and therefore if a socialisation allowance is required. This review should be completed by 31/03/2016.

Proposed Timescale: 31/03/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

The names of those responsible for pursuing personal outcome goals were not recorded and some resident's personal goals were not updated to include new goals.

8. Action Required:

Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

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

Goals in residents' personal plans will be reviewed to ensure they are person centred, SMART and that they contain details of the residents' preferences and aspirations. A responsible person will be identified to support the resident to achieve their goal; this will be time framed and following achievement of the goal it will be evaluated and a new goal will be identified. Residents' personal goals will be reviewed as part of the annual MDT review.

Proposed Timescale: 29/02/2016

Theme: Effective Services

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

There was no evidence that all residents or their families were invited to be involved in their yearly medical or social care reviews.

9. Action Required:

Under Regulation 5 (4) (c) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which is developed through a person centred approach with the maximum participation of each resident, in accordance with the resident's wishes, age and the nature of his or her disability.

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

Residents, Family and NOK will be formally invited to all MDT reviews. Staff will document evidence of formal invitation to resident, family and NOK. All returned forms will be filed on care plans. MDT Review template to include record of invitation to resident and families.

Proposed Timescale: 31/03/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Residents were living in small overcrowded chalets, which did not meet their needs, or the aims or objectives outlined in the centre's statement of purpose.

10. Action Required:

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

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

New suitable accommodation is currently being sourced for residents in the service. A decongregation plan is being developed which will be based on capacity and compatibility. Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus for the interim will be afforded more personal space. A decongregation Plan will be submitted to the Authority by March 31st 2016.

A monthly transition/decongregation meeting has commenced to ensure smooth transition of overall decongregation plan. Project Officer to be appointed to support decongregation process. Project Officer will be in place by mid May 2016.

Proposed Timescale: 30/06/2016

Theme: Effective Services

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

Equipment and facilities were not serviced or repaired to ensure they were maintained in good working order. For example, furniture, doors, and the heating system.

11. Action Required:

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

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

All equipment and facilities will be serviced or repaired to ensure they are maintained in good working order. This will include furniture, doors, and the heating system. A new integrated blind has been ordered for house where resident will not tolerate regular blinds on the window.

Maintenance list and quotes have been submitted for approval which includes shower facilities to be upgraded in three houses.

Ramps and handrails to be completed outside of one house.

The Estates and local maintenance are involved in maintaining the heating system in the service on a regular basis.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

Premises were not equipped with assistive technology aids and appliances to support and promote the full capability of the residents.

12. Action Required:

Under Regulation 17 (5) you are required to: Equip the premises, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.

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

If a resident does not have an individual communication profile a referral will be made to the Speech and Language Therapist to have their communication profile administered.

The residents' individual communication profiles will be reviewed by their key workers: where this profile identifies a need for assistive technology to support an individuals' communication system, a referral will be made to the Speech and Language Therapist.

Access to social media through the use of assistive technology for residents can be explored via staff awareness training with the HSE Assistive Technology Department.

HSE Assistive Technology representative to meet with staff to discuss how social media can be used to improve residents' contact with their natural network and enhance their life experience.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

The requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) were not met.

13. 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:

New suitable accommodation is currently being sourced for residents in the service. In the interim residents will be provided with vacuum bags which will permit additional storage space. Storage sheds will be provided for all houses to ease storage problems for cleaning utensils and other items. Curtains to promote privacy have been installed in all shared bedrooms. Visitors will be accommodated in a day service convenient to this service on week day evenings and at weekends; this is also available for residents use outside of day service provision times. Three houses have rooms available which will facilitate a communal leisure/visitors area. Residents have access to the recreational facilities on campus, including recreation hall and swimming pool. Residents have the opportunity to launder their clothing within each house.

A decongregation plan will be submitted to the Authority by March 31st 2016 which will be based on compatibility and capacity assessments. Following residents relocating to homes in the community a plan will be implemented to facilitate ensuring that residents who are remaining on campus will be afforded more space to store their clothing and personal belongings; the issues of shared bedrooms and overcrowding will be addressed as a matter of priority following the transition. Quotes for renovations including ramps and level access shower have been submitted for approval. A monthly transition/decongregation meeting has commenced to ensure smooth transition of the overall plan. Project Officer to be appointed to support decongregation process by mid May 2016. Suitable arrangements are in place for safe disposal of waste for each house within the service.

