

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0002469
<b>Centre county:</b>	Westmeath
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Joseph Ruane
<b>Lead inspector:</b>	Jillian Connolly
<b>Support inspector(s):</b>	Paul Pearson
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	5
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
06 August 2015 11:00	06 August 2015 15:00
07 August 2015 09:30	07 August 2015 16:30

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

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

**Summary of findings from this inspection**

Inspectors undertook ten inspections in eight centres operated by the Health Service Executive (HSE) through St Peter's Services in Westmeath in 2015, four of which were announced and six unannounced.

These inspections found evidence of poor outcomes for residents and areas of risk to residents relating to safeguarding and health and safety. Poor managerial oversight and governance arrangements were also a recurrent finding in these designated centres. Due to the seriousness of the concerns, HIQA issued immediate actions and warning letters. Regulatory and escalation meetings were also held with the provider and members of senior management of the Health Service Executive.

Due to the overall failure of the provider to implement effective improvements for residents identified throughout all inspections, a notice of proposal to refuse the registration of one of the centres was issued. Following on from this, the provider informed the Chief Inspector of their intention to cease the operation of four houses within the region. The purpose of this was to consolidate the staffing levels in the remaining twelve houses.

HIQA has been informed by the provider that the process for assuming operational and governance responsibility is now complete and the contract has been awarded to another service provider.

HIQA will continue to monitor these centres to ensure that the actions taken by the provider are sustained and result in continued improvements to the safety and quality of life of residents.

This inspection was conducted to follow up on matters arising from an inspection in April 2015. The inspection conducted in April 2015 was completed following an application by the provider to register the designated centre under the Health Act 2007. Major non - compliance was identified in ten of the eighteen outcomes inspected at this time. A regulatory meeting was held with the provider in May 2015 following the registration inspection in which the concerns of the Chief Inspector were communicated to the provider. Therefore the purpose of this inspection was to identify the progress made by the provider towards achieving compliance prior to a decision being made regarding the application to register the centre by the Chief Inspector.

The designated centre is located in Co. Westmeath and is operated by the Health Service Executive. The application to register was for five residents. This was the third inspection of the designated centre, with the first being conducted in November 2014. The inspection was facilitated by staff in the designated centre and feedback was provided to the provider nominee and the person in charge on the conclusion of the inspection.

Fifteen Outcomes were inspected, with major non compliance identified in them all. Inspectors found in the main, that an inappropriate or disproportionate response had been taken by the registered provider to ensure that the services provided were safe and effective.

There was repeated non compliance with regulations identified by inspectors and the absence of sustained improvement inclusive of the following areas,

- an absence of consistent meaningful opportunities for personal development of residents
- an absence of appropriate risk management
- an absence of actions following consultation with residents
- an absence of continuity of care
- an absence of nursing support when required
- an absence of staff supervision
- an inadequate response to previous failings identified by inspectors
- an absence of the review of the quality and safety of care to residents

- an absence of action to ensure residents are safeguarded against all forms of abuse

Fundamentally the inspectors found that there was an absence of continuity of care to residents which resulted in negative outcomes for residents.

There were thirty three breaches in regulation identified, twenty one of which are the responsibility of the provider and twelve of which are the responsibility of the person in charge and are outlined in the body of this report.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

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

**Findings:**

There were four failings identified in the registration inspection conducted in April 2015 in respect of ensuring that the dignity and respect of residents was maintained. There was an absence of evidence to support that residents were consulted and participate in the running of the designated centre in previous inspections.

The registered provider responded by stating that the person in charge would conduct monthly meetings in the designated centre with the residents. Inspectors confirmed that the meetings had commenced however, evidence did not support that these meetings were purposeful due to the absence of actions arising from these meetings. For example, the minutes of the meetings stated that residents expressed a wish to go on holidays. This had been discussed at more than one meeting however, there was no evidence that action had been taken to ascertain if this was achievable.

Inspectors identified non compliance in April 2015 with Regulation 9 (3) as the privacy and dignity of residents was not respected as:

- twin room was not fit for purpose
- personal documentation of residents was stored in an insecure location
- personal information was discussed in front of residents.

Inspectors found on this inspection that the actions as stated by the provider in the action plan response had been partially addressed. For example, inspectors did not observe personal information of residents being openly discussed. However, the inspectors noted that some personal information of residents remained stored in a

location easily accessible to all in the designated centre. The unsuitability of the twin room had not been addressed.

Inspectors reviewed the systems in place regarding the personal possessions of residents. Inspectors confirmed that a record was maintained of all personal possessions of residents as stated by the provider in the response to the previous action plan.

