Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Peamount Healthcare ID Community Based Service
Centre ID:	OSV-0003504
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Peamount Healthcare
Provider Nominee:	Kevin McNamee
Lead inspector:	Anna Doyle
Support inspector(s):	Conan O'Hara
Type of inspection	Announced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	4

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:
18 August 2016 09:30	18 August 2016 20:15
19 August 2016 08:30	19 August 2016 17:00

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 the designated centre. This was an announced inspection and was carried out to inform a registration decision and to follow up on actions from the previous inspection carried out in the centre in January 2016. In addition inspectors were reviewing progress in relation to a number of notifications submitted to HIQA regarding residents' finances in the centre.

Since the last inspection the provider had met with HIQA to discuss issues in this centre and Peamount services generally around the appointment of persons in

charge. The provider had given assurances to HIQA at this time, that they were actively trying to recruit persons in charge for this centre.

In response to the high level of non compliances found at this inspection the provider was called to a meeting in HIQA offices, during which the provider assured inspectors that they were taking proactive measures to address the non compliances.

Description of the service:
The centre had prepared a Statement of Purpose, however the information contained in this regarding room layout and occupancy levels in the centre was unclear. In response the provider was asked to submit clear floor plans and include them in a revised Statement of Purpose. On the day of the inspection the inspectors were informed that 27 residents were currently being supported in the centre, two of whom were not present at the inspection. One resident had been temporarily transitioned due to medical needs and the other resident was at home.

This centre is operated by Peamount Healthcare and comprises of three separate units, situated in community settings in County Dublin. The designated centre comprises of three locations two of which are located close to each other and the other one was approximately 11 km away.

The first location could accommodate 13 residents and comprised of two, one bedroom apartments, six two bed apartments and one three bedroom apartment. The second location accommodated nine residents and consisted of four apartments. Three of these apartments were three bedroom apartments located on the ground floor and one apartment was a one bedroom apartment located on the first floor. The third location accommodated four residents and comprised of two semi detached houses. Two of the locations are owned by Peamount Housing association and one location is leased from a third party.

The centre provides care to both male and female residents who have an intellectual disability, some of whom have medical needs, mobility issues and some behaviours that challenge. The model of support is based on assisted community living using the social care model. Community nursing supports are available seven days a week during the day. In addition there is an on call system in place from a nearby campus operated by Peamount for any out of hour's concerns or advice.

How we gathered evidence:
Over the course of this inspection inspectors met with 14 residents to hear their views on the quality of services provided in the centre. In addition seven residents' questionnaires were received by inspectors. Overall the feedback from residents was positive. Almost all of them stated that they were satisfied with the services provided in the centre and were happy living there. Examples of some feedback given included; that residents loved having their own rooms and apartments, and liked being able to shop and prepare their own food. However, two residents stated that there were some things that they would like changed. They stated that they were lonely sometimes and felt that unfamiliar staff would benefit from some further training around respecting residents' privacy. An example given was for new staff to knock before entering residents' rooms.

Inspectors also spoke with three family representatives and received one family questionnaire. Overall families were broadly happy with the services provided however; some families raised a number of issues around social activities and the level of support being provided to their family member. Their comments and the views of residents are reflected in the body of this report.

Some residents were unable to express their views on the quality of services in the centre and some residents chose not to meet with inspectors. In response inspectors observed practices, reviewed personal plans and observed interactions between staff and residents. The person in charge had only been recently appointed and was interviewed at this inspection. A number of staff were met and other documents were reviewed including risk assessments, staff files and financial records.

Overall judgment of our findings:
Inspectors found that 16 of the actions from the last inspection had not been implemented. Non-compliances identified at the last inspection were found to have been attributed to the lack of clear governance and management structures in place at the time, particularly in relation to the person in charges ability to ensure effective governance of the centre. This was due to a large number of other responsibilities that the person in charge had in Peamount services. The provider had being making efforts to address this non compliance, a new person in charge had been recently appointed to the role.

Significant failings were found at this inspection that was consistent with the findings at the last inspection. However, some assurances were provided through interactions with the new person in charge that the failings would be addressed. Major non-compliance was found in six of the outcomes. These included residents' rights, admissions and contracts of care, social care needs, health and safety and work force. Moderate non-compliances were found in eight of the outcomes, two of the outcomes were found substantially compliant and two were found to be compliant. The action plan at the end of this report outlines the improvements required.