An engineer's report will be submitted to the Authority in relation to plumbing in the service with this action plan

Proposed Timescale: 30/06/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Risk management arrangements did not always identify or manage risks, as required in Regulation 26. For example:

1. Risks identified when attending to residents personal care were not adequately managed.
2. Residents living together that were identified as incompatible, had inadequate controls measures in place to reduce the impact on other residents.
3. Where risks were identified, control measures in place were ineffective to prevent a re-occurrence of the incidents.

14. Action Required:

Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and

learning from, serious incidents or adverse events involving residents.

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

Risk management training is taking place on March 3rd 2016. This is available to all staff and managers; risk management responses will be incorporated into this training. Following a fall occurring within the service a review will be undertaken to ensure risks are appropriately supported and controls are effective.

Residents' intimate care plans have been reviewed and updated and now state staffing required facilitating the residents' personal care and addressing risks identified. An audit will be undertaken in all houses on Intimate Care Plans.

Residents risk assessments will include incompatibility issues and controls will be put in place to reduce these issue. Residents who are incompatible will be prioritised for relocating to the community. Following transition of residents to the community a reassessment will be undertaken within the service to address incompatibility issues. Risks management will be discussed at weekly team meetings within the house. All incidents involving peer on peer abuse will be screened as per the National Protection of Vulnerable Adults Policy, management plans will be developed and referred to the designated team and social work department for advice and follow up. Training for staff in screening and development of management plans in relation to safeguarding will be provided by The Designated Team, date to be agreed All incidents are reviewed by the Incident Review Group monthly, learning, graphs and analysis are issued following review, and this is shared with appropriate staff. Serious incidents are assessed and quality improvement plans are developed and shared across the service. Referrals to Psychology have been made for residents who require support in this area. CNS in behaviours will be involved in managing behavioural issues.

A monthly summary sheet has been placed in each incident folder in each house to ensure all staff are aware and up to date regarding incidents which have occurred within their house.

Support staff have been utilised to ensure residents have access to external activities at arranged times.

Positive Behaviour support Services meet with lead staff monthly to discuss incident recording and issues relating to challenging behaviour. Consideration is given to incidents, risk and restrictive practices, impact on other residents, efficacy of support strategies and issues around staff support. Minutes of these meetings are held locally. The Clinical Nurse Specialist in behaviours has a schedule of reviews in place for residents' behaviour support plans.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

1. Mobility assessments and the management of falls, were not adequately addressed and over 65% of staff were overdue training the safe moving and handling of residents.
2. Risk assessments were not completed for oxygen cylinders or chemicals stored in a resident's bedroom.

15. 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:

Referrals for residents requiring mobility assessments will be sent to the CNS in mobility.

A rolling manual handling training schedule is in place and staff will have up to date training by the end of April 2016. The falls policy is in place in all houses; staff are utilising a post falls assessment form following every fall and referrals are made to mobility team post falls.

Chemicals (washing powder) has been removed from the residents' bedroom and all chemicals are now stored appropriately.

Oxygen cylinder has been removed from the residents' bedroom and portable oxygen cylinder is in place. Oxygen is stored securely in the office of the house.

Risk assessments will be completed as appropriate.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

One chalet did not have emergency lighting in place.

16. Action Required:

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

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

Emergency lighting will be installed in the remaining house.

Proposed Timescale: 30/04/2016

Theme: Effective Services

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

1. Fire doors were not fitted with magnetic door devices and were kept open with wooden wedges.
2. Risks identified in an external fire risk assessment had not been addressed in a timely manner.

17. Action Required:

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

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

Magnetic door devices have been ordered and are fitted to a number of doors this work is completed in one house and devices have been ordered for the remainder of the houses which require these. Emergency lighting has been ordered for one house. A Fire hose in another house has been removed as advised.

In relation to the Fire risk assessment report, the original scope of work exceed the original tender estimates and the design team have undertaken a review of the scope of work and will be issuing plans following this.

Proposed Timescale: 31/03/2016

Theme: Effective Services

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

17 % of staff had not yet completed fire safety training.