There was a breach of regulation 13 (2) (b) in April 2015, as evidence did not support that the activities offered to residents were in line with their interests and abilities. From a review of documentation and through observing practice, it was clear that there had been an improvement in the number of activities offered to residents. For example, inspectors observed residents accessing external service providers and being supported by residential staff.

However, whilst there was an increase in activities the evidence did not adequately support that the activities were in line with the interests and abilities of residents. This was due to an absence of assessment and social care plans and subsequent evaluation of the activities. The registered provider had also stated that each resident would be facilitated by their key worker to develop a meaningful activity plan including activities in accordance with their interests by 31 July 2015. This had not occurred as of the day of inspection.

Of the sample of activities reviewed, it was unclear if the activities offered were meaningful to the resident. For example, being outside and utilising the swing chair in the grounds of the centre was considered an activity. As with the findings of April 2015, the majority of activities offered were a walk/drive/shopping.

**Judgment:**  
Non Compliant - Major

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

**Findings:**  
There were two failings identified during the registration inspection, in respect of this outcome as there was inadequate day care provision and residents were not encouraged to be active members of the community. As stated previously, there had been improvements in the provision of day service for some resident. The provider had

increased the support hours available within the designated centre to support residents to access day service. Additional supports had also been sourced externally on a part time basis for some residents.

However, a limitation to the success of the internal activities/support was the regular utilisation of unfamiliar staff in the designated centre. Inspectors were informed by staff that it was challenging to plan activities for residents due to the inconsistency of staff and this was used as a rationale for the absence of meaningful days for residents.

The registered provider stated in the response to the action plan arising from the previous inspection that the person in charge would develop links with the community. However, the person in charge did not have adequate protected time for management within the designated centre and this action had not been completed.

**Judgment:**  
Non Compliant - Major

**Outcome 04: Admissions and Contract for the Provision of Services**

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

**Theme:**  
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

An action arising from the previous inspection was that the written agreements between the resident and the registered provider had not been signed. The registered provider had stated that this would be completed by the 30 June 2015. Whilst action had been taken to address this failing, non – compliance remained. Of the sample of agreements reviewed, inspectors found that some remained unsigned.

Of the written agreements signed, there was an absence of the detail of fees that residents pay. A template was in place to assist staff with conducting an assessment of the capacity of an individual to sign their written agreement. These assessments were not completed in their entirety but staff had signed that they deemed the resident to have the capacity to sign the contract. There was also an instance identified by inspectors where residents had purchased food outside that of the terms of the written agreement due to an absence of resources.

**Judgment:**  
Non Compliant - Major



**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

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

**Findings:**

In April 2015, inspectors found that the personal plans of residents were completed by one staff member. The registered provider responded by stating that three monthly reviews would be completed for all residents in the designated centre and would include individuals nominated by the residents, their representatives and members of the multi disciplinary team. This was to be completed by the 31 July 2015.

Inspectors found no evidence that this had occurred. Personal plans did not outline the supports residents required in April 2015. The action plan submitted by the provider was that all person centred plans would be reviewed at person centred planning meetings by the 31 July 2015. This had not occurred as of the day of inspection.

Inspectors reviewed a sample of personal plans and found there were minimal changes since the previous inspection. The changes identified primarily addressed healthcare needs. As stated in the report of April 2015, each of the residents had an assessment in place which identified their health and social care needs. From this plans of care/goals were developed. The findings remained the same as of this inspection.

Inspectors found the goals to remain short term and did not promote skill building of lifelong learning. Goals included going swimming, going on holidays over the summer or visiting the family home of residents. There remained an absence of assessment of how the goals would be achieved and the supports required. In the main, there was no evidence of achievement.

There was evidence of a resident being supported to go swimming by the newly sourced day service. However, there was no evidence of plans for holidays or other goals. As stated in Outcome 1, this was also raised by residents in the recently implemented residents' meetings. It was also a recommendation in a positive behaviour support plan. However, there was no evidence that action had occurred to address achievement of same.

There was an absence of staff signatures and dates in which assessments/personal plans were completed. This had been identified on previous inspections. Due to the continuous failings and absence of sufficient improvement since the initial inspection in November 2014, staff were not yet supported to develop the skill set and competency necessary to assist residents in meeting their social care needs.

**Judgment:**  
Non Compliant - Major

**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:**

As stated in Outcome 1, inspectors had previously identified that the twin room was not fit for purpose. Inspectors also found in April 2015 that there was insufficient communal space. The registered provider informed the Chief Inspector of their intention to renovate the premises by June 2016. The provider stated that costed plans would be forwarded to the Chief Inspector by 31 August 2015. As compliance is not attended to be achieved until June 2016, the failing is repeated at the end of this report.

