

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cork City North 8
Centre ID:	OSV-0003307
Centre county:	Cork
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	COPE Foundation
Provider Nominee:	Colette Fitzgerald
Lead inspector:	Julie Hennessy
Support inspector(s):	Louisa Power
Type of inspection	Announced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
23 August 2016 09:00	23 August 2016 17:00
24 August 2016 09:00	24 August 2016 16:30

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

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

Summary of findings from this inspection

Background to the inspection

This was the second inspection of this designated centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 29 April 2015.

At the previous inspection, three outcomes were found to be at the level of major non-compliance. This inspection was carried out to assess the progress made since the previous inspection and to inform a decision to register the centre.

Description of the service

The centre provides accommodation for residents with a severe to profound disability. Residents living in this centre had complex and high-support needs and many were non-verbal.

The centre is a single-story premise on a campus and is a congregated setting. The capacity of the centre at the time of the inspection in accordance with the provider's application form to register the centre was 27. Despite the congregated setting, efforts had been made to ensure that the premises were as homely as possible and pleasantly decorated. All bedrooms were shared but bedroom spaces were personalized. The centre was bright and clean, however, ventilation was inadequate. Bathrooms were also shared but sub-divided by fixed privacy screens.

A plan was in place to de-congregate the centre on a short to long-term basis. While the provider demonstrated that this plan was being progressed by the purchase of community houses, this plan was already behind schedule due to what was described as staffing reasons. The provider was requested to submit a funded time-bound plan to HIQA as part of their application to register this centre.

How we gathered our evidence:

Inspectors met with the 22 residents who were residing in this centre at the time of this inspection and six representatives (families, friends or guardians). Inspectors also reviewed surveys completed by residents' representatives prior to this inspection. Residents' representatives told inspectors that overall they were satisfied with the care and support being provided to their loved ones. They spoke very highly of the person in charge, who they said had made the centre and the practices in the centre less institutionalized. Residents' representatives said that they found staff to be open, welcoming and kind and they were kept informed about the health and welfare of their loved ones. Negative feedback from residents' representatives was that they would like to see more outings and/or access to a day service for residents. Also, not all representatives were satisfied with how incidents or allegations had been managed by the service.

Inspectors observed staff interacting with residents in an appropriate and warm manner and supporting residents to communicate both verbally and non-verbally.

Overall judgment of our findings

Overall, the provider and person in charge demonstrated that a number of failings identified on the previous inspection had been addressed or progressed. For example, fire improvement works to the premises had been completed. Steps had been taken to improve the privacy and dignity of residents in light of the constraints of the premises. The capacity of the centre had been reduced since the previous inspection by the removal of respite services. As part of the application to register this centre, the provider was requested to assess and determine what respite services and emergency admissions (if any) could be provided in the centre.

Good practice was evidenced in relation to supporting residents' communication needs, meeting residents' healthcare needs and promoting positive family relationships. However, two major non-compliances were identified at this

inspection:

Under Outcome 6: Safe and Suitable Premises, the centre failed to provide adequate private accommodation for residents, rooms of a suitable layout for the needs of residents, suitable storage facilities, adequate ventilation or baths/showers of a sufficient number and standard suitable to meet the needs of residents.

Under Outcome 7: Health, Safety and Risk Management, an immediate action plan was issued to the provider during this inspection. Fire drill records failed to demonstrate that arrangements in place for evacuating residents in the event of a fire were adequate. The provider responded appropriately and submitted a plan outlining how this failing would be addressed.

Other improvements were required to ensure that residents had a meaningful day, in accordance with their individual needs and interests, ensuring that systems were in place to complete multidisciplinary assessment of needs for residents transitioning from the centre, the management of residents finances and complaints. Actions are outlined in an action plan at the end of this report and should be read in conjunction with findings 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):

No actions were required from the previous inspection.

Findings:

Overall, while complaints were recorded in the centre, improvements were required at organizational level. Also, the system in place for the management of residents' finances required review.

Inspectors reviewed the complaints log in the centre and found that overall, complaints were recorded in accordance with the requirements of the Regulations. However, there was one complaint where the satisfaction with the outcome had not been recorded, as required.

The complaints policy required review as it did not ensure that a second person, other than the person nominated to maintain a record of all complaints, was available to residents to ensure that all complaints were appropriately responded to and records maintained to demonstrate such assurances were in place.

Inspectors reviewed the systems in place for the management of residents' finances. For a number of residents however, monies were kept in a central account under the organisation's name. This practice is not in line with the requirements of the Regulations as it involves the provider paying money belonging to a resident into an account held in a financial institution that is not in the name of the resident to which the money belongs and without their consent. Regular audits of the financial system took place and the person in charge also completed random checks of transactions and records of monies in the centre.

