<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Dundalk Simon Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002413</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Louth</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Dundalk Simon Community</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Michele Ryan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Caroline Vahey;</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>4</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
</tr>
</tbody>
</table>
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>06 October 2015 10:00</td>
<td>06 October 2015 16:00</td>
</tr>
<tr>
<td>07 October 2015 11:00</td>
<td>07 October 2015 18:30</td>
</tr>
</tbody>
</table>

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

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

**Summary of findings from this inspection**

This was the second inspection of this centre by the Health Information and Quality Authority (The Authority).

The purpose of this inspection was to inform a decision of registration under the Health Act 2007 following an application to register the centre as a designated centre for four adults with a disability.

The inspection was announced and inspectors met with the person nominated on behalf of the provider (provider nominee) and person in charge at the
commencement of the inspection to outline the inspection process and methodology. Inspectors provided feedback to the person in charge during the inspection and at the end feedback was provided to both.

Inspectors reviewed documentation, ascertained the views of residents, the provider nominee and person in charge during this inspection, assessed the premises and reviewed arrangements in place in accordance with the requirements of the legislation and regulations during the two day inspection.

The designated centre consists of one terraced residency situated in the community that is close to all amenities. Accommodation was being provided for four male residents with no vacancies available. The centre provides facilities and support services for residents described with low to medium intellectual disability who were independent in activities of daily living with support.

The age range of residents accommodated was between 25 and 50 years of age. Inspectors were informed that the resident group had been living in this centre since 2010 and had lived together for some years prior to moving to this centre. In the main good relationships existed between residents.

The inspectors met all of the residents being accommodated. The residents were aware of the inspection process and were keen to engage with the inspectors and share their views. Residents expressed their satisfaction in respect of living with supports in the community and were satisfied with the routine day to day running of the centre which encouraged them to be independent.

Overall, while the ethos and model of care provided for residents was of supported living in a community setting, significant improvements were required in relation to the operational arrangements to provide for effective governance systems and management structures with dedicated resources to fulfil responsibilities and duties under the legislation that included appropriately skilled staff with training and supervision.

Improvements were also required in relation to the statement of purpose and function, aspects of the premises, risk management, fire safety management and precautions and development and implementation of policies and guidance documents to support the operation of a designated centre to ensure the care, support and welfare of residents.

The provider has 42 regulatory requirements to address and person in charge has 13 action requirements in order to ensure compliance with Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013 (as amended), and the National Standards for Residential Services for Children and Adults with Disabilities.

A recommendation for registration will be dependent on the provider and person in charge’s response to the action plan where improvements required are discussed within the body of this report and outlined at the end for action and response.
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:
The inspectors found arrangements in place to promote the rights, privacy and dignity of residents where choice and freedom was encouraged. However, improvements were required.

Arrangements were in place to promote freedom and ensure residents are consulted with, and participate in, decisions about their care and about the day to day running of this centre. However, the person in charge and residents had not been involved in decisions in relation to the garden project. Additionally, policies and procedures in relation to provision of information to residents, provision of personal care practices/intimate care and use of CCTV were not in place to guide practice involving residents rights.

While access to an advocate was sought to support one resident in the previous year following the last inspection, access to advocacy services for all residents had not been facilitated, and information on how to access an independent advocate or representative did not form part of the support services and information available to each resident. The identity and contact detail of advocates or advocacy services was not evident or on display in the centre. However, information about making a complaint and on human rights was displayed in prominent places.

Arrangements were in place to promote and respect resident’s privacy and dignity, including contact with and meeting persons or family in private. Resident meetings formed part of informal arrangements for consultation processes. Supported decision
making processes were described that involved staff and external persons involved in the service level agreement.

Inspectors were informed that residents were enabled to take risks within their day to day lives and of practices in place to minimise harm such as a requirement to have staff approval and/or support while out of the centre after 20:00 hours. The classification process as to whether this arrangement was a restriction or deprivation had not been examined.

While residents had similar opportunities and choices to their peers, one resident with positive behaviour support needs was accommodated in a bedroom that had no outlook/window view. This resident’s bedroom had a ski-light window, and while the resident confirmed he could operate the ski-light with a pole to open the window, there was no blind on the ski-light window as an option to block out daylight. The overall size of the bedroom was smaller than all other bedrooms which had a view from windows or from an emergency exit door. This bedroom space could facilitate a single bed only, whereas, all other bedrooms could facilitate a double size bed and additional furniture. In an evaluation record of residents’ views of the centre, inspectors noted that two of the four residents confirmed they had had a choice in their bedroom accommodation.

Procedures and arrangements were in place and described by the person in charge to enable residents to exercise choice and retain control over personal possessions and property in accordance with their preferences. Locks were available on the communal bathroom and each residents had a key to the front door of the centre and had a key to lock their bedroom. While there was a policy on the management of resident’s finances, a policy on resident’s personal property and personal possessions was not in place.

During the course of inspection inspectors found two keys positioned in the staff bathroom and were told that maintenance personnel employed by the provider entered the premises on occasion while residents and staff were out in order for them to retrieve one of the keys for the lock on the rear garden gate. This arrangement was not adequate or appropriate and an alternative arrangement to accessing the key or garden was required.

Residents had ability to participate in activities that were meaningful and purposeful to them, which suited their interests and capabilities. Examples were shared with inspectors that demonstrated residents were encouraged to maximise independence and choice. However, inspectors were informed of barriers preventing resident’s personal development and ability to transition to supported and independent living arrangements due to limited resources and dependency on the commissioners of the service.

A complaints policy was in place. The complaints procedure was displayed at the entrance to the sitting room. A dedicated log book for recording complaints was maintained, however, all complaints had not been recorded in line with the centre’s policy or regulatory requirements. Details of investigations into all complaints, the outcome of the complaint, any action taken on foot of the complaint and whether or not the person was satisfied or informed of the appeals process was not evident as required. As previously highlighted following the last inspection in July 2014, an independent advocate did not form part of the arrangements to support residents for the purposes of
making a complaint or in relation to decision making processes as required.

Inspectors were informed that an evaluation of resident’s views of the service was undertaken in August 2015 by a person referred to as a link worker between the service provider and the commissioner of the service which reported an overall level of satisfaction by residents in the services available.

**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:**
Residents had good communication skills, abilities and understanding, however, there was no policy on communication with residents.

The inspectors found that arrangements were in place so that residents were supported and assisted to communicate in accordance with their needs and preferences.

Residents of the centre had formed links with the local and wider community. They had access to radio, television, social media, internet, a local theatre, and cinema and other entertainment venues.

Access to assistive technology devices and appliances were available to promote residents’ full capabilities and facilitate needs. Each resident had a mobile phone.

Each resident’s abilities and needs were identified in the initial assessment process. Access to specialists such as speech and language therapists was on a referral basis via their GP to primary care services. However, initiating a referral was dependent on staff knowledge and ability to recognise the presentation of an identified or changing need that may require further assessment. As discussed further in outcome 11 a system of regular health screening was not in place and a lack of staff training was apparent as highlighted in outcome 17.

**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:**
Based on the information available, the inspectors were satisfied that family, personal relationships and links with the community were encouraged.

Arrangements were in place to promote resident’s family relationships and links with the community. Inspectors were informed that while family members were welcome to visit the centre, most family interaction and engagement took place external to the centre and the person in charge was yet to meet family members of two residents.

Families were encouraged to get involved in the lives of residents in accordance with resident’s wishes. The person in charge told inspectors that residents met with and travelled to visit family regularly and had overnight stays with family on a regular basis. Residents also confirmed this. However, a policy in relation to visitors or temporary absence of residents was not in place.

The inspectors were told of supports and opportunities facilitated for residents to develop personally and maintain family relationships and links with the wider community. Inspectors were told that residents were encouraged to be in the centre from 20:00 hours daily unless prearranged and agreed for safety reasons.