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, inspectors found that there were practices in place in the centre to promote residents' rights, dignity and consultation. However, improvements were required in relation to residents' finances and upholding some residents' rights in the centre.

Residents were consulted on how the centre was run through monthly residents meetings where discussions took place around activities, events, news and household issues including maintenance and fire. Residents had access to advocacy services. One resident spoken to said that they knew their rights and spoke about their previous involvement as an advocate in a national group.

There was a complaints policy in place and information on the complaints procedure was on display in a prominent area. Inspectors reviewed the complaints log for the centre which showed that all complaints were responded to in line with the centre policy. Complaints related to staffing, transport and clothes. There were no open complaints on the day of inspection. However, families spoken with stated that while they were broadly happy with the service, they felt that concerns were not always fully addressed in a timely manner.

In addition one resident informed inspectors of a concern they had with a staff member that they had reported to a social worker. While this had been followed up on the morning of the inspection, the resident informed inspectors that they were not happy with the outcome. This was discussed at the feedback meeting and assurances were given from the provider that this would be followed up.

Inspectors observed staff treating residents with dignity and respect. The centre had an intimate care policy and while intimate care plans were in place, inspectors found from a sample viewed that the plans required more detail, to guide staff in ensuring that residents' privacy and dignity was respected. In addition one resident stated in their questionnaire that sometimes new staff would not always knock before entering a room and the resident suggested that further training may be beneficial to new staff.

The centre had a policy on resident finances in place; however this did not guide practice and did not uphold residents' rights. Inspectors acknowledge that this policy is currently under review. Prior to the inspection a number of notifications regarding residents' finances had been submitted to HIQA. The provider had taken responsive action to this, by employing an external company to audit residents' finances in the centre.

The provider had also assured HIQA that residents would be refunded any monies that could not be accounted for once the audit was complete. The final report from the auditors would also include recommendations to ensure that effective systems would be introduced so as to safeguard residents' finances in the future. At the time of the inspection the report from the external auditors was not completed.

As an interim measure the provider had implemented some changes to the recording systems used to ensure residents finances were been safeguarded. However, inspectors found that these systems were not effective. For example receipts of monies spent were not clear. One receipt had a record of €30 being spent and there was no verification on the record book as to what the money was spent on.

The person in charge informed inspectors that they intended to follow up on this receipt and also intended to introduce a more robust recording system that ensured transparent and accurate records were maintained to ensure residents' finances were safeguarded.

Inspectors also found that some residents' finances were being used to pay for additional staff supports (personal assistants) from an external agency provider. These fees were substantial and inspectors were informed that these staff supported residents to achieve social care activities and also assisted with laundry and shopping.

This service was not outlined in the statement of purpose for the centre and inspectors were not satisfied that this was respecting residents rights in terms of equality as not all residents had to pay for this service.

Judgment:
Non Compliant - Major

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 assessed and supports were provided to residents. However, some improvements were required in relation to supporting residents to communicate.

The centre had a policy on communication. Individual communication needs were highlighted in residents' plans and each resident had a communication passport.

Inspectors viewed a sample of communication passports and found that they detailed resident's ability to communicate, ways in which they liked to communicate and likes and dislikes. However, some improvements were required as inspectors found that some of the information in the passports was out of date. For example, one communication passport viewed was written in 2013 and referred to an upcoming move to a new location for the resident that had already been completed.

In addition, on the first day of inspection, inspectors requested to see two communication passports as outlined in the residents personal plans. However, they were not available as they could not be found. These were made available on the second day, and inspectors found that one of these residents required a high level of support to communicate. This practice did not ensure residents' were supported to communicate at all times.

Inspectors also spoke to a resident about an activity schedule displayed in their room. However, the resident could not identify a lot of the pictures used in the schedule and stated that they did not like some of the activities presented in the schedule when the inspector informed them what they were.

Residents had access to phones, radio, television and the internet.

Judgment:
Non Compliant - Moderate

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:
The inspector found that residents were supported to develop and maintain positive personal relationships and develop links with the wider community.

The centre had a visitor's policy in place. Staff and families spoken with confirmed that there were no restrictions on visits to the centre.

The inspector reviewed contact with friends and family and found that residents maintained regular contact through phone calls, visits to the centre and visits home. One resident told inspectors that they had booked a trip abroad to visit their sister. Families spoken with and family questionnaires reviewed highlighted that the centre supported residents in maintaining their relationships. Residents in one unit of the designated centre told inspectors they visited each other's apartment daily.