Residents' forums were in place, with the most recent forum having taken place three weeks prior to this inspection. Items discussed and raised by staff on behalf of residents were meaningful. For example, where it was raised that staff were not supporting residents to go swimming, a solution was found to communicate which staff member was allocated to support this activity. Other issues documented as having being discussed related to staff needing to be more creative in engaging residents in activities and not just going for walks and staff checking whether a resident was receiving hand massage.

Inspectors found that staff endeavoured to protect residents' dignity. However, this was compromised by the design and layout of the premises and this will be discussed under Outcome 6: Safe and Suitable Premises.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that residents' communication needs were met by staff.

Individual communication requirements were highlighted in personal plans. Staff articulated and demonstrated how they supported residents to communicate using verbal and non-verbal means. Each resident had a communication passport (an individualized document that is used to pass on key information about people with complex communication difficulties). Communication passports contained key information about individuals, their families, likes and dislikes and preferred means of communication. Communication passports were in the process of being updated with the support of a nurse trained in intensive interaction communication (an approach that focuses on teaching the fundamentals of communication through developing enjoyable and relaxed interaction sequences). Inspectors observed that communication passports had already been updated for residents transitioning from the centre by the end of this year and were also in an interactive (DVD) format.

Judgment:

Compliant

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

Overall, it was demonstrated that positive relationships between residents and their families were promoted and supported.

Previously, family forums took place in the centre. In more recent months, these had been replaced by meetings with individual families to allow for discussion and preparation of transition plans for residents moving from the centre to more appropriate accommodation.

Inspectors met with a number of families who said that there was an open-door policy in the centre and they were made to feel welcome at any time. Families said that they were kept informed about the care and support being provided to their loved ones.

Activity records and discussions with staff and families indicated that residents had some opportunities to participate in outings in the community as part of a group. On a weekly basis, an outing was arranged for residents who did not have a day service and those residents who availed of this outing took turns to ensure that all residents availed of such opportunities. Recent outings included going to the beach, a wildlife park, shopping centre, library, cinema and opera house. The van available to the centre could facilitate seven residents each week (and a larger van could facilitate eight residents during the summer). In addition, significant planning had gone into ensuring that residents with complex support needs were facilitated to visit their family home or attend family occasions, such as family weddings.

Overall however, a review of activity records indicated that such opportunities for individual residents to participate in the community were limited. For example, recent activity records for one resident over a 29-day period indicated that they did not leave the campus during that period. They engaged in six activities outside of the centre but within the campus grounds during that same period (swimming in the pool on-campus on two occasions and walks around the campus on four occasions). Over a 28-day period, another resident went for two drives outside of the campus and for one walk around the campus. Also, the wish for residents to go on more social outings had been identified by families in recent reviews of personal plans. Families told inspectors that they would like to see more outings for their loved ones.

Judgment:

Non Compliant - Moderate

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:

All residents had a written contract of care available in their file.

There was an admissions policy in place in the service. Admissions to the centre were included in the Statement of Purpose. Further clarity was required in relation to admissions of residents to this centre. This will be addressed under Outcome 13: Statement of Purpose.

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):

No actions were required from the previous inspection.

Findings:

Overall, improvements were required to the assessment of residents' social and developmental needs, the assessment of needs for residents transitioning from the centre and the review of the personal plan.

Where residents were due to transfer from this centre to another centre, a transition plan was in place. However, a multidisciplinary assessment of needs was to be completed prior to this transition for all residents. While this process had commenced for

one resident, it was yet to be organized for other residents, as required by the Regulations to reflect changing circumstances.

Comprehensive assessments had been completed for residents' healthcare needs. However, comprehensive assessments of residents' social and developmental needs had not been completed to inform individualized daily programmes. As a result, it was not demonstrated that all residents had a meaningful day, in accordance with their individual interests and needs.

Residents had a personal plan in place. Personal plans were individualized and supported by other required information, including healthcare plans, risk assessments, exercise plans, mobility plans and behaviour support plans. While families and representatives had not previously been invited to attend the review of the personal plan, they were now being invited to attend. However, a review of a sample of personal plans demonstrated that the review of the personal plan was not multi-disciplinary, as required by the Regulations.