The inspectors confirmed with the provider nominee and person in charge that residents were supported with staff by the provision of a private vehicle, maintenance of their own transport (bicycle) and encouraged to use public transport for arrangements to promote engagement and activity within the wider community.

A lack of recorded evidence was available to demonstrate residents and representatives of residents formed part of the personal plan meetings and family input was facilitated and information and updates were communicated.

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

Findings:
There were no resident admissions or discharges since the last inspection. Inspectors were informed that the resident group had been living in this centre since 2010 and had lived together locally for some years prior to the move to this centre.

There was a policy in place for admission, transfers and discharges of residents. However, this policy was not sufficiently detailed to guide staff or describe criterion and procedures to be applied in practice in relation to admission, transfers, discharges and the temporary absence of residents. This is included in outcome 18 action plan.

One resident told inspectors of his plan to move on and live independently, while others considered this centre as their home indefinitely. The provider nominee told inspectors that communication with the commissioners of the service occurred annually and as needs arise in relation to service provision.

While the available admission, transfer and discharge policy was reflected in the centre’s Statement of Purpose, it also required improvement to include transparent criteria for all processes related to each resident that considers the wishes, needs and safety of the individual and the safety of other residents living in the shared accommodation, services available and limitations within the service.

A contract of care document was available outlining in brief, the terms and conditions of services to be provided and the weekly fee charged.

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:**
Each resident had a comprehensive assessment of need completed which included areas such as social, healthcare, psychological and emotional needs.

However, there was no date or signature on resident’s assessments and the inspectors could not ascertain who carried out the assessment, was there multidisciplinary input and if changes to the residents needs had been updated. There was no record in the assessments reviewed that residents and their families/representatives had been involved in the assessment process.

The inspectors discussed resident’s personal plans with the person in charge. The person in charge told inspectors she had considered and discussed the development of personal plans in accessible format with the residents for example in audio format, however, all the residents had opted to keep the plans in the current format. The person in charge informed the inspectors that the residents also requested that personal plans continue to be stored in the staff office.

Social goals were developed, with goals reviewed on a monthly basis through a resident and key-worker meeting. A record of the monthly review of goals was maintained within a key-worker folder.

Improvements were required in the area of healthcare plans and behaviour support plans. Sufficient personal plans had not been developed to manage epilepsy. Some residents who can display behaviour that was challenging including verbal aggression did not have a behaviour support plan developed. The person in charge was able to describe the action to be taken in the event residents displayed challenging behaviour. However, there was no behavioural intervention plan which outlined the step by step action to be taken to guide staff to appropriately support the residents on the consistent basis. Therefore, the inspectors were not assured that there was a consistent response to incidences of challenging behaviour to aid an evaluation.

With the exception of social care goals there was no recorded evidence of review of interventions described and recommended or with multidisciplinary input. One resident has expressed a wish to live independently and support had been sourced through a community liaison worker to assist the resident in the development of appropriate life skills such as money management. Improvement was required in communication between the centre and the community liaison worker, to support the resident to generalise new skills into his everyday life.

Residents’ wishes were not always conveyed to relevant support staff such as the job coach.
**Judgment:**  
Non Compliant - Moderate

---

**Outcome 06: Safe and suitable premises**  
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**  
Effective Services

---

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

**Findings:**  
The location, design and layout of the centre was in the main suitable for residents who were reasonably independent requiring a low level of support individually and collectively that aimed to provide accommodation in a comfortable and homely way. However, improvements were required.

The centre comprises of a three storey house, which was furnished and fitted for occupancy by the four residents that were being accommodated. Resident accommodation included four single occupancy bedrooms, two on the first floor and two on the second floor and a communal bathroom with a shower, wash hand basin and toilet located on the ground floor.

A staff office/sleepover room was located on the first floor with a window outlook/view and an adjoining staff bathroom.

All residents had personal televisions in addition to the communal television in the sitting room. Three residents had spacious bedrooms with bedroom furniture that included a double bed, while one resident had a single bed and had a smaller room with no window view or outlook.

Facilities on the ground floor included a communal utility and store area, kitchen/ dining room and sitting room for use by residents with staff support. A number of new kitchen appliances and a replacement of the worktop were confirmed since the last inspection.

Externally to the rear of the centre, a paved area, garden and path lead to a locked gate to an alleyway. The garden and surrounding area was in need of repair and attention which was highlighted on the previous inspection July 2014. The provider nominee informed inspectors that funding was approved to undertake an upgrade of this area and back garden which was to commence shortly. There was no garden furniture and few plants, features or items of interest in this area at the time of this inspection.
The inspectors were informed that most matters relating to the premises following the last inspection had been addressed or progressed. However, arrangements or quality reviews were not in place to ensure suitable and sufficient cleaning, repair and décor of the premises was maintained and further improvements were required based on the following findings:

- carpet provided in hallways, on stairs, in bedrooms and on landing areas was unclean with dark spots/stains seen in parts. A review of cloth furnishings was needed and a deep clean to include carpets, furniture and curtains had not taken place in the past year.
- bedroom floors were cluttered which may be as a result of a lack of shelving.
- chipped paintwork was seen in parts of the centre and the décor required review.
- grey/black stains was noted on bathroom ceilings and discolouration around the landing ski-light suggested inadequate ventilation or dampness.
- cobwebs were seen in storage compartments in a residents bedroom.
- windows blinds were in need of repair or replacement in the number of bedrooms.
- there was no hand towel or holder at the wash hand basin in the residents bathroom.
- extension leads, cables and electrical wires were seen in most rooms that may pose a risk. A review of the premises given the demand for electrical sockets resulting in many extension cables is recommended.
- exterior and interior lights were not functioning and lamp shades were not in place on each light fitting.
- residents did not have a bedside lamp to facilitate easy access within and beyond their bedroom when dark.
- a gap between the main/front door and the step/floor required attention.

There was reasonable space and a storage facility for the personal use of residents, however, none of the residents had a comfortable arm chair to relax in their bedroom where they had TV, DVD and/or computer games/devices.

While there were appropriate facilities and the layout aimed to promote residents’ safety, dignity, independence and wellbeing, as stated in outcome 1, one resident’s bedroom was small with a single bed, that was unable to facilitate a double bed and/or an armchair and it did not have a window to provide an outlook or view of outside for the resident.

Maintenance arrangements in place were described. All maintenance requests were communicated by staff to the provider’s main office for address or completion, which was generally carried out by personnel working for the provider group. However, a system with written records of requests and to confirm completion of maintenance was not kept in the centre. Inspectors were told that the heating/boiler had a been leaking over the previous weekend but had continued to work to heat the home. The heating system was repaired during the inspection by day two (Wednesday).

Arrangements were in place for the safe disposal of general waste. However, it was confirmed that suitable arrangement for the disposal of medication or clinical waste was not in place, as outlined in outcome 12.

Adequate car parking was available; however, a suitable storage area residents' bicycles, (other than under the external fire escape steps) required consideration to protect it for...
Judgment:
Non Compliant - Moderate

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:
The inspectors found that arrangements to ensure the health and safety of residents, visitors and staff required significant improvement.

While there was a health and safety statement dated January 2015, this document was not signed for approval in practice.

A lack of policies and procedures for risk assessment and management including emergency planning was found. These requirements were highlighted on the previous inspection.

A risk management framework had not been developed to identify, assess and put in place controls in relation to risk and/or measure the probability that an action or activity (including inaction) that may have a negative impact related to the health or welfare of a resident or resident group.

A process to map and rate risks against probability/likelihood of occurrence and severity of impact had not been developed or implemented in practice and a lack of awareness and knowledge of processes and systems regarding risk management was evident based on the findings.

