

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002662
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	RehabCare
Provider Nominee:	Rachael Thurlby
Lead inspector:	Mary Moore
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 13 April 2016 09:15 To: 13 April 2016 19:00

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

Outcome 02: Communication
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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was unannounced and was the first inspection of the centre by the Authority. In this centre, the provider provided services and supports to three residents assessed as having high support needs.

The inspection was facilitated predominately by the person in charge but also by front-line staff. The inspector met and spoke with staff, reviewed records and listened and observed as staff interacted with residents and provided supports to them.

The inspection findings were satisfactory and a good level of regulatory compliance was evidenced. The location, design and layout of the premises were suited to its stated purpose and met the individual and collective needs of the residents; it was welcoming and homely in presentation.

There was evidence of good practice in hearing the voice of residents who were non-verbal and in the provision of positive, therapeutic behavioural supports to them.

Staff spoken with, the records seen and the practice observed indicated that the residents were the focus of the service. Staff spoke and wrote respectfully of residents and put supports in place that maximised resident independence, social inclusion and positive relationships. An ethos of positive risk enablement guided these supports.

The inspector reviewed ten outcomes; the provider was judged to be compliant in five of these and in substantial compliance with the remaining five. The areas requiring action by the provider are discussed in the body of the report and in the action plan at the end of the 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 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

Resident's needs were assessed as high including their communication needs. On visual inspection and in the records reviewed there was evidence of good practice in supporting residents to communicate and in supporting staff to understand what was communicated.

Communication was integral to behaviour management guidelines in terms of both interpreting behaviours and preventing an escalation of behaviours.

On a day to day basis to hear the voice of residents who were non-verbal, to facilitate consultation, establish choices and preferences and agree individual planners, staff utilised the role of facial expressions and gestures, manual signing (Lamh), PECS (picture exchange communication systems), choice boards, visual schedules and planners, talking mats and visual social stories. One resident was currently exploring the integration of PECS with assistive technology.

Judgment:

Compliant

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

Each resident had a support plan based on an assessment of their strengths and where support was required by staff. The support plans were extremely detailed; reflected the knowledge that staff had of each resident and the experience that they had of what worked and what did not work for each resident. The inspector concluded that the resident, their needs and positive outcomes for them was the focus of the support plan.

The support plan incorporated the process for agreeing and progressing personal goals and objectives for each resident. Responsible persons and timeframes were identified and there was photographic evidence of accomplishment. There was congruence between the support plan, behaviour management guidelines and risk assessments. Collectively staff utilised all of these to support residents to safely enjoy new experiences and positive quality of life outcomes; the learning from goals was seen to be transferred to daily routines, for example how a newly required skill or activity could replace an established behaviour by providing the resident with the same sensory stimulus.

Throughout the support plan and in the daily narrative notes staff evidenced how they established consultation with and the participation of the resident in the plan through the use of assistive communication strategies. Each resident had a pictorial version of their support plan. A succinct synopsis of each support plan was also available to staff.

Transitional plans were seen for supporting residents when moving into adult residential services.

Each resident had a key worker; staff confirmed that the key worker in residential care linked with the key worker in the day service and they met formally on a quarterly basis to ensure consistency and continuity of supports.

There was evidence that residents had the required support from the multidisciplinary team such as psychiatry, occupational therapy and behaviour therapy. Support plans were reviewed by staff on a regular basis; however, an annual review of the support plan that was multidisciplinary as required by Regulation 5 (6) (a) was not strongly evidenced.

Judgment:

Substantially Compliant

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

The premises was purpose built on a site operated by the provider and located within walking distance of all local amenities. Also located on the site were another designated centre and the day resource centre.

The premises was of relatively recent construction, two-storey with resident accommodation provided on both floors. Residents presented with high support needs and while the premises offered them safety and security it was welcoming, homely and personalised in presentation.

Each resident had their own bedroom, rooms offered sufficient space to meet their needs including provision for personal storage. Two of the three bedrooms were en-suite with universally accessible sanitary facilities; two further facilities were provided one on each floor.

Communal, kitchen and dining space was laid out to meet the needs of residents particularly in relation to their need for personal space and the management of environmental stimuli such as noise. Communal, kitchen and dining space was available on both the ground and first floors.

Adequate provision was made for storage and staff accommodation including office space.

Adequate facilities were in place for the management of laundry.

Residents had access to a secure garden; it was clear that this area was accessed and utilised by them and laid out and equipped to meet their needs with seating, a swing and a wooden cabin where further solitude if required could be secured.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

The inspector saw both organisational and centre specific safety statements that were signed as read and understood by staff.