Residents were supported to maintain links with the community based on their individual choices. Residents were engaged in day services and involved in holidays, shopping, bowling, cinema, visits home and dining out.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
Overall inspectors found that the actions from the last inspection had not been fully implemented and that improvements were required in the admissions policy, contracts for the provision of services and residents fees in the centre.

Since the last inspection the provider had undertaken to have a written contract for the provision of services for each resident that included the support and care to be provided and where appropriate the fees and additional fees to be charged. This had been due for completion on 29 February 2016. However, inspectors found that this had not been implemented. A copy of a draft contract was made available to inspectors, however it did not include all of the services provided and the fees and additional fees where appropriate.

Residents had tenancy agreements in place. However, they did not detail the amount of rent charged and were not signed by the resident or the landlord.

In addition, while some residents spoken to were clear about the amount of rent they were charged, others were not clear and were not aware of a rent supplement that they received, which inspectors were told was paid into residents personal accounts. There were no records available to inspectors to confirm this payment, as residents financial records were being audited.

There was no admission policy in place in the centre that included transfers, discharges and the temporary absence of residents in the centre. Inspectors were informed that no new admissions were being accepted from agencies or persons external to Peamount services and that the current vacancies in the centre would only be filled by residents wishing to transfer from campus based settings or from other locations in this centre. At the time of the inspection one resident had been temporarily transferred to a more high support setting for respite care following a hospital admission. While there was no policy in relation to this, inspectors were satisfied that the transition had been based on the welfare of the resident in question.

Judgment:
Non Compliant - Major

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Overall inspectors found that the actions from the last inspection had not been fully implemented and improvements were required to ensure that residents assessed needs were being met.

Since the last inspection the provider had undertaken to have a comprehensive assessment of need completed for each resident by 31 March 2016. Inspectors found that the provider was introducing a new assessment of need for all residents however there was still some significant work required. Therefore this action was not completed.

From a sample of personal plans viewed, inspectors found that the assessment of need was not detailed enough and did not include all residents assessed needs in terms of healthcare, social care and independent living skills in their homes. For example one plan did not include in the assessment of need, that a resident was at risk of falls or had a significant health condition.

In addition there were no interventions in place for some assessed needs. For example one residents plan stated that they were at risk of choking. However, there were no speech and language guidelines in place around this and no detailed risk assessment in place around supervision for this resident, particularly given that the resident spent considerable time alone in their apartment during the day. In addition some of the assessed healthcare needs had no health action plans in place to guide staff.

Residents had access to allied health professionals including occupational therapy, speech and language, GP and psychiatry. However inspectors reviewed minutes of a meeting held for one resident in May 2016 that stated a referral should be made to an allied health professional. This had not been completed and staff spoken to confirmed this. In addition concerns around supports and advice for staff around one residents' healthcare needs that was raised at an MDT in June 2016 had not been addressed.

Inspectors found that it was not clear how life skills were taught in the centre and the supports residents required to maintain or enhance these skills. For example there were no structured plans in place around the supports residents required for shopping, laundry, cleaning, meal preparation and socialisation in the centre.

Some parts of residents' plans were in an accessible format for residents. For example communication plans, falls prevention and an all about me plan that detailed residents likes/dislikes and things that were important to them. This had been an action from the last inspection.

Some residents who smoke had a risk assessment in place and the inspectors saw where the resident had been provided with information and supports around smoking. However, some interventions in place for a resident who smoked did not have details of whether this had been done in consultation with the resident and while staff were clear

as to why it was implemented, this was not documented in the personal plan.

There was no clear system in place to review the effectiveness of plans. This had been an action form the last inspection. Inspectors were informed that residents would have a multidisciplinary review every three months; however this had not been completed for all residents. In addition it was not always evident if residents or their representatives were involved in their personal plans. This had been an action from the previous inspection.

Information from one family questionnaire stated that they were waiting a number of months for a copy of their family members personal plan, had not been made aware of their initial move to the centre and raised concerns around the supports their family member received for social development, meal preparation and evening activities in the centre.

Judgment:
Non Compliant - Major

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

Theme:
Effective Services

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

Findings:
Overall inspectors found that the actions from the last inspection had been implemented with the exception of one which still required improvements.