As set out in Regulation 26, a risk management policy which included the matters of hazard identification and management of specified risks, with suitable measures to control risks and arrangements for identification, recording, investigation and learning from serious incidents was not in place.

Adequate policies and procedures to control the following specified risks were not in place:
(i) the unexpected absence of any resident,
(ii) accidental injury to residents, visitors or staff,
(iii) aggression and violence, and
A system for assessment, management and ongoing review of risks was therefore not in place. While a record of some generic risk assessments was available, an active risk register to identify and assess hazards and risks, including those found on inspection, was not maintained that included the following:

- A lack of individual and operational risk assessments to ensure residents' health and safety was evident
- A lack of resources, on-going deficiencies in governance arrangements, staff training and core staff to sufficiently support the operation of a designated centre presented as a risk to the care and welfare of residents
- All staff had not received mandatory training or refresher training, and training relevant to their roles and responsibilities and competence assessments or performance reviews were not maintained
- Staff were working alone with the resident group for lengthy durations of up to 16 hours
- Residents' needs may not be recognised or met as staff members lacked training, skills and/or experience relevant to their roles and responsibilities
- Residents were at risk due to the lack of documentary evidence of the suitability of staff members that worked directly with them
- A lack of written and operational policies was found

Effective fire safety management systems were not in place which had been highlighted on the previous inspection July 2014.

A lack of daily, weekly, monthly or quarterly checks to ensure adequate precautions against the risk of fire and means of escape from the centre was found that included:

- The fire alarm system and emergency lighting had not been serviced or maintained on a regular basis. While this was reportedly addressed during the inspection a record of confirmation was not available and was to be forwarded to the Authority following the inspection. This remains outstanding. However, a recently dated service record for fire extinguisher and fire blanket was maintained and on display in the centre
- Fire evacuation arrangements were inadequate. Means of escape had not been checked on a regular basis. In the event of an emergency evacuation from the kitchen area the procedure was to exit via the back door along the garden path and out the rear gate. However, the gate was locked and the key to unlock it was not readily available, as it was located/stored on the first floor in staff accommodation
- The escape route for residents and staff on the first and second floors was via a fire exit door located in a resident's bedroom on the first floor that lead out onto an external metal stairs into the rear garden. The resident had a key to enable him to lock his bedroom door when in or out of his bedroom, however, this factor and potential obstruction if the door was locked had not been identified or risk assessed for control purposes
- One resident's bedroom on the second floor did not have a window to provide an alternative escape route should exit from the floors below be unavailable
- Moss posing a potential slip hazard was found on the external metal stairs available as an emergency exit means to the rear garden
- The light over the external metal fire escape stairs was not functioning
- All staff had not participated in the fire evacuation drill- day or night
Other risks found in the centre included:
• a snib lock on the communal bathroom door may prevent entry in the event of an emergency or incident or if a resident may require staff or emergency support
• the nail was exposed on the wall at the side of residents wash hand basin
• a maintenance checklist or audit of the premise to include an assessment of the state of repair internally and externally to include décor, furniture, fittings and means of escape routes was not maintained or recorded
• an excessive amount of electrical extension leads and plugs were seen throughout the centre that had not been risk assessed. Inspectors were told that that the electricity supply would trip/ go off if the washing machine and dryer were used at the same time
• an out alone policy document included an insufficient timeframe of two hours before contacting gardai if a resident had not been contactable or was found to be missing
• a key to the filing cabinet where medication and confidential records of residents and staff were stored was found accessible in the staff bathroom on the first day of inspection, but, was subsequently removed by the person in charge when the associated risks were highlighted to her.

A policy for the prevention and control of infection to include vaccination, cross infection risks and the appropriate management of personal care practices including clinical waste was not available to guide practices. As highlighted on the previous inspection, suitable procedures described and arrangements seen did not promote the prevention and control of infection. For example, wash sponges and items seen in the communal bathroom were for general use by residents and tooth brushes were stored communally within a kitchen cupboard. There was no hand drying facility in the communal bathroom and paint work in parts was discoloured.

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:
The inspectors found that while arrangements were described of measures to protect residents being harmed or suffering abuse, staff had not received training in this regard which was highlighted on the previous inspection and the policy and procedures outlined required improvement to ensure residents were sufficiently safeguarded and protected by practices and persons supporting them.

While inspectors were informed that residents independently maintain personal care, a policy was not in place for providing personal intimate care to guide staff to appropriately support each resident.

Residents reported they felt safe in the centre and would speak to staff or family member about concerns. However, appropriate and suitable policies, procedures and training arrangements were not in place to ensure residents are safeguarded and protected from abuse to ensure any incidents, allegations or suspicions of abuse were recorded, appropriately investigated and responded to appropriately and ensure that there are no barriers to staff or residents disclosing abuse in line with national guidance and legislation.

Inspectors were told of one resident with behaviour that challenged, however, during discussion and from reading information within resident files it was apparent that the behaviour of another resident was also challenging for staff. There was no policy in place for the provision of positive behavioural support or record in personal plans to outline the interventions for use and evaluation. On further enquiry, inspectors found that all staff working at the centre had not received training in managing behaviour that is challenging including de-escalation and intervention techniques as required.

A policy on the use of restrictive procedures and physical, chemical and environmental restraint was not in place as required.

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

**Findings:**
The provider nominee and the person in charge told inspectors they were aware of their legal responsibilities to notify the Chief Inspector, and, where required, have notified the
Chief Inspector since the last inspection.

**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:**
The inspectors found that arrangements were in place to ensure the general welfare and development needs of residents were promoted. Residents had opportunities to experience new skills, social participation, education, training and employment. However, there was no policy on access to education, training and development.

Educational achievement of residents was evident. Arrangements were in place for residents to undergo training and development, and examples were shared of previous experiences. Ongoing assessments and established links with case workers were described for each resident by the person in charge to develop their educational, employment or training skills and potential.

Social activities, internal and external to the centre were available to residents to promote general welfare and development.

There was evidence of opportunities for residents to participate in meaningful activities, appropriate to their interests and capacities.

All of the residents communicated freely and openly with the inspectors and described their work opportunities, involvement in new experiences, social participation and education. Although transport was available for residents to attend day care/work programmes of their interest, some of the residents prefer to walk, cycle or take public transport. There was evidence of residents sustaining family links and personal relationships. Residents have a variety of technological equipment to assist in improving the general development and the quality of their lives.

**Judgment:**
Compliant
### Outcome 11. Healthcare Needs

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

**Theme:**

Health and Development

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

**Findings:**

Residents within the centre had access to a GP and dentist in the community. All residents had an assigned social worker. Residents had also been referred to an occupational therapist for assessment of independent living skills. Referral to a dietician if required could be made through HSE primary care, and the person in charge outlined plans to make referrals to a dietician pending the outcome of blood tests to be arranged.

Some improvements were required in relation to regularising and ensuring timely access to healthcare for interventions. For example, a GP’s recommendation for follow up blood testing the previous week had not been organised to date. The inspectors discussed this with the person in charge and an appointment was subsequently organised.

Residents did not have an annual health screening or check-up with their GP. The inspectors discussed this with the person in charge, who outlined the residents only attend the GP if they become unwell.

There was evidence that residents were encouraged to take responsibility for their own health and medical needs for example, inspectors were told that one resident tended to his own medication, arranging collection of medication from a local pharmacy and self-administering his own medication with staff supervision.

The fridge was stacked with ample supplies of fresh and varied food. Residents were actively involved in the preparation and cooking of their own meals. One resident was observed preparing his own lunch. There was a menu plan in place and the person in charge informed the inspector that this is discussed as part of the monthly residents meeting. Residents take turns to cook an evening meal every week; however, the person in charge informed the inspectors the evening meal plan had not changed for a number of months as per resident’s choice. Improvement was required in the area of menu planning to ensure residents had a variety in their diet and to develop a broader range of independent cooking skills.