Inspectors further found that the main bathroom was not clean as of the announced inspection in April 2015. Inspectors found that the provider had satisfactorily addressed this failing on this unannounced inspection.

**Judgment:**  
Non Compliant - Major

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

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

**Theme:**  
Effective Services

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

No actions were required from the previous inspection.

**Findings:**

In April 2015, inspectors found that the systems in place for the management of risk were inadequate and not implemented in practice. Inspectors found on this inspection that the specific actions as stated by the provider in the action plan response had been taken.

However, the assessments conducted did not adequately reflect the actual level of risk within the designated centre. For example, an assessment had been conducted to ascertain the risk present to residents in the absence of a nurse being on duty in the centre. This had been risk rated as medium. Considering all of the factors inclusive of the needs of the residents and the impact to the safety of residents if an incident such as a seizure occurred in the absence of a nurse, inspectors deemed the actual risk as high. This was due to the provider not ensuring that non nursing staff had the necessary training and skill set to support residents in the absence of nursing staff. There had been incidences when there had been no nurse on duty for the centre.

An assessment had also been conducted on the risk of residents being absent without leave as stated in the action plan response to the April 2015 inspection. One control measure was that the front door would remain locked at all times. This was also a control measure in place in April 2015. In April 2015, inspectors deemed this to be ineffective as they observed the door to be unlocked. Inspectors found that the door remained unlocked at times on this inspection.

A risk assessment had also been conducted to assess the service user experience due to a high volume of unfamiliar staff. This had been deemed a low risk to residents. The cumulative findings of this inspection and the outcomes for residents are indicative that this is an invalid rating.

Inspectors found that the final exits were key operated which could result in unnecessary delay in the event of an emergency. The provider had stated in the action plan response that this would be addressed by the 31 August 2015. However inspectors determined that this time frame was inadequate, as a report commissioned by the registered provider from an external expert in fire management had identified this in March 2015 and recommended that this be completed within a three month period i.e. June 2015.

Inspectors also reviewed the personal evacuation plans of residents and found them to be not reflective of the actual circumstances. For example, it stated as a control measure that there is always two staff members present in the designated centre. Inspectors observed at times there was only one staff present. A review of the rosters also confirmed that there had been times were a staff member was lone working. The risk assessment also stated that fire drills take place weekly. However, the records maintained demonstrated that there had not been a fire drill conducted since the previous inspection.

On this inspection, inspectors observed residents going out utilising the transport provided by the registered provider. Inspectors queried with staff had they submitted evidence to the provider of their competency to drive i.e. a driving licence. Staff stated they had not. On review of staff files as stated in Outcome 18, inspectors confirmed this. Inspectors determined a considerable risk to be present to the welfare of residents as there was no evidence that staff were competent to drive.

**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:**

In November 2014, inspectors found that whilst there were policies and procedures in place, incidents of unexplained bruising had not been investigated in line with the organisational policy. The provider stated in their response to the failing that an investigation was conducted with immediate effect. This investigation had been submitted to the Chief Inspector and had substantiated the findings of inspectors.

On this inspection it was identified both through the progress notes of residents and through accident/incident forms, that incidences which could be considered allegations or suspicions of abuse had not been investigated in line with organisation policy. These incidents had occurred post April 2015 and included verbal allegations by residents and incidents of unexplained bruising.

Inspectors reviewed the training records for staff and found that staff had not received up to date training and that there had been no change to number of staff who had read the policy on safeguarding implemented by the Health Service Executive in December 2014. Management at the feedback meeting stated to their knowledge all staff had received the training but the records or staff knowledge were not indicative of same.

Staff were not clear on who the designated liaison person was for the service. Agency staff interviewed stated that they had heard of the policy however, had not been trained or inducted in same.

In April 2015, inspectors found that residents were individually accessing services from external providers without the supervision of staff. However, there was no evidence that the external providers had received the appropriate Garda vetting. The provider had stated in the action plan response that Garda vetting would be obtained for all external staff. In the interim, staff would supervise the activities.

As of the day of inspection, this Garda Vetting had yet to be obtained and inspectors observed that residents continued to access external activities without the supervision of staff. When this practice was queried with staff, staff stated that they were not aware of the requirement to supervise residents in this context. Inspectors also found that one staff member did not have confirmation of Garda clearance in their staff file.

Inspectors reviewed the systems in place for the safeguarding of residents' personal finances and were not assured that the practice in the designated centre was robust. Inspectors found instances in which residents' personal funds were utilised for items outside of the terms of the written agreements. There was no evidence that residents had consented to same.

There was one failing identified in respect of positive behaviour support in April 2015. This was as the provider had stated that following the November 2014 inspection, all staff employed in the designated centre would receive training in positive behaviour support by January 2015. This had not occurred by the announced inspection in April 2015. The absence of this training resulted in no evidence that staff had implemented proactive and reactive strategies to assist with behaviours identified.