Five residents had access to a day service, either full-time or on a shared basis. However, 17 residents did not have access to any day or activation programme either within or external to the centre that had been developed to meet their individualized needs. Other activities and therapies were provided in the centre by staff. These included sensory activities, music, beauty treatments, massage, story-telling, sitting outside and watching television. However, the activities coordinator who previously ran these programs was on extended leave and staff had not received any training to support therapies or activation for residents. Staff told inspectors that they would be open to receiving such training. Staff endeavoured to meet residents' needs in the absence of the activities coordinator post or any relevant training by providing activities and therapies based on residents known likes and dislikes and previous experiences supporting the activities coordinator. External providers came to the centre and facilitated different therapies. Beauty therapy was offered once a week, pet therapy once a week and a music session was held once a month.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

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

Theme:

Effective Services

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

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

Findings:

At the previous inspection, it was found that the design and layout of the centre compromised the privacy and dignity of residents and did not adequately meet their needs and circumstances as required by schedule 6 of the Regulations.

Since the previous inspection, the provider had reduced the numbers of residents in the centre by reducing the number of available respite beds in the centre. Improvements had been made in a number of areas, for example, privacy screens were available in all bedrooms and more appropriate screening had been provided in bathrooms. Efforts had been made to make the centre as homely as possible and bedroom areas were individualized with photographs, personal effects and personal items. Furniture and fittings were overall in good condition and communal spaces were suitably decorated and equipped with pictures, flowers, lamps, sensory items, music equipment and televisions.

However, many of the limitations of the premises remained due to failings related to the fundamental design and layout of the centre. For example, all bedrooms were shared. Bedrooms opened directly onto communal spaces and/or corridors. Also, there was an enclosed 'veranda' attached to each bedroom, which provided access to the outside. Some verandas were in turn used as quiet spaces for residents, meaning that residents accessed those spaces through the bedrooms of other residents. Other verandas were used as storage spaces for equipment or items, meaning again that they were accessed through bedrooms to retrieve those items. Storage for personal effects was inadequate and some residents clothing was stored in cupboards located in other residents' rooms. Sanitary facilities were not always adequate and ensuite facilities were accessed by residents from other bedrooms. Bathrooms were shared, although fixed screens had been installed to promote residents' privacy and dignity as far as possible. There was inadequate ventilation in the centre, resulting in odours at certain times of the day.

A plan to de-congregate the centre by moving residents to alternative accommodation has been outlined. While the provider demonstrated that this plan was being progressed by the purchase of community houses, this plan was already behind schedule due to what was described as staffing reasons. Five residents had been scheduled to move to community houses by the end of May 2016 and this move had yet to take place at the time of inspection (at the end of August 2016). The provider was requested to submit a funded time-bound plan to HIQA as part of their application to register this centre.

Judgment:

Non Compliant - Major

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

Overall, significant improvement was required to ensure that the arrangements in place for evacuating residents from the centre were adequate and an immediate action plan was issued during this inspection.

At the previous inspection, a number of failings were identified in relation to fire safety. These related to gaps in the provision of fire safety training for staff, obstructed means of escape and issues relating to the building.

At this inspection, a review of fire drill records demonstrated that the arrangements in place for evacuating residents in the event of a fire were inadequate. The two most recent day-time drills took six minutes 30 seconds and six minutes to evacuate the centre (on 4 March 2016 and 3 July 2016 respectively). The most recent fire drill that simulated night-time conditions with all residents present was carried out on 3 October 2015 and took 16 minutes to evacuate the centre. The provider was required to take immediate action to address the unsatisfactory arrangements in place. The provider responded adequately to the immediate action plan and submitted a plan outlining how they planned to ensure that residents could be evacuated safely from the centre.

Other fire safety measures were in place and servicing records indicated that servicing of the fire alarm system, emergency lighting and fire equipment was within their servicing dates.

All residents had a personal emergency evacuation plan (PEEP). While PEEPs were individualized, they required more specific information, as specified by the guidance in the PEEP itself. For example, transfer procedures, methods of guidance and numbers of staff required to assist residents to evacuate in the event of a fire were not specified.

Since the previous inspection, the services of a competent person in fire safety had been engaged and a fire safety survey report had been completed. The report identified seven fire safety upgrading recommendations to the building. The provider confirmed in writing that all seven works had been completed in full.

At this inspection, inspectors found that all staff had received training in fire safety. However and again at this inspection, not all means of escape were kept free from obstruction as one means of escape was obstructed by a large mobile privacy screen. In addition, all final fire exit doors were locked with a key, which was removed from the door. The person in charge explained that staff who carried the keys for the centre had a master key for each door and there was a break-glass unit with an emergency key in the event of a actual emergency. However, it was not demonstrated that the arrangements in place were adequate as not all staff on duty carried a master key and suitable alternatives had not been explored. In addition, a risk assessment had not been completed in relation to locked final exit doors in the event of a fire.