Routine weights of residents were maintained and recorded. However, a policy and staff training (discussed in outcome 17) in relation to monitoring of nutrition, intake and weight, to include food and hand hygiene requirements was required to ensure staff were sufficiently knowledgeable to identify signs and symptoms for referral to the GP or primary care for further assessment.
As discussed in outcome 2, referral to the GP for allied healthcare assessment was dependent on staff knowledge and ability to recognise the presentation of an identified or changing need that may require further assessment as a system of regular health screening was not in place.

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
A medication management policy was not available or in place. One resident was on prescription medication for epilepsy that was stored in a filing cabinet in the staff office/room. The inspectors were informed that the resident’s condition was well controlled and he self-medicates twice a day with the supervision of staff who record this practice. Staff were unable to confirm if an examination of bloods was required or carried out as a result on being on the medication for epilepsy.

On examination of the filing cabinet, inspectors found prescription medication directed for the named residents as described by the person in charge, however, other medication was also available that had not been identified to a resident’s name. On enquiry the person in charge told inspectors and confirmed in records that two residents had been on this medication in 2013. Procedures and arrangements in relation to the storage of medication, and return and/or disposal of medication was not sufficiently safe and were unclear resulting unused stock remaining in the centre.

Inspectors were told that staff were not trained in medication administration or management (side effects), and confirmed that training in epilepsy, first aid and/or emergency response had not been provided for all staff working at the centre.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The inspectors found that the statement of purpose did not meet the requirements of the Regulations. This requirement was reported on the previous inspection in July 2014.

While the statement of purpose outlined the service that is to be provided in the centre, it was unclear or insufficiently detailed to include all requirements of schedule 1 as follows:

- criteria used for admission, including emergency admission
- the number, age and gender of residents whom it is intended to accommodate
- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing compliment was not detailed or specified
- the organisational structure of the designated centre
- the arrangements for dealing with reviews of resident’s individualised personal plan
- details of any specific therapeutic techniques used in the designated centre and arrangements for their supervision
- arrangements for residents to access education, training and employment
- arrangements for making the complaint
- arrangements for fire precautions and associated emergency procedures in the designated centre.

Inspectors were informed that the centre closes Christmas eve to 2 January each year, however this was not stated in the statement of purpose.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The inspectors found that the designated centre was not resourced to ensure the effective delivery of care and support in accordance with the aims and objectives of the designated centre. The nominated person in charge worked on a full time basis in the delivery of residents’ support care with three hours weekly allocated in respect of managerial responsibility which entails consistent monitoring. This was highlighted on the previous inspection.

An effective management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision was not evident.

Suitable and sufficient management systems were not in place to ensure the service provided is safe, appropriate to residents needs/wishes, consistent and effectively monitored, as outlined throughout outcomes within this report.

Inspectors confirmed that an annual review of a quality and safety of care and supports in the designated centre had not been completed by the registered provider.

The person nominated by the registered provider, had not carried out an unannounced visit to the designated centre at least once every six months or more frequently to prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. This requirement was highlighted on the previous inspection.

The registered provider had not ensured that effective arrangements were in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering and facilitate staff to raise concerns about the quality and safety of the care and support of residents.

Both the person in charge and the person nominated by the registered provider had been appointed to their roles since the last inspection in July 2014. Both were interviewed during this inspection and acknowledged limitations within the organisation, operational resource and their knowledge in relation the regulatory requirements of carrying on the business of a designated centre. They had limited experience and no previous involvement in the management of a designated centre; however, both told inspectors they were developing an understanding and working knowledge of regulatory requirements based on the requirements of the application process and in preparation for this announced inspection to inform a decision of registration.

While both had not been involved in the previous inspection, they were aware of the
previous inspection findings and provided inspectors with an update on the progress of the action plan and highlighted some barriers encountered for completion within specified timeframes.

Improvements were made in some outcomes of the action plan following the last inspection, however, further significant improvements were required as outlined in this report and primarily in relation to the governance and management arrangements, appropriateness of staff in positions of responsibility and as lone workers, operational systems and management of risks, provision of dedicated resources, and guidance documents or approved policies to support the operation of the service as the designated centre.

Audits and quality review meetings were not sufficiently maintained on a regular basis to identify risks, trends, determine outcomes and inform governance and management arrangements to ensure effective support to residents and to promote the delivery of safe, quality services.

Throughout the inspection the person in charge demonstrated knowledge of residents’ living in the designated centre. However, inspectors found that the designated centre was not sufficiently resourced to ensure the effective delivery of care and support in accordance with the Health Act 2007.

A lack staff personnel and/or resources was a contributory factor in excessive working hours and shift patterns rostered and in place which is discussed further in outcome 17.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
The provider nominee and person in charge were aware of the responsibility and requirement to notify the Chief Inspector of any proposed or unplanned absence of the person in charge. However, a suitable person to participate in the management of the centre during any period of absence of the person in charge had not been nominated or confirmed. This requirement was highlighted on the previous inspection.
**Judgment:**
Non Compliant - Moderate

**Outcome 16: Use of Resources**
*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

**Theme:**
Use of Resources

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

**Findings:**
The provider nominee was unsure if the designated service will be effectively resourced to meet the needs and changing needs of residents. Resources were not being regularly reviewed to ensure there were sufficient resources to meet the demands of the service to achieve its stated purpose and residents' needs.

Deficiencies in relation to the statement of purpose, premises, staff training, operational policies, administration and management arrangements, and maintenance of records was previously highlighted in July 2014 inspection and continue to require improvement.

While progress was acknowledged in parts, the recurrent non-compliance in these outcomes found on this inspection did not demonstrate the centre was sufficiently or effectively resourced to deliver a safe and appropriate service.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Responsive Workforce

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

**Findings:**
On the basis of the information available on inspection and from discussion with the provider nominee and the person in charge, the inspectors found that staffing arrangements in place did not ensure that an adequate number of appropriately skilled and trained staff were available to consistently support residents.

A lack of staff and/or resources was a contributory factor in excessive working hours and shift patterns rostered and in place. An actual and planned staff roster was available to outline staff on duty to support residents from 5pm to 9am weekly and over a 24 hour basis Saturday to Sunday. The person in charge and other support staff were rostered to work from weekly (Monday to Friday) which included a sleepover duty (00:00 to 08:00hrs). At the weekend staff worked excessive hours/shifts that were from 09:00hrs on a Saturday morning to the following Sunday morning at 09:00hrs. The provider nominee and person in charge were aware that this shift and current rostering arrangements combining working and sleepover shifts required improvement and was to be addressed. A plan was described as in process to address this matter; however, it had not been completed for implementation.

The person in charge and residents told inspectors that the staffing level of one support person was adequate to meet their support needs as they were primarily independent and said there was always a staff member available when they returned to the designated centre within the arranged support hours.

Residents were at risk due to the lack of documentary evidence of the suitability of staff members that worked directly with residents. Staff worked long shifts, alone, in an absence of appropriate training and supervision or performance review arrangements. Two staff had supervision records maintained in the centre and both highlighted a need for relevant training.

There was no training programme in place for staff. All staff working at the centre had not completed mandatory and relevant training as required. This requirement was highlighted on the previous inspection. Training in risk management, adult safeguarding and protection, fire safety, moving and handling, first aid-health and safety, infection prevention and control, food safety and nutrition, positive behaviour support, epilepsy, communication, managing behaviour that is challenging including de-escalation and intervention techniques and medication management had not been provided to all staff supporting residents and working in the centre.

The provider nominee and person in charge described the recruitment practices related to the centre. However, a policy to reflect recruitment, selection and garda vetting of staff and practices described was not in place to include procedures and documents required under schedule 2 or demonstrated in practice.