The safety statement included the procedures for the identification and assessment of risks and the recording, reporting and investigation of accidents, incidents and adverse events.

The inspector reviewed the local risk management folder; this included a suite of generic risk assessments, the risks as specifically required by Regulation 26 (1) (c) as well as risks specific to the centre and as they applied to individual residents. The controls identified in the latter were somewhat broad but this was addressed in the risk assessments contained in residents' support plans as these identified the specific control measures to be implemented by staff to minimise the identified risks. There were a large number of risk assessments in place but the inspector was satisfied that this reflected residents' high support needs and staff commitment to positive risk and enablement.

The provider had a centre specific business continuity staff that set out for staff the actions to be taken in defined emergency situations; the plan included alternative accommodation for residents if required.

The inspector saw that emergency lighting and an automated fire detection system were in place. Escape routes and exits were clearly indicated, final fastenings were thumb-turn devices. Fire action notices were prominently displayed and in a visual format that enhanced their accessibility to residents.

Fire fighting equipment was prominently positioned and there was evidence of fire doors (labelled).

Fire related records were maintained in the fire fact file. The inspector saw certificates confirming that the fire detection system, fire fighting equipment and the emergency lighting were inspected and tested at the prescribed intervals and most recently in February 2016, January 2016 and March 2016 respectively. In addition staff maintained records of the in-house daily, weekly, monthly and quarterly inspection of fire safety measures. There was evidence of the inspection, servicing and work completed on the fire detection system in the last quarter of 2015 but the certificate had not been completed to reflect this work; this was brought to the attention of the person in charge.

Training records indicated that staff were provided with fire safety training on an annual basis and most recently in January 2016.

Simulated fire drills were convened on a regular basis; records of seven such exercises completed in 2015 were seen by the inspector. Drills were convened at different times and for six of these exercises good and adequate evacuation times were recorded as achieved. However, the most recent on the 17 November 2015 recorded an evacuation time of seven minutes 30 seconds, well outside of what is recommended. Staff had identified the barrier and a potential plan but could not however confirm if an evacuation drill had been completed since; each resident had a current personal emergency evacuation plan but these reflected neither the identified barrier nor the mitigating plan.

Judgment:
Substantially Compliant

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

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

Findings:

There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, risk assessments and staff training. The names of the designated persons were prominently displayed as were the contact details for the national confidential recipient.

Staff said that there had been no incident of alleged, suspected or reported abuse or any known concerns for the welfare and wellbeing of any of the residents. The person in charge told the inspector that she was confident that all staff clearly understood what constituted abuse, would and had exercised their responsibility to safeguard residents by bringing concerns to her attention. Staff confirmed this and their commitment to ensuring the "best" for residents at all times. Residents were reported by staff to have a strong sense of personal space; records seen supported that staff were attuned to resident's concerns and worries and any altered patterns of behaviours.

Each resident had a personal/intimate care plan that outlined the support required from staff but also incorporated the residents right to independence, privacy, dignity and choice.

There was evidence to support a positive, evidence based approach to the management of behaviours that posed challenges and/or risks to residents themselves, staff and other residents. The provider's policies promoted a therapeutic response and the use of restrictive interventions only as a last resort; this was evidenced in practice.

Behaviour management guidelines/plans (BMG) were in place and these were recently reviewed by the newly appointed behaviour therapist. The person in charge confirmed that ongoing review based on priority of needs was planned by the behaviour therapist. Staff reported a decreased incidence of behaviours that challenged and this was reflected in records seen including the recent reviews by psychiatry. When asked by the inspector for a rationale for the decreased incidence of behaviours staff said that this resulted from staff engagement with and the consistent implementation by staff of behaviour management guidelines, systems that enhanced communication with residents and respect for and adherence to the importance of routine for residents. The inspector saw that the BMG focussed on communicating, understanding, safety and the use of restrictive practice only as a last resort; other antecedents including physical pain were the first consideration and this was reflected in the records of medication administered.

The observations of the inspector reflected the BMG, for example the provision of and respect for personal space, downtime and minimal environmental noise, access to preferred sensory stimuli, adherence to the daily routine and planner and the use of augmentative communication tools.

Restrictive practices such as environmental restraint and medication as required were in use for the safety of residents and others but these were minimal, formally identified by staff, sanctioned and reviewed through the providers planned restrictive practices authorisation process.