At the previous inspection, it was found that the procedures in place for protecting residents from risk of a healthcare associated infection were not adequate due to the inappropriate storage of care-related equipment and disposal of clinical waste. At this inspection, it was demonstrated that equipment was regularly cleaned and maintained and clinical waste containers were secured. Plans to increase storage in the laundry area had been approved, however, there was no obvious hazard identified with the lack of storage. Staff were dedicated to the laundry area or assigned laundry duties each day and there were arrangements in place for the management of soiled and unsoiled laundry. There were arrangements in place for cleaning of the centre with an external contractor providing cleaning services during the week and scheduled duties at weekends. However, the arrangements in place for the prevention and control of blood-borne viruses were not adequate as it was not clear how any spillages would be adequately managed (e.g. in the event of blood-stained vomitus or diarrhoea). In addition, the risk assessment for the prevention and control of blood-borne viruses required review as the control measures were generic and did not capture all of the measures in place in practice e.g. in relation to the management of continence wear, use of showers or the taking of bloods.

At the previous inspection, improvements were required to risk assessments. Inspectors reviewed the risk register at this inspection and found that risk assessments had been completed for key risks. However, further improvement was required. Risk assessments did not always outline additional controls required or what the residual risk was after controls had been implemented. For example, the evacuation of residents from the centre at night-time had been identified as a high risk but additional controls had not been outlined to identify how the risk was being reduced to an acceptable level. Some bedrails had been made within the service and it was not clear whether those bedrails had been assessed by a suitably qualified person. In addition, the risk assessment for those bedrails was incomplete. Also, where an escalated risk had been included in the risk register in May 2016, there was no record of how this had been addressed.

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:

Overall, findings from the previous inspection had been progressed. Internal procedures were followed as they related to the safeguarding of vulnerable adults.

Where there had been an allegation of verbal abuse, the organisation had followed its own internal procedures and reporting requirements. Support from members of the multidisciplinary team (MDT) was provided from where required (from psychology and the clinical nurse specialist in communications). Relatives were informed of how to seek independent advocacy on behalf of residents. Safeguarding measures were in place, including individual safeguarding plans where required and monthly team safeguarding discussions. All staff had received an updated training session in January 2016 in relation to the protection of vulnerable adults.

At the previous inspection, not all staff had received up to date training in relation to positive behaviour support. At this inspection, training records indicated that one new staff member required this training and a request for same had been sent to the training department.

At the previous inspection, the registered provider had not ensured that procedures in relation to restrictive interventions reflected national policy and evidence based practice. At this inspection, it was not demonstrated that the centre's guidance had been followed where physical holds were required for the taking of bloods, for example, a risk assessment had not been completed. Other restrictive practices were documented and recorded and had been approved by the organisation's restrictive practices committee.

A multi-element behaviour support plan was in place for residents who required positive behaviour support. The plan had been reviewed as required by a behaviour support specialist.

Staff with whom inspectors spoke were observed to interact with residents in an appropriate and warm manner. Staff demonstrated an understanding of how to respond to suspicions, allegations or incidents of abuse in accordance with the organisation's policy.

Judgment:

Substantially Compliant

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:

At the previous inspection, instances where restrictive procedures or restraint had been used were not always recorded on the quarterly returns to HIQA, as required by the Regulations.

Since the previous inspection, all restrictive practices used were recorded on the quarterly returns to HIQA. Clarity was required in relation to some practices that were recorded as it was not clear what the restrictive practice entailed e.g. a cosy chair was included on the returns and it was not clear how or whether this was a restrictive practice.

Judgment:

Substantially Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

As previously mentioned under Outcome 5, five residents had access to a day service, either full-time or on a shared basis. Where residents were due to complete their particular programme, another programme had been secured. Where a review of the personal plan had identified that residents may benefit from such a day programme, this was being actively pursued by the person in charge.

Failings relating to day or activation programs for 17 other residents were previously addressed under Outcome 5: Social Care Needs.

Judgment:

Compliant

Outcome 11. Healthcare Needs

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that residents' healthcare needs were met by staff and by access to medical and allied health professionals.

Residents' had access to a general practitioner (GP) and consultants if required. Residents with epilepsy also availed of the services of an epilepsy outreach clinic. Residents had access to allied healthcare professionals and clinical nurse specialists, including physiotherapy, occupational therapy, speech and language therapy, a clinical nurse specialist in communication, psychology and dietetics.