The provider stated that a review would be conducted by the 22 July 2015. Inspectors found that this had not occurred and it remained challenging to ascertain the strategies utilised by staff to support residents.

There was also evidence of an absence of consistent support to residents who required same. There was evidence that this had a significant impact on the quality of their life however, support from the appropriate discipline such as psychiatry had not occurred due to staff shortages and an absence of continuity of care.

**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:**

As stated in Outcome 8, inspectors found incidences which could be classified as allegations or suspicions of abuse. However, as they had not been processed in line with national policy, the Chief Inspector had not been notified as required by Regulation 31.

There was also an absence of notifications informing the Chief Inspector of the change to the person in charge as required by Regulation 14 and 32.

**Judgment:**

Non Compliant - Major

**Outcome 10. General Welfare and Development**

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

**Theme:**

Health and Development

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

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

**Findings:**

A failing of regulation 13 (4) (a) was identified in April 2015, as residents did not engage in activities that promoted skill building and lifelong learning. As stated previously, progress had been achieved in this area and there had been an increase in the day care provision provided to residents.

However, improvements were still required to ensure that residents who did not have the opportunity to engage in a formal day service had the opportunity for education, training and development. The provider had stated in the action plan response that this would be achieved by April 2015, but this had not occurred as of the day of inspection.

**Judgment:**

Non Compliant - Major

## Outcome 11. Healthcare Needs

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

### Theme:

Health and Development

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

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

### Findings:

Inspectors found in April 2015, that residents who had a diagnosis of epilepsy were at risk if a registered nurse was not present. The registered provider responded by stating that all staff would receive training in medication required by residents in the event of a seizure. This was to be completed by the 31 July 2015. As of the day of inspection, this had not occurred.

Findings on this inspection further demonstrated that there was a significant risk to residents. For example, there was an incident in which residents did not receive any of their medication at the prescribed time due to the absence of a nurse. On the day of inspection, staff responsible for the welfare of residents were also not aware of their diagnosis of epilepsy.

Inspectors found that there was an absence of care plans in place for residents with a diagnosis of epilepsy. Inspectors were informed that they were available in draft form, but as the care plans were not available in the personal plans of residents it was of no benefit.

There was evidence that when an acute health care need arose for a resident, such as the commencement of antibiotics, a plan of care was put in place. Inspectors found that there had been a substantial improvement in residents' access to allied health professionals. Further improvement was required as there was evidence of resident's health care needs not being appropriately assessed despite evidence supporting that there was a change in the resident's needs.

For example, there was residents who were documented as being on a weight reducing diet. However, this was not under the guidance of the appropriate allied health professional. There was evidence of a dramatic weight loss in a short period of time and this had not been referred to the General Practitioner (GP).

Inspectors found where residents' blood pressure was different to that of their base line, a review had not occurred. It was documented that a resident required an x ray in June 2015 yet no referral had been made as of this inspection. There was also, as stated in Outcome 8, evidence of residents requiring access to allied health professionals and this not being facilitated due to staffing levels.

As stated in the action plan response, improvements had been achieved in documenting the nutritional intake of residents. However, inspectors found the primary focus of this was on residents' food intake as opposed to fluid intake and this required review.

**Judgment:**  
Non Compliant - Major

### **Outcome 12. Medication Management**

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

**Theme:**  
Health and Development

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

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

#### **Findings:**

An action arising from the previous inspection was that whilst medication errors were recorded, there was no evidence that adequate control measures or actions had resulted to reduce the likelihood of a re-occurrence.

On this inspection, inspectors found that inadequate measures had been implemented to action this failing. There was an occasion identified where residents did not receive their medication. Whilst some actions had been taken in line with policy post this incident, these were not effective in assuring compliance or adhering to the centres policy.

**Judgment:**  
Non Compliant - Major

### **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:**

Since the inspection in April 2015, there had been a change to the person in charge of the designated centre. This was the third individual nominated to be the person in charge of the designated centre.

The new person in charge has the responsibility of two designated centres. Inspectors were informed that the person in charge was included in the staffing compliment for the other designated centre in which they have responsibility for. This results in them completing day and night duty. Inspectors were informed that due to this structure, the person in charge was not in a position to actively participate in the management of the designated centre and the findings of this inspection were reflective of this.

Staff stated that the person in charge was not a regular presence in the designated centre. Inspectors determined that this was an unsatisfactory arrangement and fundamentally impacted on the ability of improvement to occur, compliance with regulations to be achieved and ultimately, positive outcomes for residents.