However, there was one environmental modification in use, the purpose of which was not explicitly stated in any documentation seen including individual BMG. There was a stair-gate with sliding bolt at each end of the staircase. The gates were in position during the inspection while residents were in the house, the sliding bolts were not used and residents were seen to voluntarily open and close the gates and access the upstairs. The person in charge said that the gates served as a physical reminder to residents of the boundary to the personal space of other residents. This was not however explicitly stated for example in the BMG or in support plans as either a measure to protect personal space or as an adjunct to preventing behaviours that challenged.

Judgment:
Substantially 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):

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

Findings:

Staff reported that residents generally enjoyed good health; there was evidence that staff monitored resident wellbeing and sought appropriate intervention as necessary. Residents had access to General Practitioner (GP) services including ongoing access to their family GP. There was further evidence of access to other services as appropriate to assessed needs including psychiatry, behaviour therapy, occupational therapy and dental care and treatment. A resident's right to refuse treatment was acknowledged but there was discussion and intervention as necessary to ensure resident health and well-being.

Staff further supported health and general well-being through regular monitoring of body weight, the maintenance of dietary intake records and the provision of specific dietary requirements or preferences; these supports were all outlined in the support plan. However, while staff did also maintain records of elimination, these were not informed by the use of an evidence based descriptor tool; this was recommended to the person in charge at verbal feedback.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

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

Findings:

Medications were supplied to the centre by a community based pharmacy. Arrangements were in place for the secure storage of medication and staff implemented other measures to monitor the ongoing safety of medication management practices including the daily count of medications in stock.

Medications in stock were seen to have a current prescription and were supplied on the basis of individual usage. All medications seen were appropriately labelled and corresponded with the prescription held by the centre. A random sample of medication administration records completed by staff corresponded with the prescription record.

Staff confirmed that no medications were administered in an altered format (crushed); discontinued medications were signed and dated as such. Medication reviews were regular and completed by either the GP or the psychiatrist.

Each resident had a detailed medication management plan including a protocol for the administration of PRN (as required) medications including those prescribed as an adjunct to the management of behaviours; the protocol reflected the behaviour management guidelines.

Residents required full assistance from staff in managing their medication; however, staff had not fully completed the assessment tool used to support the basis for this conclusion.

Some minor improvement was required. One PRN protocol seen was not clear on the daily maximum dosage to be administered of one medication. It was not clear whether the protocol had not been updated to reflect recent changes to the prescription or if the maximum dosage stated referred to the combined maximum dosage of both the regular and PRN prescription.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose

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

Theme:
Leadership, Governance and Management

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

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

Findings:

Prior to the inspection the inspector reviewed the statement of purpose submitted to the Chief Inspector in January 2016. The statement contained much but not all of the information specified in Regulation 3 and Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults With Disabilities) Regulations 2013.

The statement of purpose contained insufficient detail of the specific care needs that the designated centre met in practice, there was insufficient detail of the arrangements for supporting residents to access education, training and employment. The statement of purpose did not reflect the good practice seen as to how staff consulted with and facilitated the participation of residents.

Judgment:
Substantially Compliant

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

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

Findings:

These inspection findings support effective governance of the centre. There was a clear management structure in place consisting of the team leader who was also the PPIM (Person Participating in Management), the person in charge and the regional manager. The person in charge told the inspector that the PPIM had recently gone on leave but a suitably qualified and experienced replacement was identified and was shortly to commence working in the centre.

The person in charge worked full-time, was suitably qualified for the role and had established experience in the supervision of supports and staff. The person in charge had three main areas of responsibility, two designated centres and the day resource centre all of which were located together on this site; the person in charge was based on-site and therefore readily accessible to residents and staff. The person in charge told the inspector that she had a temporary allocation of a further area of responsibility, another resource centre, but it had been agreed between her and the provider that this was only for a six-month period. The person in charge was mindful of her regulatory responsibilities; the person in charge readily answered any queries in relation to staffing, the operation of the designated centre, residents and their required supports.

Staff confirmed that they operated a system of delegating duties and responsibilities such as for medication management, resident finances or the completion of the staff rota. The person in charge said that this developed staff skills, knowledge and accountability. Staff spoken with were clear on their respective roles, responsibilities and

reporting relationships and described supportive and collaborative working relationships in the centre.

The person in charge reported to the regional manager and confirmed that she had ready access as required to the regional manager; opportunities for discussion, learning and peer support were facilitated through structured regional management meetings and team leader meetings.

Staff confirmed that there was an on call out of hour's manager available within the wider organisation and the rota was readily available to staff. Support and advice was also available from other designated centres in the area.

There was a structured system of formal supervision for all grades of staff.