A comprehensive assessment of residents' healthcare needs had been completed for all residents and informed residents' healthcare plans. Healthcare plans were in place based on each activity of daily living, including diet and nutrition, mobility and positioning requirements, continence care, prevention of constipation, intimate care, treatment of infections, oral hygiene, enteral feeding and skin integrity. A comprehensive catheter care plan and risk assessment was in place where required. Each resident had a 'hospital passport', which documented key information in the event of an admission to the acute sector e.g. any allergies, diagnoses, medications, dietary and communication needs.

Breakfast and light snacks were prepared by staff in the centre, with main meals (lunch and dinner) prepared in the central kitchen on campus and transported in hot trolleys. Inspectors observed that the kitchen was well stocked with eggs, cereal, porridge, yogurts, bread, cold meats and fruit.

Where residents were on a special diet, input from the dietician and speech and language therapy informed meal plans and dietary plans. Inspectors spoke with staff in the kitchen who were very knowledgeable about residents' likes and dislikes, special requirements and how to prepare food and drinks in accordance with instructions of the dietician and/or speech and language therapist.

Inspectors observed that residents who had an enteral feeding regime had a clearly documented and prescribed plan in place. Inspectors observed staff preparing and delivering the enteral feed in accordance with residents regimes.

However, some healthcare plans required attention. For example, while there was an assessment tool for pain, there was no corresponding care plan that outlined how a resident's pain was being managed or in relation to the administration of pain relief e.g. which pain relief to use for different symptoms and in what order pain relief should be administered ('first line / second line...'). In addition, where it was difficult to weigh residents, alternative means of determining whether residents had lost or gained weight had not been explored.

Staff of all grades demonstrated knowledge of what to do in the event of an incident of choking and practice drills took place in the centre to simulate such incidents.

Judgment:
Substantially 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):

No actions were required from the previous inspection.

Findings:

Medicines for residents were supplied by a community pharmacy. Inspectors saw that the pharmacist was facilitated to meet her obligations to residents in accordance with the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland.

There was a medicines management policy and had been reviewed in July 2015. The policy detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines. The person in charge outlined that nurses administered medicines in the centre. Nursing staff members with whom inspectors spoke demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements.

Secure storage was provided for medicines that were to be stored at room temperature. Robust measures were in place for the storage and management of medicines requiring additional controls in line with the relevant legislation and professional guidance. However, inspectors saw that the key was left in the refrigerator dedicated to the storage of medicines that required refrigeration. The refrigerator was located in an unlocked office. Inspectors observed that the office was accessed by non-nursing staff, residents and visitors. This was brought to the attention of the person in charge who put steps in place to ensure a robust system for key holding on the first day of the inspection.

A sample of medication prescription and administration records was reviewed by an inspector. Medication administration records identified the medications on the prescription and allowed space to record comments on withholding or refusing medications. However, the inspector noted that one medicine had not been administered as prescribed. This was brought to the attention of the clinical nurse manager by the inspector and she put appropriate measures in place to clarify the prescription on the first day of the inspection.

Some residents required their medicines to be administered in a modified form such as crushed. Alternative preparations, such as liquids, were used where possible. If medicines were to be crushed, this was prescribed individually on the resident's

prescription sheet by the prescriber.

The inspector saw that medicines which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. A written record was maintained of the medicines returned to the pharmacy which allowed for an itemised, verifiable audit trail.

A system was in place for reviewing and monitoring safe medicines management practices. Storage of medicines, management of medicines requiring additional controls, administration of medicines and medicines management documentation were reviewed monthly by the clinical nurse manager and an action plan was generated where appropriate. There was evidence that measures were put in place to address the actions.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

This outcome was not inspected at the previous 10-outcome monitoring inspection. At this inspection, inspectors found that a written Statement of Purpose was available that outlined the aims, objectives and ethos of the designated centre. However, the Statement of Purpose required review to ensure that it met the requirements of Schedule 1 of the regulations and accurately reflected the service that could be provided in the centre.

The capacity of the centre to provide respite services required review and clarification in the Statement of Purpose. In addition, the capacity of the centre to receive emergency admissions in light of the long-term plan to de-congregate the centre required review and clarification in the Statement of Purpose.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

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

Findings:

At the previous inspection, an annual review of the quality and safety of care and support in the designated centre was not available. At this inspection, inspectors found that an annual review of the quality and safety of care provided in the centre had taken place in July 2016 and a report was available of that review. While the review identified areas that required action, there was no action plan arising from the review to allow for tracking of identified actions. This was discussed with the representative of the provider and the person in charge at the close of the inspection.