The cumulative findings of this inspection, further evidence that the governance and management systems were ineffective. The person in charge reported to the assistant director of nursing, who in turn reported to the disability manager. The disability manager reported to the general manager. The general manager is the person nominated on behalf of the provider.

The repeated non – compliance identified by inspectors and the absence of sustained improvement inclusive of the following:

- an absence of consistent meaningful opportunities for personal development of residents
- an absence of appropriate risk management
- an absence of actions following consultation with residents
- an absence of continuity of care
- an absence of nursing support when required
- an absence of staff supervision
- an inadequate response to previous failings identified by inspectors
- an absence of the review of the quality and safety of care to residents
- an absence of action to ensure residents are safeguarded against all forms of abuse.

Therefore the failings from the previous inspection are repeated in this report.

**Judgment:**

Non Compliant - Major

**Outcome 16: Use of Resources**

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

**Theme:**

Use of Resources

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

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

**Findings:**

Inspectors reviewed the staffing compliment assigned to the designated centre and found that at the time of inspection, staffing levels were sufficient to meet the needs of the residents. There were occasions identified from records in which the staffing levels were below the standard compliment and this had resulted in negative outcomes for resident and risk to residents such as the omission of administering medication.

The provider had increased the compliment of staffing as of the previous inspection and had further increased the opportunities for some residents to access formal day programmes facilitated by staff external to the designated centre.

However, the cumulative findings of this inspection is that whilst the staffing levels appeared to meet the needs of residents, the centre remained insufficiently resourced to ensure compliance with Regulation 23 (1) (a) as the delivery of care and support was not shown to be effective.

**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:**

Inspectors reviewed the four matters arising from the previous inspection and found the actions stated by the provider had not been completed as per the action plan response submitted to the Chief Inspector. Whilst, as stated previously, there had been an increase in the number of staff in the designated centre, the impact this had on the improvement to the quality of life of residents was negligible.

The provider had stated in the action plan response to the failing of regulation 15 (1) that a review would be undertaken of the structure of the designated centre and that a deputy person in charge would be appointed. The time-frame provided for this to occur was 31 August 2015, therefore had not been reached as of the day of inspection. However, in the interim, the changes observed by inspectors consisted of the removal of a full time person in charge for the designated centre, to a person in charge shared with another designated centre. This resulted in a decrease in the resources available for the governance and management of the designated centre as opposed to an increase. As a result, the evidence did not support that staff had been provided with the support necessary to develop the skill to ensure residents were supported to engage in a meaningful and purposeful activity.

The registered provider had stated that staff would receive supervision every eight weeks however, this had not occurred as of the day of inspection and staff confirmed that they had not received supervision by members of the management team.

The absence of supporting residents to experience positive outcomes was further impacted by the regular use of unfamiliar staff in the designated centre. At the time of writing this report, the registered provider was required to submit weekly reports to the Authority.

One aspect which required reporting upon was the use of non – permanent staff in the designated centre. A desk top review of the reports since the last inspection demonstrated that unfamiliar staff were utilised regularly with total hours varying from 85.75 hours per week to the highest being 194.25 hours per week.

Each unfamiliar staff in the centre is required to complete an induction within the designated centre. A review of these inductions by inspectors, evidenced that twenty six new staff had been employed to work in the residents' home since December 2014. The management team stated that they had been endeavouring to secure familiar staff to support residents, but there was an absence of continuity of care evident throughout the findings of this inspection. Nursing care was, as identified elsewhere in this report, not always available.

Staff still required additional supports to have the skill set and competency to ensure positive outcomes for residents. Inspectors reviewed the training records for staff in the designated centre and found that the training as stated by the registered provider had not been completed in the appropriate time frame. This included:

- Medication Management
- Positive Behaviour Support
- Protection of Vulnerable Adults

**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:**  
A failing identified on the previous inspection was that of the sample of staff files reviewed there was no proof of identity for staff and this was still the case. The provider had not completed the action from the previous inspection in relation to this. The provider also did not have proof that staff had a valid driver's licence.

There was no record to support that one staff had received Garda Vetting.

As stated in Outcome 5, there remained an absence of staff signatures and dates on documentation. The record of the nutritional intake required improvement as it primarily focused on food intake as opposed to fluid intake.

**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:***

Jillian Connolly  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0002469
<b>Date of Inspection:</b>	06 August 2015
<b>Date of response:</b>	27 August 2015

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

The minutes of resident's meeting did not demonstrate that outcomes and requests were purposeful and resulted in action.