While some staff training records were available, CV’s and a garda vetting record for one staff was available; a complete file with documents in accordance with schedule 2 was not available for all staff working in the centre in accordance with the regulations.
Judgment:  
Non Compliant - Major

Outcome 18: Records and documentation  
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:  
Use of Information

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

Findings:  
The inspectors found a lack of systems in place to ensure records required under the Health Act 2007 were maintained in the centre.

All residents records were not maintained on an individual basis in residents personal files as the use of and daily log with information pertaining to all residents was completed as a daily record. Service records for all safety equipment, policy documents, communications and staff records and other general records required improvement to ensure they were maintained appropriately, available and completed.

A copy of current insurance cover for the centre and vehicle was available in the centre.

As highlighted in other outcomes and on the previous inspection, many of the required written operational policies specified in schedule 5 were not available or sufficiently detailed, dated or approved for practice that included the following:
• The prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies
• Admissions, including transfers, discharge and the temporary absence of residents
• Incidents where the resident goes missing
• Provision of personal intimate care
• Provision of behavioural support
• The use of restrictive procedures and physical, chemical and environmental restraint
• Residents personal property, personal finances and possessions
• Communication with residents
• Visitors
• Recruitment, selection and garda vetting of staff
• Staff training and development
• Monitoring and documentation of nutritional intake
• Provision of information to residents
• The creation of, access to, retention of, maintenance of and destruction of records
• Health and safety, including food safety, of residents, staff and visitors
• Risk management and emergency planning
• Medication management
• Access to education, training and development
• CCTV in use

The resident’s guide available did not reflect the premise and facilities of this centre and did not include a summary of the statement of purpose and function, contract to be agreed with residents and complaints process. This requirement was highlighted on the previous inspection.

The inspectors found that records to be completed that related to residents and staff was not sufficiently maintained in the centre. However, records available were stored securely.

A directory of each resident was available and was to be further developed to combine all residents’ information and include the requirements of the regulations.

Some records reviewed including the roster did not to include full names, the date, author and those/parties involved. As outlined in outcome 6, a record of maintenance requests and completion was not kept in the centre.

The provider nominee and person in charge was aware of the requirements in relation to the retention of records, however, a policy was not in place or completed to reflect the requirements of the legislation.

**Judgment:**
Non Compliant - Major

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Sonia McCague
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Dundalk Simon Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002413</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>06 and 07 October 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19 November 2015</td>
</tr>
</tbody>
</table>

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:
Access to advocacy services for all residents had not been facilitated.

Information on how to access an independent advocate or representative did not form part of the support services and information available to each resident.

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

**Please state the actions you have taken or are planning to take:**
Information on how to access an independent advocate or representative will form part of the support services and information available to each resident.

Access to advocacy services for all residents will be facilitated.

**Proposed Timescale:** 31/12/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangement whereby maintenance personnel employed by the provider enter the premises while residents and staff are out was not adequate or appropriate and an alternative arrangement to accessing the key or garden was required.

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

**Please state the actions you have taken or are planning to take:**
All residents and staff will be consulted re maintenance personnel accessing the house to undertake repairs when they are not in the house and same will be noted in their file.

**Proposed Timescale:** 30/11/2015

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A resident with positive behaviour support needs was accommodated in a small bedroom that had no outlook or window view.

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

**Please state the actions you have taken or are planning to take:**
Resident will be consulted re his personal preferences in regard to his room.
Proposed Timescale: 30/11/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Barriers described as preventing one resident’s assessed needs and wishes to transition to supported independent living arrangements was due to limited resources.

4. Action Required:
Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

Please state the actions you have taken or are planning to take:
All residents are now on waiting list for local authority housing.

Timescale: To be determined by Louth Local Authority

Proposed Timescale: 19/11/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An independent advocate did not form part of the arrangements to support residents for the purposes of making a complaint or in relation to decision making processes.

5. Action Required:
Under Regulation 34 (1) (c) you are required to: Ensure the resident has access to advocacy services for the purposes of making a complaint.

Please state the actions you have taken or are planning to take:
Information on how to access an independent advocate or representative will form part of the support services and information available to each resident.

Access to advocacy services for all residents will be facilitated.

Proposed Timescale: 31/12/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All complaints had not been recorded in line with the centre’s policy or regulatory
requirements. Details of investigations into all complaints, the outcome of the complaint, any action taken on foot of the complaint and whether or not the person was satisfied or informed of the appeals process was not evident as required.

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

Please state the actions you have taken or are planning to take:
All formal complaints will be recorded in line with the project’s policy or regulatory requirements by the nominated person (PIC). Details of investigations into all formal complaints, the outcome of the formal complaint, and any action taken on foot of the formal complaint will be recorded going forward.

Proposed Timescale: 30/11/2015

Outcome 05: Social Care Needs
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Healthcare plans and behaviour support plans had not been developed or recorded to inform staff of the intervention/s required to manage assessed and identified needs.

7. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident’s assessed needs.

Please state the actions you have taken or are planning to take:
An annual multi-disciplinary review on each resident will be undertaken, supported by the keyworker on the disability team, and will involve the family of each resident with the consent of that resident.

In addition healthcare plans and behaviour support plans will be developed and recorded to inform staff of the intervention/s required to manage assessed and identified needs.

Proposed Timescale: Q1 2016 onwards

Proposed Timescale: 31/03/2016
Theme: Effective Services
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no record in the assessments reviewed that residents and their families/representatives had been involved in the assessment process.

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

Please state the actions you have taken or are planning to take:
An annual multi-disciplinary review on each resident will be undertaken, supported by the keyworker on the disability team, and will involve the family of each resident with the consent of that resident.

Timescale: Q1 2016 onwards

Proposed Timescale: 31/03/2016
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no recorded evidence of review of interventions described.

9. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:
An annual multi-disciplinary review on each resident will be undertaken, supported by the keyworker on the disability team, and will involve the family of each resident with the consent of that resident.

Timescale: Q1 2016 onwards

Proposed Timescale: 31/03/2016
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no recorded evidence of multidisciplinary person plan reviews.

10. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
An annual multi-disciplinary review on each resident will be undertaken, supported by the keyworker on the disability team, and will involve the family of each resident with the consent of that resident.

Proposed Timescale: Q1 2016 onwards

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no date or signature on resident’s assessments and the inspectors could not ascertain who carried out the assessment, was there multidisciplinary input and if changes to the residents needs had been updated.

11. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
All residents’ assessments will be reviewed, signed and dated by the members of the team who undertook the assessment.

An annual multi-disciplinary review on each resident will be undertaken, supported by the keyworker on the disability team.

Proposed Timescale: Q1 2016 onwards

**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:**
Arrangements or quality reviews was not in place to ensure suitable and sufficient cleaning, repair and décor arrangements of the premises was maintained.
12. **Action Required:**
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

**Please state the actions you have taken or are planning to take:**
Arrangements are planned to review, in partnership with the residents and staff, decor preferences.

A maintenance inventory will be undertaken and priced, with costs then submitted to the HSE as a funding request.

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One resident’s bedroom was small with a single bed, that was unable to facilitate a double bed and/or an armchair and it did not have a window to provide an outlook or view of outside for the resident.