The representative of the provider had completed an unannounced visit to the centre within the previous six months and a report of that visit was made available to inspectors at this inspection. The visit involved an assessment of 13 outcomes, including key aspects of quality and safety of care, such as personal plans, complaints, safeguarding, healthcare needs, premises, medication management and governance and management of the centre. The report identified areas that required action and an action plan allowed for tracking of those actions.

Audits were also completed in the centre, including in relation to medication management, privacy, dignity and modesty, meal-times, cleanliness of the environment and fire safety.

Overall, while there were systems in place to review the quality and safety of care provided in the centre that identified areas that required improvement, some key failings in relation to fire drill times and activation programmes for residents had not been identified. Also, the capacity of the centre to provide respite services or emergency admissions had not been considered.

The person in charge of the centre worked in the centre since 2013 and held the post of clinical nurse manager level 2 (CNM2). She was supported in her role by two clinical nurse managers (CNMs1), who deputised at times when the person in charge was not in the centre. The person in charge and CNM1s demonstrated that they knew residents and their needs well. Relatives spoke very highly of the person in charge and staff team as a whole. Relatives emphasised the positive improvements that had taken place in the centre since the person in charge commenced in her role in terms of making the centre

more homely and less institutionalized.

Judgment:
Substantially Compliant

Outcome 15: Absence of the person in charge

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

Theme:
Leadership, Governance and Management

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

Findings:
There were suitable arrangements in place in the event of an absence of the person in charge. There had been no occasion when the person in charge had been absent from the centre for a period of time exceeding 28 days since commencement of the regulations. There were two clinical nurse managers (CNM1) who deputised at times when the person in charge was absent from the centre. A senior staff nurse was identified as being in charge on the roster at times when there was no CNM on site.

Judgment:
Compliant

Outcome 16: Use of Resources

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

Theme:
Use of Resources

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

Findings:
At the previous inspection, failings were identified in relation to health and safety and the premises. Since the previous inspection, the provider had taken adequate steps to address key failings. For example, fire improvement works recommended by an external competent person in the area of fire safety had been implemented in full. Privacy screens had been purchased to afford additional privacy and dignity.

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):

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

Findings:

Overall, a review of staffing arrangements, training records and staff meetings indicated that staffing numbers and skill mix in the centre met the assessed needs of residents at the time of inspection. Staff training needs to support activities and programmes for residents required review.

An actual and planned staff roster was in place in the centre. While there were challenges filling the roster due to planned and unplanned leave, the required number of nursing and care staff to meet residents' assessed needs were being maintained.

A review of training records indicated that staff received appropriate training, including refresher training, as part of a continuous professional development programme. Where new staff had commenced in the centre, they had been scheduled for training. For example, staff had training in relation to fire safety, the protection of vulnerable adults, hand hygiene, incident reporting, catheterization, communication, first aid, critical care, dialysis. Emergency situations were practiced, including in relation to episodes of choking, CPR (cardio-pulmonary resuscitation) and a major aquatic incident (drowning).

However and as previously discussed under Outcomes 5 and 10 residents did not have a day service and it was not demonstrated that their needs had been adequately assessed and were being met on an individualized basis. It was not demonstrated that staff had been provided with the necessary training to ensure residents had a meaningful day, appropriate to their individual needs, abilities and interests.

Staff meetings took place and included weekly handover reports at which relevant topics were discussed. A review of topics at the most recent meeting included discussion of safeguarding, hand hygiene, swimming, recording of meals and cleaning records.

Unit meetings also took place on a six-monthly basis. A review of the most recent two meetings this year to date indicated that topics discussed included restrictive practices, the emergency plan for the centre, the management of monies, transition plans and the role of the key-worker.

Judgment:
Substantially Compliant

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:

While overall records required under the regulations were maintained as required, gaps were identified in relation to staff files and fire records.

At the previous inspection, policies and procedures, including those on medication management and the use of restraint, required review. Since the previous inspection, policies in relation to medication management and the use of restraint had been reviewed. However and as identified in other centres, the complaints policy did not meet the requirements of regulation 34(3)(a) and (b). This has been included as an action under Outcome 1 of this report.

At the previous inspection, gaps were identified in relation to staff files. At this inspection, a sample of staff files were reviewed in order to ascertain the effectiveness of the recruitment procedures in place. Of the sample reviewed, one file was incomplete as it did not contain a copy of the qualifications of that staff member, as required under Schedule 2 of the regulations.

At the previous inspection, recording in relation to resident assessments and associated care plans were not always complete, as required under Schedule 3 of the regulations. At this inspection, records in respect of each resident and other records to be kept in the centre were maintained as required. The directory of residents contained the

information required under the regulations. While the insurance certificate for the centre viewed had expired, the up-to-date certificate was submitted to HIQA the day following the inspection.