The nominated provider was known to staff and staff confirmed her visits to the centre.

The person in charge confirmed that the centre had been the subject of the annual review and unannounced visits to the centre as required by Regulation 23 (1) and (2). Reports from both undertaken in February and March 2016 and September 2015 were available for inspection. The audit process was based on the Outcomes utilised by the Authority and a high level of compliance with the critical components was identified by the providers own auditors on each visit. Based on these satisfactory inspection findings the inspector was satisfied that the provider's own process was accurate and transparent.

Families had been invited by the provider to provide feedback on the services and supports provided; the feedback received was positive and complimentary.

Judgment:
Compliant

Outcome 17: Workforce

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

Theme:
Responsive Workforce

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

Findings:

Recruitment was centralised. As this inspection was unannounced staff files were not available for the purpose of inspection; arrangements were made with the person in charge for staff files to be available for the next inspection.

There was a planned staff roster that was managed by staff themselves under the supervision of the team leader and the person in charge. Staffing levels and arrangements were informed by resident's needs and risk assessments, for example additional staff supports were required by some residents for community based outings or activities. Night time staffing consisted on one "waking" and one "sleepover" staff. The inspector was satisfied that the staff supports described by the person in charge were as observed during this inspection.

Some staffing deficits had arisen recently due to vacated posts. The inspector was reassured that this was managed by the person in charge to ensure consistency of staff and supports for residents. The person in charge offered existing staff additional shifts, utilised relief staff from the resource centre that were known to residents and confined the use of agency staff to one staff. Overall there was evidence that staffing arrangements were planned and delivered to meet residents' needs.

The inspector having spoken to the person in charge and reviewed staff records was satisfied that staff training was monitored by the person in charge to ensure that staff completed all mandatory and additional training; this included relief and agency staff. Staff training records were reviewed by the inspector and indicated that staff had current training in fire safety, protection and safeguarding, and responding to behaviours that challenged. Additional completed training included medication management training, person centred planning, food safety, first aid, risk management, augmentative communication techniques and providing personal care.

There was a planned training schedule for 2016 that included required mandatory refresher training, training required by agency staff and additional relevant training including autism awareness.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by RehabCare
Centre ID:	OSV-0002662
Date of Inspection:	13 April 2016
Date of response:	05 May 2016

Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

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

An annual review of the support plan that was multidisciplinary as required by Regulation 5 (6) (a) was not strongly evidenced.

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 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:

The Behavioural Therapist, in conjunction with support staff and family members will complete an assessment and interventions for one service user.

A referral to Occupational Therapy for a sensory integration assessment for one service user to be submitted.

Each service user will have an annual needs assessment completed, involving relevant multidisciplinary supports.

Proposed Timescale: 31/08/2016

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 most recent fire drill report of the 17 November 2015 recorded an evacuation time of seven minutes 30 seconds, well outside of what is recommended. Staff had identified the barrier and a potential plan but could not however confirm if an evacuation drill had been completed since; each resident had a current personal emergency evacuation plan but these reflected neither the identified barrier nor the mitigating plan.

2. 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:

Three staged fire evacuations will be completed and service users' personal emergency evacuation plans will be reviewed and amended as required.

A fire drill was completed on the 17 April 2016 with an evacuation time of 3 minutes.

Proposed Timescale: 31/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff said that stair-gates served as a physical reminder to residents of the boundary to the personal space of other residents. This was not however explicitly stated for example in the BMG or in support plans as either a measure to protect personal space or as an adjunct to preventing behaviours that challenged.

3. Action Required:

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

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

The presence of the stair gates will be reviewed with the Behavioural Therapist; the reason will be clearly described and identified on both the service users' BMG and support plans.

Proposed Timescale: 31/05/2016

Outcome 12. Medication Management

Theme: Health and Development

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

One PRN protocol seen was not clear on the daily maximum dosage to be administered of one medication. It was not clear whether the protocol had not been updated to reflect recent changes to the prescription or if the maximum dosage stated referred to the combined maximum dosage of both the regular and PRN prescription.

4. Action Required:

Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

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

The PRN protocol has been amended to clarify the maximum dosage of medication to be administered and will be signed by the GP on 11/05/2016.

Proposed Timescale: 11/05/2016

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 contained much but not all of the information specified in Regulation 3 and Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults With Disabilities) Regulations 2013.

5. 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 and Function will be amended to reflect the specific current supports provided for service users, including access to education, training and employment, as well as the communication supports provided in the service to all residents.

Proposed Timescale: 31/05/2016