Improvements to the premise were required based on the following findings:
- carpet provided in hallways, on stairs, in bedrooms and on landing areas was unclean with dark spots seen in parts. A review of cloth furnishings was needed and a deep clean to include carpets, furniture and curtains had not taken place in the past year
- bedroom floors were cluttered which may be as the result of a lack of shelving
- chipped paintwork was seen in parts of the centre and the colour scheme required review
- grey/black stains was noted on bathroom ceilings and discolouration around the landing ski-light suggested inadequate ventilation or dampness
- cobwebs were seen in storage compartments in a residents bedroom
- windows blinds were in need of repair or replacement in the number of bedrooms
- there was no hand towel or holder at the wash hand basin in the residents bathroom
- extension leads, cables and electrical wires were seen in most rooms that may pose a risk. A review of the premises given the demand for electrical sockets resulting in many extension cables is recommended
- exterior and interior lights were not all functioning
- residents did not have a bedside lamp to facilitate easy access within and beyond their bedroom when dark
- a gap between the main/front door and the step/floor required attention

A suitable storage area for one residents bicycle (other than under the external fire escape steps) required consideration in the plan for development of the rear area and garden facilities.

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:
A review with the resident in question will be conducted in November 2016 re his room.

A maintenance inventory will be undertaken and priced, with costs then submitted to the HSE as a funding request.

Consideration will be given to suitable storage for bicycles in the plan for development of the rear area and garden facilities. Costings will be submitted to the HSE

Proposed Timescale: 31/12/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A risk management policy which included the matters set out in Regulation 26 including hazard identification and management of risks, the measures in place to control identified risks and arrangements for identification, recording, investigation and learning from serious incidents was not in place.

14. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
A review of the risk management policy within the project will be undertaken.

HSE has committed to up-skill staff on conducting risk assessment.

Proposed Timescale: Q1 2016 onwards.

Proposed Timescale: 31/03/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A risk management framework was not in place to include a risk register that identified and assessed all hazards and risks.

Adequate measures and actions were not in place to manage risks found on inspection that included the following:
• a lack of individual and operational risk assessments to ensure residents' health and safety was evident
• a lack of resources, on-going deficiencies in governance arrangements, staff training and core staff to sufficiently support the operation of a designated centre presented as a risk to the care and welfare of residents
• all staff had not received mandatory training or refresher training, and training relevant to their roles and responsibilities and competence assessments or performance reviews were not maintained
• staff were working alone with the resident group for lengthy durations of up to 16 hours
• residents’ needs may not be recognised or met as staff members lacked training, skills and/or experience relevant to their roles and responsibilities
• residents were at risk due to the lack of documentary evidence of the suitability of staff members that worked directly with residents
• a lack of written and operational policies was found
• the fire alarm system and emergency lighting had not been serviced on a regular basis
• fire evacuation arrangements were inadequate as the key to unlock the rear gate was not readily available at the fire exit
• the potential obstruction of the fire exit and escape route for those accommodated on the first and second floors was not risk assessed for control purposes
• one residents' bedroom on the second floor did not have a window to provide an alternative fire escape route should exit from the floor below be unavailable
• the external metal stairs available as an emergency exit means to the rear garden had moss posing a potential slip hazard
• the light over the external metal fire escape stairs on the first floor was not functioning
• all staff had not participated in the fire drill- day or night
• a snib lock on the communal bathroom door may prevent entry in the event of an emergency or incident or if a resident may require staff or emergency support
• the nail was exposed on the wall at the side of residents wash hand basin
• a maintenance checklist to include an assessment of fire escape routes on the regular basis was not maintained or recorded
• the key to the rear gate and filing cabinet where medication, resident and staff records were stored was accessible in the staff bathroom on the first day of inspection, but subsequently removed by the person in charge when risks were highlighted
• a maintenance checklist or audit of the premise to include an assessment of the state of repair internally and externally to include décor, furniture and fittings was not maintained or recorded
• an excessive amount of electrical extension leads and plugs were seen throughout the centre that had not been risk assessed
• an out alone policy document included an insufficient timeframe of two hours before contacting gardai if a resident had not been contactable or was found to be missing.

15. **Action Required:**
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.
Please state the actions you have taken or are planning to take:
HSE has committed to up-skill staff on conducting risk assessments

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate policies and procedures to control and respond to the risk of the unexpected absence of any resident was not in place.

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

Please state the actions you have taken or are planning to take:
The project will develop a new policy to control and respond to unexpected absence.

Proposed Timescale: Q1 2016 onwards

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate policies and procedures to control the risk of accidental injury to residents, visitors or staff was not in place.

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

Please state the actions you have taken or are planning to take:
Policies and procedures to control the risk of accidental injury to residents, visitors and/or staff will be developed.

Proposed Timescale: Q2 2016 onwards

**Proposed Timescale:** 30/06/2016
**Theme: Effective Services**

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate policies and procedures to control and manage the risk of aggression and violence was not in place.

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

Please state the actions you have taken or are planning to take:
Adequate policies and procedures to control and manage the risk of aggression and violence will be developed.

Proposed Timescale: Q2 2016 onwards

**Proposed Timescale:** 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate policies and procedures to control and manage the risk of self-harm was not in place.

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

Please state the actions you have taken or are planning to take:
Adequate policies and procedures to control and manage the risk of self-harm will be developed.

Proposed Timescale: Q2 2016 onwards

**Proposed Timescale:** 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable arrangements for identification, recording, investigation and learning from serious incidents was not in place.
20. **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:**
A policy comprising arrangements for identification, recording, investigation and learning from serious incidents will be developed.

Proposed Timescale: Q2 2016 onwards

---

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A system for assessment, management and ongoing review of risks was not in place.

A lack of awareness and knowledge of processes and systems regarding risk management was evident.

21. **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:**
HSE has committed to up-skill staff on conducting risk assessments

---

**Proposed Timescale:** 31/03/2016

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A policy for the prevention and control of infection to include vaccination, cross infection risks and the appropriate management of personal care practices including clinical waste was not available to guide practices.

Suitable procedures and training arrangements were not in place for the prevention and control of cross infection.

Personal wash sponges and items were seen in the communal bathroom that was for general use by residents., and tooth brushes were stored communally within a container in a kitchen cupboard. There was no hand drying facility in the communal
22. **Action Required:**
Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

**Please state the actions you have taken or are planning to take:**
Personal wash sponges and personal items are now segregated and a supply of paper towels will be provided immediately.

A policy for the prevention and control of infection to include vaccination, cross infection risks and the appropriate management of personal care practices, including clinical waste, will be developed to guide practice.

In addition suitable procedures and training arrangements will be put in place for the prevention and control of cross infection.

Proposed Timescale: Q2 2016 onwards

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Effective fire management systems and plans were not in place.

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

**Please state the actions you have taken or are planning to take:**
Fire officer from Louth County Council visited the project following Monitoring Visit (2014). Upgrading works were subsequently undertaken. Follow up visit with Fire officer Louth County Council planned for 2016.

Fire certificate has been forwarded to HIQA following Inspection (2015).

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place to maintain fire safety systems, means of escapes and building services.

24. **Action Required:**
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
Fire escape will be cleared of moss immediately.

Fire certificate has been forwarded to HIQA following Inspection (2015).

Follow up visit with Fire officer Louth County Council planned for 2016

**Proposed Timescale:** 30/06/2016

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A lack of daily, weekly, monthly or quarterly checks to ensure adequate precautions against the risk of fire and means of escape from the centre was found

25. **Action Required:**
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**
Daily, weekly, monthly or quarterly checks (as appropriate in keeping with guidelines) will be undertaken to ensure adequate precautions against the risk of fire and means of escape from the centre.

Proposed Timescale: November 2015 onwards

**Proposed Timescale:** 30/11/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not in place to test and maintain fire all equipment- alarm

26. **Action Required:**
Under Regulation 28 (2) (b)(iii) you are required to: Make adequate arrangements for testing fire equipment.
### Please state the actions you have taken or are planning to take:
Fire certificate forwarded to HIQA following Inspection 2015.

All fire equipment is serviced annually and recorded. Smoke alarms will be tested every month. Fire evacuation drill will be executed twice yearly unannounced and recorded.

Proposed Timescale: November 2015 onwards

---

### Proposed Timescale: 30/11/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements were not in place to ensure adequate means of escape, test and maintain emergency lighting.