However, servicing records of tests of fire equipment conducted in the centre were not available for review during this inspection. While records were submitted following the inspection, they were not being held in the centre as required under Schedule 4 of the Regulations.

In addition, inspectors saw that two medication administration records were not complete. Where a dose range was prescribed (e.g. one to two tablets), the actual dosage administered to the resident was not recorded on the medication administration record.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Julie Hennessy
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:	Cork City North 8
Centre ID:	OSV-0003307
Date of Inspection:	23 August 2016
Date of response:	6 October 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

For a number of residents, monies were kept in a central account under the organisation's name. It was not demonstrated that this practice was in line with the Regulations as consent had not been obtained and the account was not in the name of the resident to which the money belonged.

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 12 (4) (a) and (b) you are required to: Ensure that the registered provider or any member of staff, does not pay money belonging to any resident into an account held in a financial institution, unless the consent of the resident has been obtained and the account is in the name of the resident to which the money belongs.

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

The Finance Department of the organisation is currently reviewing the financial controls in place for resident monies. Liaison with families and staff to review the current process and controls is on-going.

Proposed Timescale: 31/12/2016

Theme: Individualised Supports and Care

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

The complaints policy required review as it did not ensure that a second person, other than the person nominated to maintain a record of all complaints, was available to residents to ensure that all complaints were appropriately responded to and records maintained to demonstrate such assurances were in place.

2. Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

A second person from the Senior Management Team of the organisation has been nominated to respond to complaints made.

Proposed Timescale: 06/10/2016

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:

As detailed in the findings, supports to develop and maintain links with the wider community required further development.

3. 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:

The staff roster is being reviewed by the PIC to facilitate the release of a staff member to enable residents participate in more activities in the Community.

Proposed Timescale: 01/10/2016

Outcome 05: Social Care Needs

Theme: Effective Services

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

The review of the personal plan was not multi-disciplinary, as required by the Regulations.

4. 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:

A plan has been developed in conjunction with the multi-disciplinary team to review individual personal plans. A time frame has been agreed with the MDT to review these on a quarterly basis over a 12 month period.

Proposed Timescale: 30/10/2017

Theme: Effective Services

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

Comprehensive assessments of residents' social care and developmental needs had not been completed and did not inform individualized daily programmes.

5. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

An assessment for all residents regarding social and developmental needs will be carried out.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

Where residents were due to transfer from this centre to another centre, a multidisciplinary assessment of needs was to be completed prior to this transition for all residents.

6. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

The PIC has agreed a plan in conjunction with the multi-disciplinary team to carry out individual assessments for residents who have been identified to transition from the current designated site.

Proposed Timescale: 31/10/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

The centre did not meet the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) as it failed to provide adequate private accommodation for residents, rooms of a suitable layout for the needs of residents, suitable storage facilities for personal use of residents, suitable storage for other required items and equipment required by residents, adequate ventilation, baths/showers of a sufficient number and standard suitable to meet the needs of residents.

7. Action Required:

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

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

The plan developed in conjunction with the funding body to de-congregate this centre will reduce the number of residents over a period of time.

A group of 5 are due to transfer by the end of 2016 to new accommodation. Two more buildings have been identified in the Cork area and these will enable the transfer of an additional 4 by mid-2017 and another 4 individuals by the end of 2017.

The remaining 11 residents will transfer to other centres within the organisation by the end of 2018, at which time the centre will close.

The accommodation for the remaining residents will be improved in the areas of storage facilities, etc as the number of residents reduce.

Proposed Timescale: 31/12/2018 (for final transfers)

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:

As detailed within the findings, further improvement was required to the identification of hazards, assessment and control of risks. For example, in relation to fire safety, infection control, bedrails and how escalated risks were addressed within the service.

8. 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:

A plan was submitted by the PIC and Provider nominee detailing the plans to address issues relating to fire safety.

Risk assessments for individual infection control issues will be completed. The bed-rail assessment algorithm will be used to review all uses of bed rails.

Proposed Timescale: 30/11/2016

Theme: Effective Services

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

The arrangements in place for the prevention and control of blood-borne viruses were not adequate as it was not clear how any spillages would be adequately managed. In addition, the risk assessment required review as the control measures were generic and did not capture all of the measures in place in practice.

9. Action Required:

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

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

On site protocol will be developed for the prevention and control of blood-borne viruses. Risk assessment will be reviewed and updated to reflect site /individual specific control measures.

Proposed Timescale: 14/10/2016

Theme: Effective Services

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

Fire drill records did not demonstrate that the arrangements in place for evacuating residents in the event of a fire were adequate.