The designated centre comprised of three locations and comprised of apartments in two locations and two semi-detached homes in the third location.

In all of the locations with the exception of one, the residents guided the inspectors around their homes. Inspectors found that each resident had their own bedroom which was personalised to their own tastes and contained ample storage facilities. Some residents had a large amount of personal possessions stored in their bedrooms, however they stated that they were happy with this arrangement.

There was adequate showering and toilet facilities in each location. Each apartment/ house had a kitchen cum dining area and adequate cooking facilities were available. There was adequate communal space for residents. Assistive devices were provided to

maximise independence for residents. For example a call alert system was in place in each location for residents to use in the event off them requiring assistance. Residents spoken with were very clear about how to use this bell.

Inspectors found there to be ample storage; however there was some equipment that was no longer in use was being stored in the centre. For example, a stair chair was in place in one of the locations that was no longer being used and some equipment for personal care that was no longer required was stored in one bathroom.

Since the last inspection the provider had undertaken to carry out maintenance work that had been highlighted at the last inspection. Inspectors found that this work had been completed.

However, inspectors found that some areas of the centre required further maintenance work. For example, on the second day of the inspection, one resident informed inspectors that they had no hot water in their en-suite. The resident had reported the issue to maintenance themselves a number of days before the inspection. This was addressed by the end of the inspection.

In addition, inspectors were informed that the kitchens in the two semi detached houses had recently had some refurbishment work completed. However, inspectors found that some of the kitchen cabinets were peeling and the boilers in both of these houses were left exposed in both kitchens which did not make it welcoming or homely for residents.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

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

Findings:
Overall, inspectors found that there were policies and procedures in place for risk management and emergency planning in the centre. However, improvements were required in the areas of risk management and fire and the three actions required from the last inspection were not completed to a satisfactory level.

The centre had an up-to-date health and safety statement and a policy in place in relation to missing persons. The risk management policy in place included the specific risks outlined in Regulation 26. Inspectors found that unit specific risk registers were

maintained in electronic format in each unit. Risk assessments included medication, slips, trips and falls, storage of oxygen, fire, and smoking.

However, as identified in the previous inspection the risk management system required improvement. Inspectors found that not all risks were assessed for example residents being left unsupervised was not assessed. In addition, inspectors found that a unit's risk register included risks from other units as well as individual risk assessments for residents who were not in the unit. Staff had not completed risk assessment training. This had been part of the action plan from the last inspection.

Inspectors found that there were some fire safety arrangements in place. The centre had fire alarms, emergency lighting and fire fighting equipment in place and these had been serviced appropriately, The centre had an evacuation plan in place which detailed the residents and the supports required. However, as identified in the previous inspection, the arrangements in place for evacuating all persons in the designate centre required improvement. For example, there was no information on how a resident who is insulin dependent would be supported in the event of an evacuation.

The emergency plan also did not include a safe location for residents to go if unable to re-enter the centre. Personal emergency evacuation plans (PEEPs) were in place for each resident however the plans did not adequately detail the supports required for each resident. For example, the PEEP for one resident who had a hearing impairment did not outline how they would be alerted should they need to evacuate the centre.

Inspectors found that there were gaps in staff fire training records. This had been an action from the last inspection. Staff spoken to by inspectors said they felt unsure on their ability to complete an evacuation. The centre completed one fire drill in 2015 and one fire drill in the year to date. Inspectors reviewed fire drill reports and found that they identified issues such as residents refusing to leave/needing encouragement. Inspectors acknowledge that residents spoken to were clear in what to do in the event of a fire and showed inspectors how they would respond.

Inspectors reviewed a sample of incidents and accidents. Incidents and accidents forms were not stored on site as incidents and accidents are reviewed by a team centrally. It was evident that incidents and accidents were followed up as needed through meetings and action plans. However, it was not evident that the outcomes of these meetings and action plans were being appropriately fed back to staff. For example, a wandering alert system was put in place for one resident in response to an incident but staff were unsure what it was for when asked by inspectors.

Inspectors found that there were systems in place in relation to infection control and the centre employed household staff in place. Hand washing facilities were adequate and personal protective equipment was available. However, while inspectors found that the centre for the most part was clean, areas still needed to be addressed. For example, some shower areas were not clean and furniture had large amounts of dust on them.