<sup>1</sup> 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) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

The weekly residents meeting currently taking place has identified plans and goals for the week ahead, one staff member has been identified who will chair this meeting initially and guide the service users in identifying goals and formulating a weekly plan. The local weekly paper is being purchased and discussed at the meeting to help identify upcoming events. Menus are agreed for the week and a review of the past weeks events takes place The presence of a full time person in charge will ensure the plans identified are followed through

**Proposed Timescale:** 24/08/2016

**Theme:** Individualised Supports and Care

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

The privacy and dignity of residents was not respected in that

- twin room was not fit for purpose
- personal information was discussed in front of all residents

**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:**

Hand over between shifts now takes place in the utility room. Staff have been reminded of the importance of maintaining confidentiality and this is reflected in the minutes of the house meeting of 20/08/2015

A protocol is being drawn up in conjunction with the two service users around bed times and use of the en-suite, this is in the absence of the extension to the house which is at the planning stage.

**Proposed Timescale:** 24/08/2015

**Theme:** Individualised Supports and Care

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

Activities offered to residents were not in accordance with their interest and ability.

**3. Action Required:**

Under Regulation 13 (2) (b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests, capacities and developmental needs.

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

A referral has been sent to the OT for assessment of all service users in relation to identifying appropriate meaningful activities. Training has also been organised with CNS in activities to guide staff in identifying appropriate activities .Outreach has commenced for three residents. Another resident has been reintroduced to a structured day service on a phased basis. Person Centred Plans are in the process of being updated to reflect meaningful activities for the individual service users.

**Proposed Timescale:** 31/08/2015

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

**Theme:** Individualised Supports and Care

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

Residents were not active members of the community or involved in same.

**4. Action Required:**

Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

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

Two residents are currently being supported to access a local sports partnership initiative on a weekly basis. Residents attend mass on a weekly basis. One resident who has expressed an interested in attending a Novena and Bingo locally is being supported to do so. The local paper is used as resource to educate and inform staff and residents of local events. In addition two residents have enrolled in the local library to the sample services available. A calendar of local annual events will be maintained giving approximate timeframes for events such as Heritage week, Local Agriculture Shows, drama, musicals, seasonal events e.g. Christmas and Easter.

**Proposed Timescale:** 28/09/2015



## Outcome 04: Admissions and Contract for the Provision of Services

**Theme:** Effective Services

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

Not all of the written agreements had been signed. The fees were not stipulated in the written agreements.

**5. Action Required:**

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

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

Four families have been issued with and signed the Contract of care and the structure of fees has been explained to them. One family have yet to return the contract but staff are assisting them with the document.

**Proposed Timescale:** 30/09/2015

## 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:**

The personal plans were completed by one member of staff.

**6. 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:**

Five staff who had received training on Person Centred Planning (PCP) have now received refresher training and are rolling out training on the development of PCPs to all staff in the designated centre. Further support will be provided to staff when completing the PCP by the PIC and members of the MDT. Families will also be invited to contribute to the PCP and be active participants in the goal setting and achieving the optimum outcomes. Training in relation to responsibility of the key worker has been provided to some staff with remaining staff to receive this training by 28th September 2015. Audits of the PCPs will be conducted by Senior Management on a regular basis.

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

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

Personal plans were not reflective of consultation with residents.

**7. Action Required:**

Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

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

A person centred planning meeting will be scheduled for each resident .The goals will be agreed with the resident and family member. The role of the keyworker will be highlighted and each key worker supported to maximise positive outcomes for the resident. Training will be delivered to staff on the process and review dates set. The presence of a PIC will facilitate the implementation of the plans. Advocacy referrals have been made in relation to people who are non-verbal and have no family links.

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

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

There was an absence of information to support how the personal plan would be achieved.

**8. Action Required:**

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

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

The PIC will ensure the recommendations outlined in each person centred plan will be implemented in the agreed time frame. Staff will be supported through the process, families and residents consulted and on site training provided .Keyworkers will be trained and supported by senior staff and management in developing meaningful goals for each resident

**Proposed Timescale:** 28/09/2015

**Theme:** Effective Services

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

Personal plans did not outline the supports residents required.

**9. Action Required:**

Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

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

All the person plans will be reviewed immediately. In addition, as outlined above Five staff who had received training on Person Centred Planning (PCP) have now received refresher training and are rolling out training on the development of PCPs to all staff in the designated centre. Further support will be provided to staff when completing the PCP by the PIC and members of the MDT. Families will also be invited to contribute to the PCP and be active participants in the goal setting and achieving the optimum outcomes. Training in relation to responsibility of the key worker has been provided to some staff with remaining staff to receive this training by 28th September 2015. Audits of the PCPs will be conducted by Senior Management on a regular basis. Training is to be provided to the staff in the development of a person centred plan.

**Proposed Timescale:** 28/09/2015

**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

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

The twin room in the designated centre is not fit for purpose. There is inadequate communal space.