18. Action Required:

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

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

Rolling Fire Training schedule in place which will ensure staff have ongoing fire training and staff have been advised until this training is completed they will be unable to take up duty. There are 5 staff within this service who have not undertaken fire precaution training. All 5 staff will all have received fire precaution training by March 31st 2016

Proposed Timescale: 31/03/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all staff had received training in managing behaviours that challenge, despite some residents displaying severe incidents of physical and psychological aggression.

19. 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:

A rolling schedule of mandatory training has been developed within the service to facilitate staff receiving training in managing behaviours that challenge. All staff working in the area will have completed this training by the 31st March 2016 and refresher training will continue to take place throughout the year as and when required.

Proposed Timescale: 31/03/2016

Theme: Safe Services

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

1. The management of behavioural incidents were not individually reviewed and support measures put in place by the managers.
2. Some residents behavioural support plans were not adequately implemented or reviewed following changes in their behaviours.

20. Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

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

The newly aligned clinical support services, Positive Behavioural Support Services, is currently addressing the format/content of behaviour support plans to ensure a balance of proactive/reactive strategies.

All support plans will be required to 1) identify function of behaviour, 2) list proactive strategies, 3) define reactive strategies, and 4) assess impact upon other residents

Each support plan will be required to produce evidence of the effectiveness of support strategies on the defined behaviour and will be discussed in monthly meetings.

All incidents of behavioural issues will be reviewed individually and appropriate support measures will be put in place.

Referrals will be made to the CNS in behaviours and Psychology to ensure appropriate follow up to changes in behaviours; this will include comprehensive pro and reactive strategies in the BSP.

Proposed Timescale: 17/02/2016

Theme: Safe Services

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

Residents' assessed as living in unsuitable environments that was impacting on their physical and emotionally wellbeing as well as their peers quality of life, had not been adequately managed.

21. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Residents risk assessments will include incompatibility issues.

Residents living in overcrowded accommodation where incidents of peer on peer abuse have occurred will be prioritised for transitioning to the community. Training for staff on safeguarding screening will be provided by The Designated team, date for same to be decided.

Following the initial transitioning occurring within this service a reassessment of the service will be undertaken to address the issue of overcrowding and incompatibility issues.

All incidents involving peer on peer abuse will be screened as per the National Protection of Vulnerable Adults Policy, management plans will be developed and referred to the designated team and social work department for advice and follow up. MDT Reviews will be undertaken to assess the effectiveness of management plans which have been put in place for incidents of peer on peer abuse.

Additional communal space has been made available for residents in a day service in close proximity to the service; this is available in the evenings and at weekends to ease the problem of overcrowding in the houses.

All incidents are reviewed by the Incident Review Group monthly, learning, graphs and analysis are issued following review, and this is shared with appropriate staff. Serious incidents are assessed and quality improvement plans are developed and shared across the service. Referrals to Psychology have been made for residents who require support in this area. CNS in behaviours will be involved in managing behavioural issues

A rolling schedule of mandatory training has been developed to ensure all staff are trained appropriately for their role and to ensure staff have the knowledge and skills to manage behaviours that challenge. This is a priority for the service in 2016 and will continue throughout the year in order to achieve full compliance.

Proposed Timescale: 31/03/2016

Theme: Safe Services

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

The impact of restrictive practices on all residents living in the houses were not adequately monitored or reviewed.

22. Action Required:

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

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

Positive Behaviour support Services meet with lead staff monthly to discuss incident recording and issues relating to challenging behaviour. Consideration is given to incidents, risk and restrictive practices, impact on other residents, efficacy of support strategies and issues around staff support. Minutes of these meetings are held locally. The Restrictive Practice Group will review all referrals and make recommendations on all restrictive practices to ensure they are adequately monitored.

Training for staff on the impact of restrictive practices on residents will be provided by the Psychologist Dept.

Proposed Timescale: 31/03/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

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

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

23. Action Required:

Under Regulation 13 (4) (b) you are required to: Ensure that where residents are in transition between services, continuity of education, training and employment is maintained.

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

Activities will be provided for residents in line with their personal preferences. Support hours are available to facilitate residents integrating into their community to partake in individual interests away from campus.