This was discussed with the person in charge and at the feedback meeting and inspectors was informed that there had been ongoing issues with the agency who provided cleaning services. The person in charge stated that a meeting had been

scheduled with the cleaners to discuss these issues and documentation was provided confirming this. In addition, the cleaning equipment was not maintained to a high standard. For example floor mops were dirty and stored in some bathroom areas.

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:
Inspectors found that the actions from the last inspection had not been fully implemented and improvements were required in restrictive practices in the centre.

Since the last inspection the provider had undertaken to ensure that all staff would undertake training in safeguarding vulnerable adults. Inspectors found that not all staff had completed this training. Staff spoken to were aware of what to do in the event of an allegation of abuse and were aware of the procedures to follow. Residents spoken with said that they would talk to staff if they were concerned and all of them said that they felt safe in the centre.

Inspectors also found from a review of incidents that an allegation of abuse had not been reported as per the services own policy. However inspectors were satisfied that this allegation had been followed up.

A number of notifications had been submitted to HIQA regarding residents' finances. The provider had employed an external auditor to complete a full review of this. The outcome of this was to be submitted to the Authority.

There was a policy in place on behaviour support in the centre. Some residents had some behaviours that challenge and from the sample of support plans viewed, inspectors found that they contained adequate information to support residents.

At the start of the inspection, inspectors had been informed that there were no restrictive practices in the centre. However, over the course of the inspection it was found that bed rails and a wandering device were in place for two residents. There were no records to support that these practices were being regularly reviewed in the centre.

Judgment:
Non Compliant - Moderate

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:
Inspectors found that one of the actions from the last inspection had not been fully implemented and that a record of all incidents occurring in the centre was not maintained in the centre.

Since the last inspection the provider had undertaken to ensure that all allegations of abuse were notified to HIQA and quarterly notifications would be submitted as required under the regulations. Inspectors found that quarterly notifications had been made to HIQA.

However, from a review of incident reports and records in the centre, inspectors found that a number of incidents had not been notified to HIQA. These included, one unexplained absence of a resident from the centre, one allegation of abuse and two restrictive practices in the centre, that included bed rails and a wandering alarm.

Judgment:
Non Compliant - Moderate

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:
Overall, inspectors found that the general welfare and developmental needs of residents' were promoted. Residents were afforded opportunity for new experiences, social participation and education and training in the day services they attended. However, some improvements were required.

Inspectors spoke with and observed residents, staff and viewed documentation and found that the residents were provided with activation in line with their preferences. Residents attended day services or were actively retired. Residents told inspectors about activities they are involved in which included bowling, art, music, cinema, dining out, holidays, mass, shopping and attending day services in Peamount. All residents stated that they loved living in the centre.

Residents were also encouraged and supported to improve their independent living skills where appropriate. For example, in one location, all residents were able to tell inspectors the code for the alarm on the front door and were able to disengage the alarm themselves. In addition, inspectors spoke to three residents who resided in one apartment. The residents stated that they enjoyed living in the centre and told inspectors how they all contributed to cooking meals, laundry, some cleaning and grocery shopping in the centre.

However, some improvements were required to ensure that all resident had opportunities to participate in actives in accordance with their needs and preferences. Over the two days of inspection, inspectors observed some residents in two locations not engaged in meaningful activities for significant periods of time. Residents were seated in chairs with no apparent stimulation.

One resident told inspectors that they were very lonely in the centre and that there was not much to do during the day. Inspectors reviewed activity records and found that there were significant gaps in the recording of activities for example one activity sheet recorded one activity 'Pottery' for the month of June. In addition families stated that they would like some more evening activities for their family member.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

Findings:
Overall inspectors found that residents were supported to enjoy best possible health, however improvements were required in health action plans and the assessment of need.

Inspectors found that residents had access to their own general practitioner. Nursing staff were available in the centre to support and assist residents with their healthcare needs. However, some healthcare plans had not been reviewed since August 2013 and there were no plans for some residents assessed needs. Inspectors spoke to staff about the supports residents required around these needs and found that staff were knowledgeable in this area and knew how to support residents.

Residents spoken to were very aware of their healthcare needs and were able to tell inspectors about upcoming medical appointments that they were due to attend.

Inspectors observed some meals for residents. Residents chose their menus themselves and went shopping for groceries in the community with staff support. There was information on healthy eating education available in one location.

Some residents prepared meals themselves and talked about meals that they liked to prepare. One mealtime was observed where residents were being supported to prepare a meal. The food provided looked appetizing and nutritious. Residents were observed in preparing and serving the meal.