**10. Action Required:**

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

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

Initial Plans were revised to provide an enhanced designated centre. These enhanced plans are with HSE Estates and are ready to be submitted for planning permission to include the following improvements to the house;

Extend and convert one bedroom to living room space.

Provision of two extra bedrooms with ensuite bathrooms to eliminate sharing of bedrooms.

Extension of utility room to accommodate office space.

Provision of storage area.  
Provision of car park to front of property.  
Review of existing corridor width. What is the expected date for submission for planning.

The extension to this designated Centre is approved in principle by the HSE. The HSE is awaiting the final drawings for the revised plans, which are due to be submitted for planning permission in the next 3-4 weeks. Costings are not available until these final drawings are submitted; however as mentioned above the HSE is committed to the building of this extension. .In the interim period a protocol has been drawn up to safeguard the privacy of the two residents sharing the one bedroom.

**Proposed Timescale:** 30/12/2016

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

**Theme:** Effective Services

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

The systems in place for the management of risk were inadequate and were not implemented in practice.

**11. Action Required:**

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

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

The PIC and senior management will conduct a review of all risks and control measures as pertaining to the house and the residents. All staff will receive training in risk management. Individual risk assessments will be reviewed every 3 months or sooner if required. All staff at this designated centre with the exception of two have attended fire safety training in 2015. These two staff have been prioritised to attend the next fire safety training session. All staff will attend Moving and Handling training on a three yearly basis. A missing person drill will be conducted and the outcome audited. An emergency response plan will be developed involving all staff and detailed in the Safety Statement. The PIC will ensure that each staff member is aware of their responsibilities in relation to the emergency plan.

**Proposed Timescale:** 30/09/2015

**Theme:** Effective Services

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

The final exits were key operated which could result in unnecessary delay in the event of an emergency.

**12. 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:**

A requisition has been submitted for all exit doors to be fitted with thumb turns. Emergency lighting is provided and lighting at external exits. Daily checks are carried and recorded out to ensure they are in working order.

**Proposed Timescale:** 01/09/2015

### **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:**

There was an absence of assessment and review to support residents experiencing behaviours that challenge.

**13. Action Required:**

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

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

The behaviour support staff will undertake a review of all behaviour support plans. Training will be scheduled on site for all staff. Proactive and reactive strategies will be reviewed.

**Proposed Timescale:** 08/09/2015

**Theme:** Safe Services

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

There were inadequate implementation of safeguards to protect residents.

**14. Action Required:**

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

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

1. All staff with the exception of one who is on sick leave were provided by the PIC at staff house meeting an update on the policy, Safeguarding the Vulnerable Persons at Risk of Abuse National policy and procedures. 20/08/2015 Completed

2. In addition the HSE has organised for training to be provided to all staff by an external agency on this policy. 30/10/2015

**Proposed Timescale:** 30/10/2015

**Theme:** Safe Services

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

Staff had not received updated training as stated in the action plan response by the provider from the inspection conducted in November 2014 and also from the inspection conducted in April 2015.

**15. 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:**

All staff will receive updated training on Safeguarding residents. Updated training has commenced in July 2015 and all staff will be trained by 30th October 2015.

**Proposed Timescale:** 30/10/2015

**Outcome 09: Notification of Incidents**

**Theme:** Safe Services

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

The Chief Inspector had not been notified of allegations or suspicions of abuse.

**16. Action Required:**

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

A desk top of all reported incidents is currently underway. Following on from that relevant notification will be submitted. A preliminary screening has commended on allegations of abuse.

**Proposed Timescale:** 31/08/2015

**Outcome 10. General Welfare and Development**

**Theme:** Health and Development

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

Activities that residents engaged did not consistently promote skill development or life long learning.

**17. Action Required:**

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

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

Staff has commenced skills training in relation to money management with one resident. The HSE has also commissioned an external agency to work with this resident to commence work sampling in the community. A formal day service has been put in place for three other residents. Access to the local library and time spent reading relevant topics in the local and national papers commenced.

**Proposed Timescale:** 14/09/2015

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Residents who had a health care need or who experienced a change in their health care needs were not always provided with appropriate health care.

**18. 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:**

All health care plans are in the process of being reviewed by Health Professionals and outstanding investigations have taken place.

All regular monitoring will be followed up and recorded in a consistent manner.

**Proposed Timescale: 28/09/2015**

**Theme: Health and Development**

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

Residents did not consistently get access to allied health professionals.

**19. Action Required:**

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

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

All health care plans are in the process of being reviewed by Health Professionals and outstanding investigations have taken place.

All regular monitoring will be followed up and recorded in a consistent manner.

**Proposed Timescale: 28/09/2015**

**Outcome 12. Medication Management**

**Theme: Health and Development**

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

There was an absence of appropriate action taken following medication errors.