Proposed Timescale: 29/02/2016

Theme: Health and Development

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

There were limited activities available and residents often chose not to participate in these activities due to no structured programme being available.

24. Action Required:

Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

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

Activities will be provided for residents in line with their personal preferences. Additional support hours are available to facilitate residents integrating into their community to partake in individual interests. A referral to the Adult Referral Committee will be made for residents to access opportunities for education, training and employment where appropriate and sampling of community based activities will be undertaken also.

Proposed Timescale: 29/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

In a few cases, where residents had chronic medical conditions, there was no up to date care plan in place, or it had not been reviewed following residents healthcare needs changing.

Resident's healthcare plans were not linked to the recommendations of the allied health professionals.

Resident's were not referred to the allied health professionals following changes in their healthcare needs.

25. Action Required:

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

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

Resident's healthcare plans will be linked to the recommendations of the allied health professionals.

Resident's will be referred to the allied health professionals following changes in their healthcare needs.

An audit schedule of residents' personal plans is underway within the service. Quality and Safety Walkabouts will include a review of individual personal plans. A care planning group has been established within the service to facilitate supporting staff in the care planning process. The Practice Development Coordinator is a member of this group. The care planning group feeds into the Quality and Safety Governance group meeting regularly.

Proposed Timescale: 17/02/2016

Theme: Health and Development

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

There was no menu sent in advance to advise residents of their meal choices for the day.

One resident on a healthy eating diet was limited to a salad most evenings.

26. Action Required:

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

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

Consultation with the dietician has been undertaken to increase the residents' choice of foods in the evening while adhering to all nutritional guidelines.

Picture format menus will be available in all houses facilitating the opportunity for choice in meals for the residents.

Residents are supported to exercise choice in their daily lives by being provided with opportunities to shop in their local communities through the provision of social support hours; procurement cards have been supplied to facilitate these opportunities. Preparation of meals within their homes is facilitated following shopping outings. Each resident will have access to adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences within their homes.

Residents can access the restaurant while attending day services if they so wish.

Proposed Timescale: 29/02/2016

Theme: Health and Development

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

There were limited choices of food/ snacks prior to or after the lunch time schedule in the canteen.

27. Action Required:

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

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

Extra snacks will be provided before and after lunch for residents to improve variety and choice for residents in the restaurant.

All staff will ensure that a good selection of snacks and beverages are available for residents within their homes. Equipment to facilitate making snacks such as sandwich toasters and juicers will be provided

Proposed Timescale: 29/02/2016

Theme: Health and Development

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

Residents' meals were provided from a centralised kitchen, which limited residents' choice and independence.

28. Action Required:

Under Regulation 18 (1) (a) you are required to: Support residents, so far as reasonable and practicable, to buy, prepare and cook their own meals if they so wish.

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

To support residents' choice and independence procurement cards have been supplied to facilitate the opportunity for residents to shop for desired foods. Residents are supported to cook and prepare meals in their own house. The service has engaged with a local professional who will provide staff and residents with training around healthy cooking. Food hygiene training will be undertaken with staff within this service in preparation for community living.

Proposed Timescale: 31/03/2016

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:

A revised Statement of Purpose has not been submitted to HIQA to reflect the reconfigured designated centre.

29. Action Required:

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

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

A revised Statement of Purpose has been submitted to the Authority to reflect the reconfigured designated centre

Proposed Timescale: 12/02/2016

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 responsibilities of the director of services/person in charge were found to be excessive to allow for effective governance operational management or administration of the centre on a day- to- day basis as required by the regulations.

30. 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 staff at CNM 3 level has been appointed from the Learning Disability team for 2-3 days a week to support the current PIC and facilitate the achievement of the national standards. HSE National Recruitment is currently undertaking a campaign to appoint a permanent PIC for this designated area. We expect this campaign to be concluded and a person to have taken up position by the 1st June 2016.

Proposed Timescale: 01/06/2016

Theme: Leadership, Governance and Management

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

The governance and management of the centre failed to manage risks and protection issues for residents by ensuring the day to day documentation was well maintained in the centres.

31. Action Required:

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

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

All residents have an individual risk assessment in place; all risks identified are managed and reviewed appropriately.