27. **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:**
All fire equipment is serviced annually and recorded. Emergency lighting was reviewed in November 2015 and will be reviewed annually.

Fire evacuation drill will be executed twice yearly, unannounced and recorded.

Proposed Timescale: November 2015 and onwards.

---

### Proposed Timescale: 30/11/2015
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations was not in place.

The ground floor rear fire exit via a locked garden gate was not accessible as the key to unlock the gate was located and stored on the first floor.

The first floor escape route for residents and staff on both the first and second floors was via a fire exit door located in one resident's first floor bedroom that lead out onto
an external metal stairs also into the rear garden. The resident had a key to enable him to lock his bedroom door when in or out of his bedroom, however, this factor and potential obstruction if the door was locked had not been identified or risk assessed for control purposes to ensure adequate arrangements and or/alternatives.

Two residents bedrooms were on the second floor, however, one resident had a skylight window and did not have a window to provide an alternative escape route should exit from the first floor below be unavailable.

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

**Please state the actions you have taken or are planning to take:**
The resident in room with access to fire exit door will be asked to leave key out of door when he is in room sleeping, and spare key will be available in staff room if needed when resident is out of the house.

Adequate arrangements for evacuating all persons in the project and bringing them to safe locations will be formulated in consultation with LCC Fire Officer.

Proposed Timescale: November 2015 onwards

| **Proposed Timescale:** 30/11/2015 |
| **Theme:** Effective Services |

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not received training in fire safety and evacuation procedures

29. **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:**
Arrangements will be made for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes. Costs to be submitted to the HSE.

Proposed Timescale: December 2015 onwards
### Proposed Timescale: 30/11/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not participated in the fire evacuation drills at suitable intervals.

**30. Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
Fire evacuation drill will be executed twice yearly unannounced and recorded.

Proposed Timescale: November 2015 onwards

### 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:**
All staff working at the centre had not received training in managing behaviour that is challenging including de-escalation and intervention techniques as required.

**31. 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:**
All staff working in the project will be provided with an opportunity to have training/receive guidance in managing behaviour that is challenging, including de-escalation and intervention techniques, from the Community HSE multi-disciplinary team including the clinical psychologist.

Proposed Timescale: Q1 2016 onwards

### Proposed Timescale: 31/03/2016

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**
All staff working at the centre had not received training in safeguarding and protecting residents as required.

Appropriate and suitable policies, procedures and staff training arrangements were not in place or maintained to ensure staff are trained to detect, prevent and respond to abuse and ensure residents are safeguarded and protected.

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

**Please state the actions you have taken or are planning to take:**
Copies of the new Vulnerable Adults Policy (VAP) have been made available within the project.

Details of the role of the recently appointed safe guarding team (Area 8) will be forwarded to the project once the team has bedded down.

All staff working in the project will be provided with an opportunity to have training /guidance to detect, prevent and respond to abuse, and to ensure residents are safeguarded and protected from the community, by HSE multi-disciplinary team including the clinical psychologist.

Proposed Timescale: Q1 2016 onwards

**Proposed Timescale:** 31/03/2016

**Outcome 11. Healthcare Needs**
**Theme:** Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have an annual health screening or regular check-up with their GP.

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

**Please state the actions you have taken or are planning to take:**
Annual medical, dental and other health related reviews will be planned for all residents in partnership with the HSE Adult ID multi-disciplinary team and the clients’ GP, families and carers.
<table>
<thead>
<tr>
<th>Proposed Timescale: Q1 2016 onwards</th>
</tr>
</thead>
</table>

**Proposed Timescale:** 25/01/2016  
**Theme:** Health and Development  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some improvements were required in relation to timely access to healthcare for interventions.

34. **Action Required:**  
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

**Please state the actions you have taken or are planning to take:**  
Annual medical reviews will be planned for all residents.

Proposed Timescale: Q1 2016 onwards

<table>
<thead>
<tr>
<th>Proposed Timescale: 25/01/2016</th>
</tr>
</thead>
</table>

**Proposed Timescale:** 25/01/2016  
**Theme:** Health and Development  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Improvement was required in menu planning to ensure residents had a variety in their diet and to develop a broader range of independent cooking skills.

35. **Action Required:**  
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

**Please state the actions you have taken or are planning to take:**  
New menu options have been implemented and will be reviewed formatively.

The service will develop a broader range of independent cooking skills opportunities in line with the residents’ individual choice.

Proposed Timescale: November 2015 onwards

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/11/2015</th>
</tr>
</thead>
</table>

---

Page 47 of 59
### Outcome 12. Medication Management

**Theme:** Health and Development

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

A medication management policy was not available to guide place.

Procedures and arrangements in relation to the storage of medication, return and/or disposal of medication was not sufficient to guide safe practice as medication not in use since 2013 remained in the centre.

Staff were not trained in medication administration, supervision or management.

Staff were not trained in epilepsy, first aid and/or emergency response to ensure appropriate and suitable practices.

#### 36. Action Required:

Under Regulation 29 (4) (c) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

Out of date medication has been disposed of since Inspection (2015). Going forward, monthly audits of the medication in the service will take place to ensure no out of date medicines are in the house.

First aid training has been undertaken to NFQ 5 since Inspection (2015).

At the time of inspection, only one client was taking medication and he was self-administering with oversight from the staff. Training for staff in the self-administration of medication will be provided. Costs to be provided to the HSE.

Brainwave will be contacted to provide training for staff in management of epilepsy.

Proposed Timescale: Q1 2016 onwards

**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:**
The statement of purpose did not meet the requirements of the Regulations.

The statement of purpose was unclear or insufficiently detailed to include all requirements of schedule 1 as follows:

- criteria used for admission, including emergency admission
- the number, age and gender of residents whom it is intended to accommodate
- the total staffing complement, in full-time equivalents, for the designated centre with the management and staffing compliment was not detailed or specified
- the organisational structure of the designated centre
- the arrangements for dealing with reviews of resident’s individualised personal plan
- details of any specific therapeutic techniques used in the designated centre and arrangements for their supervision
- arrangements for residents to access education, training and employment
- arrangements for making the complaint
- arrangements for fire precautions and associated emergency procedures in the designated centre.

Inspectors were informed that the centre closes Christmas eve to 2 January each year, however this was not stated in the statement of purpose.

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

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be reviewed in light of the issues raised by the Inspectors with the support of the HSE.

Proposed Timescale: December 2015 onwards

### Proposed Timescale: 31/12/2015

---

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that the designated centre was not sufficiently resourced to ensure all staff had the necessary qualifications, skills and experience to effectively deliver care and support in accordance with the aims and objectives of the designated centre.

The nominated person in charge works full time in the delivery of residents’ care and had been allocated three hours weekly in respect of managerial responsibility which entails consistent monitoring.
38. **Action Required:**
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**
The Review of the staffing complement in partnership with the HSE Louth Disability Service is underway.

Proposed Timescale: November 2015 onwards

A person in charge with the necessary qualifications, skills and experience is being recruited.

---

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An effective management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision was not evident.

39. **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:**
The management structure for the Project already provided has identified the lines of authority and accountability and specifies roles and details responsibilities for all areas of service provision.

An update on this structure will be notified following review of the staffing in partnership with the HSE in 2016.

---

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
Suitable and sufficient management systems were not in place to ensure the service provided is safe, appropriate to residents' needs/wishes, consistent and effectively monitored, as outlined throughout this report.

40. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
Review of the staffing complement in partnership with the HSE Louth Disability Service is underway. Management system will be included in the overarching review.

Proposed Timescale: November 2015 onwards

---

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

The Registered Providers is failing to comply with a regulatory requirement in the following respect:
An annual review of a quality and safety of care and supports in the designated centre had not been completed by the registered provider.