**20. Action Required:**

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

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

Following a medication error a desk top review highlighted recommendations which are being implemented in full. A flowchart has been developed to guide staff unfamiliar with the Centre in the appropriate action to take in the event of a drug error. Allocations Officer has been tasked with ensuring that a nurse is available for medication administration.

**Proposed Timescale: 01/09/2015**



## 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:**

The person in charge could not fulfil their statutory responsibility.

**21. Action Required:**

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

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

A suitably qualified person has been identified as PIC and is rostered to work 39 hours weekly in a supernumerary capacity in the designated centre

**Proposed Timescale:** 03/09/2015

**Theme:** Leadership, Governance and Management

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

The management systems in place were inadequate to ensure that the services were safe and effective.

**22. 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:**

A suitably qualified PIC has been appointed to the designated centre on a full-time basis .This is in addition to the current level of staffing

**Proposed Timescale:** 14/08/2015

**Theme:** Leadership, Governance and Management

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

Staff require additional support to ensure that the support to residents is appropriate.

**23. 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:**

Performance Management Policy will be developed and implemented in the designated centre

**Proposed Timescale:** 30/09/2015

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

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

The designated centre was not sufficiently resourced to meet the needs of residents.

**24. 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:**

An independent review of staffing to include, skill mix, up skilling and rosters has been concluded and will be implemented by management as appropriate. The appointment of three staff nurses has been approved and national recruitment agency are actively processing these posts. In the interim, agency staff are rostered on to lines in the designated centre to ensure continuity.

**Proposed Timescale:** 30/09/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

Staff did not have the appropriate skill set to ensure residents were supported to engage in meaningful and purposeful activity.

**25. 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:**

The provision of outreach has been sourced from an external provider with experience in the area of day service provision .Training and support has been sought from a CNS

in Activities to provide guidance to the regular staff in the designated centre .A social skills training program has been identified and the residents will be assessed for inclusion in this initiative Training on developing pcps will commence on site in the designated centre, specifically for key workers to support and guide the process

**Proposed Timescale:** 30/09/2015

**Theme:** Responsive Workforce

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

Nursing care was not provided when required.

**26. Action Required:**

Under Regulation 15 (2) you are required to: Ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.

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

Staffing will be provided as stipulated in the statement of purpose.

**Proposed Timescale:** 28/09/2015

**Theme:** Responsive Workforce

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

Due to the regular use of unfamiliar staff residents were not consistently provided with continuity of care.

**27. Action Required:**

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

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

The current induction process will be reviewed immediately and staff nurses trained in the process of induction. The allocation officer has been instructed to book agency cover allowing extra 30 minutes to facilitate induction time. All efforts will be made to fill vacant lines in designated centre with regular staff or regular agency staff .Rosters will be monitored to ensure a regular staff is on duty at all times.

**Proposed Timescale:** 25/09/2015

**Theme:** Responsive Workforce

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

Staff did not have appropriate training.

**28. Action Required:**

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

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

All mandatory and relevant training has been offered to all staff however some staff who did not avail of this training will be directed to attend and training re-scheduled. A review of all training records is currently underway and will inform a schedule of training that will be drawn up. This schedule of training will commence immediately and will be monitored by the PIC in relation to staff attendance

**Proposed Timescale:** 16/10/2015

**Theme:** Responsive Workforce

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

There was an absence of appropriate staff supervision.

**29. 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:**

The presence of a full-time PIC in the designated centre 5/7 days will facilitate on site supervision. The development of Policy on staff supervision and performance will enhance the supervision of staff and provide leadership and support to the staff team

**Proposed Timescale:** 17/08/2015

**Outcome 18: Records and documentation**

**Theme:** Use of Information

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

There was an absence of proof of identity for staff in staff records. There was an absence of evidence of Garda clearance for one staff.

**30. Action Required:**

Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

All staff files are being currently reviewed and will be completed as per Schedule 2 of the Health Act 2007. All personnel files will be held securely in the designated service.

**Proposed Timescale:** 30/09/2015

**Theme:** Use of Information

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

Improvements were required to the documents to be maintained under Schedule 3 as there was an absence of staff signatures and dates.

**31. Action Required:**

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

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

All documents required under Schedule 3 will be provided and signed and dated as appropriate.

**Proposed Timescale:** 28/09/2015

**Theme:** Use of Information

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

Improvements were required to the records maintained regarding the nutritional intake of residents.

**32. 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:**

Daily records of nutritional intake will be recorded with reference to the dieticians recommendation and in line with the requirements of Schedule 4 The PIC will ensure daily records are kept and will review the plan of care with the dietician.

**Proposed Timescale:** 28/09/2015