All incidents are inputted onto the NIMS system and individually reviewed on a regular basis. Incident summary sheet is present in all incident logs to facilitate increasing staff awareness of incidents within the home.

All incidents of abuse are screened by the designated officer as per National Protection of Vulnerable Adults Policy, management plans are developed and both are submitted to the designated team and social work department for their review and recommendations.

Documentation relating to risk management and safeguarding of vulnerable adults is provided in each house.

A clearly defined management structure in the designated centre is in place as per organisational chart that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

The management structure in the service has been reviewed to ensure a clearly defined management structure with identified lines of authority and accountability in place. As part of this review a number of meetings have taken place with the relevant managers outlining all staff roles, responsibilities and accountability within individual units.

Proposed Timescale: 17/02/2016

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was limited availability of accessible vehicles to transport residents to and from their day services and on social outings.

32. Action Required:

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

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

Approval has been received for the purchase of a suitable vehicle for the service. Delay has occurred due to non availability of the identified vehicle.

Proposed Timescale: 31/03/2016 depending on suitable vehicle being sourced.

Outcome 17: Workforce

Theme: Responsive Workforce

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

Inspectors found that staff deployment still required review to ensure consistent, familiar staff supervised residents at all times.

33. Action Required:

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

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

A staffing review has taken place within the service and all efforts are made to ensure appropriate and consistent staffing. Regular meetings are held with agency service providers requesting consistent, well trained experienced staff. Managers are aware of the importance of consistent familiar staff when completing the weekly rosters. The use of agency staff has reduced within the service and has been replaced by intern care assistants. The service is undertaking a local recruitment campaign in an effort to secure permanent staff for the service. The recruitment campaign will be primarily aimed at long term consistent agency staff

Proposed Timescale: 15/06/2016

Theme: Responsive Workforce

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

In some units there was no actual or planned staff rota showing the actual staff that were working on duty during the day and at night in the centre.

34. Action Required:

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

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

All houses will have a planned and actual rota in place for day and night time.

Proposed Timescale: 17/02/2016

Theme: Responsive Workforce

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

17% of staff had not completed fire safety training, 66% of staff had not completed training in manual handling and 35% of staff had not completed training in the management of behaviours that challenge.

Staff had not received training in risk management and were not fully confident in completing risk assessments and managing and preventing accidents /incidents in the centre.

35. Action Required:

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

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

Rolling schedules of mandatory staff training have been developed.

Records of staff training are maintained in each house.

A risk management workshop will be facilitated on March 3rd 2016 within the service to ensure all staff are confident in completing risk assessments and managing incidents and accidents. The following are the completion dates within this service of mandatory training

Fire –March 31st 2016,

Risk Management – March 3rd 2016,

Manual Handling – May 30th 2016,

Studio 3, - June 30th 2016,

Safeguarding – Up to date as of Feb 29th 2016,

Hand hygiene – May 30th 2016

Proposed Timescale: 30/06/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Some staff did not have Garda vetting forms on file.

36. Action Required:

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 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:

It is a priority that all staff working within our service have the appropriate documents as specified within the legislation. We are currently undertaking this on a voluntary basis as there is an ongoing national industrial relations issue that has prevented us from undertaking this on a compulsory basis. A memo will be issued to staff and discussion at team meetings will be undertaken to request staff to submit the required vetting documentation voluntarily. The percentage of staff vetted within the service is 78% at this time.

Proposed Timescale: 30/06/2016

Theme: Use of Information

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

Inspectors found that in one unit, there were no accidents /incidents reports maintained in the unit and staff were unaware of where the other incident forms were stored.

A resident had gained access to the staff office and destroyed numerous documents including their care notes.

37. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

Regular minuted team meetings will occur within houses where incidents/accidents will be discussed. All staff are aware of the reporting protocol regarding accidents and incidents. An incident management group meet regularly to analyse incidents and make

appropriate recommendations. There is an incident/accident folder in each house which contains a monthly summary sheet for increased awareness and easy access for staff. All houses will receive a record of reviewed incidents analysis and graphs on a regular basis.

Documentation will be stored in a safe appropriate secure place to ensure the risk of damage is minimised. Documentation will be archived as per HSE policy.

Proposed Timescale: 29/02/2016