In addition, residents' personal emergency evacuation plans (PEEPs) required more specific information, as specified by the guidance in the PEEP form itself.

10. 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:

Multi-disciplinary review of fire drill records and fire drills took place. Measures put in place to reduce time scale in evacuating residents. Residents are transferring through horizontal evacuation initially. Reviews have taken place with staff to ensure that staff members prioritise which compartments are evacuated first in the event of fire following a check of the fire panel. An Action Plan was submitted to HIQA outlining the outcomes of this review. Review of individual PEEPs were completed as part of this review.

Proposed Timescale: 06/10/2016

Theme: Effective Services

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

Not all means of escape were kept free from obstruction.

All final fire exit doors were locked with a key, which was removed from the door-lock. It was not demonstrated that the arrangements in place to ensure means of escape in the event of a fire were adequate as not all staff on duty carried a key and suitable alternatives had not been explored.

11. Action Required:

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

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

As part of the action plan and MDT review the exit door lock system was reviewed. Door locks to be changed to master locks with keys on all exit doors. Each staff member will have a key on their person when on duty. The locks have been ordered and this work is scheduled as a priority.

Proposed Timescale: 07/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

It was not demonstrated that the centre's guidance had been followed where physical holds were required for the taking of bloods, for example, a risk assessment had not been completed.

12. Action Required:

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

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

The PIC will carry out a review of physical interventions in relation to taking bloods. Risk Assessments will be updated where required.

Proposed Timescale: 07/11/2016

Theme: Safe Services

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

Training records indicated that one staff member required training in relation to positive behaviour support.

13. Action Required:

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

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

A training plan is in place for staff member to attend MAPA.

Proposed Timescale: 15/10/2016

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:

Clarity was required in relation to some practices that were recorded in the quarterly returns as it was not clear what the restrictive practice entailed e.g. a cosy chair was included on the returns and it was not clear how or whether this was a restrictive practice.

14. Action Required:

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

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

The piece of equipment was prescribed for postural support; however the use of a lap strap to prevent the resident from sliding out of the chair classifies it as a restrictive intervention, under guidance from the organisation's own policy.

Proposed Timescale: 06/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

As detailed in the findings, some healthcare plans required attention in relation to pain management and determining whether residents had lost or gained weight.

15. 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:

Multi-disciplinary reviews, utilising tools such as the DIS DAT, the FLACC Behavioral Pain Assessment Scale will be carried out and individual pain management support plan will be developed. A staff member has recently qualified as a RNP and will be part of this team. A referral has been sent to the dietician regarding a specific resident in seeking support and advice around the individual person's weight.

Proposed Timescale: 07/11/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The Statement of Purpose required review to ensure that it met the requirements of Schedule 1 of the regulations, accurately reflected the service being provided in the centre and the long-term plan to de-congregate the centre.

16. 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 Resident Guides have been reviewed and updated, copies have been submitted to HIQA.

Proposed Timescale: 06/10/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

While there were systems in place to review the quality and safety of care provided in the centre that identified areas that required improvement, some key failings had not been identified and the capacity of the centre to provide respite and emergency admissions required review.

17. 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:

The PIC and Provider Nominee are reviewing the provision of short-breaks and emergency short-breaks. The outcome of this review is that the number of short-break beds available has been reduced to 1. As the centre is de-congregated this facility will be discontinued in this designated centre.

Proposed Timescale: 06/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

It was not demonstrated that staff had been provided with the necessary training to support residents activities.

18. 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:

The PIC will arrange refresher training for staff members in areas such as sensory stimulation in conjunction with staff members with expertise in these areas. Also refresher training will be explored with the Physical Activities Department.

Proposed Timescale: 30/11/2016

Outcome 18: Records and documentation

Theme: Use of Information

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

Where a dose range was prescribed (e.g. one to two tablets), the actual dosage administered was not recorded on the medication administration record.

19. 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:

MARs have been reviewed. MARs now specify actual dosage of medication to be administered.

Proposed Timescale: 06/10/2016

Theme: Use of Information

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

Records of tests of fire equipment conducted in the centre were not available for review during the inspection.

20. 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:

Records of tests of fire equipment in 2016 will be submitted to HIQA

Proposed Timescale: 10/10/2016

Theme: Use of Information

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

A review of a sample of staff files indicated that the system for obtaining information and documents in respect of staff currently and previously employed at the designated centre was not sufficiently robust.

21. 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:

The PIC has reviewed all staff records with the HR department. Any omissions have been identified, rectified and staff records updates will be completed with staff members.

Proposed Timescale: 14/10/2016