This requirement was reported following the previous inspection in July 2014.

41. **Action Required:**
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

**Please state the actions you have taken or are planning to take:**
The Provider Nominee will undertake an annual review of the quality and safety of care and support in the project and will ensure that such care and support is in accordance with standards.

Proposed Timescale: Q2 2016 and annually thereafter

---

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in
The person nominated by the registered provider, had not carried out an unannounced visit to the designated centre at least once every six months or more frequently to prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

**Please state the actions you have taken or are planning to take:**
The Provider Nominee will undertake a bi-annual review of the quality and safety of care and support in the project and will ensure that such care and support is in accordance with standards.

Proposed Timescale: Q2 2016 and every six months thereafter.

---

**Proposed Timescale:** 31/03/2016  
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider had not ensured that effective arrangements were in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they were delivering.

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

**Please state the actions you have taken or are planning to take:**
Regular meetings every 3 weeks have been undertaken as a matter of practice by the Provider Nominee with the PIC. It is now planned to minute these meeting.

Proposed Timescale: December 2015 onwards
<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>Suitable arrangements were not in place to facilitate staff to raise concerns about the quality and safety of the care and support of residents.</td>
</tr>
<tr>
<td><strong>44. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>Regular meetings every 3 weeks have been undertaken as a matter of practice by the Provider Nominee with the PIC. It is now planned to minute these meetings.</td>
</tr>
<tr>
<td>Proposed Timescale: December 2015 onwards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/12/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 15: Absence of the person in charge</strong></td>
</tr>
<tr>
<td><strong>Theme:</strong> Leadership, Governance and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>A suitable person to participate in the management of the centre during any period of absence of the person in charge had not been confirmed.</td>
</tr>
<tr>
<td><strong>45. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 33 (1) you are required to: Notify the chief inspector in writing of the procedures and arrangements that are or will be in place for the management of the designated centre during the absence of the person in charge.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>A review of the staffing complement in partnership with the HSE Louth Disability Service has commenced. Costing to be submitted to the HSE</td>
</tr>
<tr>
<td>Proposed Timescale: November 2015 onwards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/11/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 16: Use of Resources</strong></td>
</tr>
</tbody>
</table>
Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider nominee was unsure if the designated service will be effectively resourced to meet the needs and changing needs of residents.

Resources were not being regularly reviewed to ensure there were sufficient resources to meet the demands of the service to achieve it stated purpose, aims and objectives, and residents needs.

Deficiencies in relation to the statement of purpose, premises, staff training, operational policies, administration and management arrangements and maintenance of records was previously highlighted in July 2024 inspection.

Recurrent non compliance in these outcomes found on this inspection did not demonstrate that the centre was sufficiently resourced for the delivery of care.

The nominated person in charge worked on a full time basis in the delivery of residents’ support care with three hours weekly allocated in respect of managerial responsibility for monitoring.

46. 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:
Review of the staffing complement and the service delivery model, taking consideration the changing needs of the residents, in partnership with the HSE Louth Disability Service, has commenced. Costing to be submitted to the HSE.

Proposed Timescale: November 2015 onwards

Proposed Timescale: 30/11/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing arrangements in place did not ensure that an adequate number of core staff were available who were appropriately skilled and trained to support residents.

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

**Please state the actions you have taken or are planning to take:**
Review of the staffing complement and the service delivery model, taking consideration the changing needs of the residents, in partnership with the HSE Louth Disability Service, has commenced. Costing to be submitted to the HSE.

Proposed Timescale: November 2015 onwards

<table>
<thead>
<tr>
<th>Proposed Timescale: 30/11/2015</th>
<th>Theme: Responsive Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>A complete file with documents in accordance with schedule 2 was not available for all staff working in the centre in accordance with the regulations.</td>
</tr>
<tr>
<td><strong>48. Action Required:</strong></td>
<td>Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>HR staff files will be compiled with required documentation and held securely at the residential project.</td>
</tr>
<tr>
<td>Proposed Timescale: Q1 2016 onwards</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/03/2016</th>
<th>Theme: Responsive Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>There was no training programme in place for staff.</td>
</tr>
<tr>
<td><strong>All staff had not completed mandatory and relevant training prior to working at the centre.</strong></td>
<td></td>
</tr>
<tr>
<td>Training in adult safeguarding and protection, fire safety, moving and handling, first aid-health and safety, infection prevention and control, food safety and nutrition, positive behaviour support, communication, managing behaviour that is challenging including de-escalation and intervention techniques and medication management had</td>
<td></td>
</tr>
</tbody>
</table>
not been provided to all staff supporting residents and working in the centre.

Staff did not have relevant and consistent training to ensure they were sufficiently knowledgeable to identify a need for further assessment and referral to GP or Allied Health Care professional.

49. **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:**
Regular staff supervision schedule will be drawn up where each staff member will receive supervision regularly undertaken by the PIC and this meeting will be recorded.

During these sessions training needs analysis will be undertaken and a training plan will be made to move towards addressing same.

Proposed Timescale: Q1 2016 onwards

**Proposed Timescale:** 31/03/2016

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An absence of appropriate supervision or performance review arrangements was found.

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

**Please state the actions you have taken or are planning to take:**
Regular staff supervision schedule will be drawn up where each staff member will receive supervision regularly undertaken by the PIC and this meeting will be recorded.

Proposed Timescale: Q1 2016 onwards

**Proposed Timescale:** 31/03/2016

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

Policies required and specified in schedule 5 were not available or sufficiently detailed, dated or approved for practice that included the following:

- The prevention, detection and response to abuse, including reporting of concerns and/or allegations of abuse to statutory agencies
- Admissions, including transfers, discharge and the temporary absence of residents
- Incidents where the resident goes missing
- Provision of personal intimate care
- Provision of behavioural support
- The use of restrictive procedures and physical, chemical and environmental restraint
- Residents personal property, personal finances and possessions
- Communication with residents
- Visitors
- Recruitment, selection and garda vetting of staff
- Staff training and development
- Monitoring and documentation of nutritional intake
- Provision of information to residents
- The creation of, access to, retention of, maintenance of and destruction of records
- Health and safety, including food safety, of residents, staff and visitors
- Risk management and emergency planning
- Medication management
- Access to education, training and development
- CCTV in use

51. Action Required:

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

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

VAP has been provided to staff in the project.

Support will be provided to staff within the project with regard to implementation of the VAP by the Assistant Director of Nursing Louth Disability Services.

Proposed Timescale: Q1 2016 onwards

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Use of Information</td>
</tr>
</tbody>
</table>

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

The resident’s guide available did not reflect the premise and facilities of this centre and did not include a summary of the statement of purpose and function, contract to be agreed with residents and complaints process.
52. Action Required:
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
A new residents guide will be put together in 2016

Proposed Timescale: Q2 2016 and updated thereafter

Proposed Timescale: 31/03/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A guide in respect of the designated centre and service had not been prepared.

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

Please state the actions you have taken or are planning to take:
A new residents guide will be put together in 2016

Proposed Timescale: Q2 2016 and updated thereafter

Proposed Timescale: 30/06/2016

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of the information and documents in relation to staff specified in Schedule 2 were not available.

54. 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.
<table>
<thead>
<tr>
<th>Please state the actions you have taken or are planning to take:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR staff files will be compiled with required documentation and held securely at the residential project.</td>
</tr>
<tr>
<td>Proposed Timescale: Q1 2016 onwards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Use of Information</td>
</tr>
</tbody>
</table>

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All records to be completed that related to residents and staff was not sufficiently maintained in the centre.

**55.  Action Required:**
Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
HR staff files will be compiled with required documentation and held securely at the residential project.

Proposed Timescale: Q1 2016 onwards.

| Proposed Timescale: 31/03/2016 |