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

Findings:
Overall the inspectors found that the action from the last inspection had been completed. However significant improvements were required in a number of areas.

Since the last inspection the provider had undertaken to ensure that prescription sheets were rewritten to ensure that the information contained on the prescription was legible. Inspectors found that the information on the prescription sheets viewed was legible. However, other discrepancies were noted on a number of prescription sheets viewed.

For example some medications as required (PRN) medication did not have indications for use recorded on the prescription sheet. Some PRN medications had protocols in place around their administration however, some had two protocols in place for the same medication, with differing information recorded on both. In addition labels on PRN medication stored in one location of the centre were not clear.

The medication policy for the centre was in draft format only on the day of the inspection. All staff were required to have completed training on the administration of medication in the centre, however some staff training was not refreshed and therefore staff were not covered to administer emergency medication for the treatment of epilepsy to residents who required it. Inspectors found that some staff were not aware of why residents were prescribed some medications.

There were systems in place for the disposal of unused/discontinued medication in the centre. This had been recently implemented by the person in charge who had met with the resident's pharmacist to discuss this. Some residents had medication presses in their bedrooms where appropriate and some residents' medications were stored centrally in a medication press.

Inspectors found that the medication press in one location was not adequate to store all of the required medication appropriately. In addition inspectors found that medications stored in some residents medication presses was no longer prescribed on the prescription sheet. The person in charge contacted the residents GP to confirm if this medication had been discontinued and inspectors were informed that the medication had not be rewritten on the prescription sheet by the GP the previous day.

Medications were dispensed from a local pharmacy in blister packs where appropriate for storage purposes. An identification card was attached to each blister pack that gave details on the medications stored in the blister pack. This identification card was used by staff to audit medications received from the pharmacy to ensure that the medication stored in the blister pack corresponded with the medication on the identification card and the prescription sheet. Inspectors were informed that two staff were required to check and sign the card as record that medications were checked. However inspectors found that this was not always completed.

All residents had risk assessment completed for self administration of medication. However, the information recorded was contradictory in some parts of the assessment. For example one assessment completed stated that the resident required level one supports, meaning that they required occasional verbal reminders to take medications and required support around ordering and storage of medications. However the assessment stated that the resident required assistance with opening containers and that staff supervision was required around certain medications.

Inspectors found that a significant number of medication errors had occurred in the centre since the last inspection. Inspectors were informed that a service medication committee reviews all medication errors in the centre. However, the review was not available in the designated centre and the person in charge stated that feedback from medication errors in the centre was not always sent back to the centre and therefore the learning from same was not being implemented.

Inspectors were also made aware of a meeting held with the person in charge and the resident's pharmacist to discuss and implement audits on medications practices in the centre.

Judgment:
Non Compliant - Major

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall inspectors found that the actions from the last inspection had not been fully implemented and improvements were still required.

At the last inspection there was no statement of purpose available in the centre. Part of the action plan included that when the statement of purpose was completed, it would be submitted to HIQA. This had not been submitted to HIQA prior to this inspection.

Inspectors found at inspection that a Statement of Purpose had been prepared in the centre. However improvements were still required. These included:
- The floor plans of the rooms in the designated centre including their room sizes were not clear.
- The whole time equivalents employed in the centre was not correct and did not include the use of personal assistants for some residents.
- The organisational structure for the designated centre was not included.
- The PPIM's listed on the document were not consistent with what had been notified to HIQA.
- Not all services being provided from the centre were included. For example staff from the centre assisted residents in another location managed by Peamount for periods during the day and week.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
Overall inspectors found that the actions from the last inspection had not been fully implemented. Given the non compliances found at this inspection inspectors were not assured that the governance and management structures in place since the last inspection were effective so as to ensure the safety and quality of care provided to residents. However inspectors acknowledge that a new person in charge had only recently been appointed in the centre and that this may have a positive impact on future service provision in the centre.

Since the last inspection a new person in charge had been recently appointed. They were present throughout the inspection and it was evident that they had considerable previous experience as a person in charge. They were very knowledgeable about the regulations and their role as the person in charge. They were very aware of the failings identified during the inspection and were informing inspectors throughout the inspection of how they intended to address non compliances. The person in charge was employed in a fulltime capacity and they were supernumerary in order to have oversight over the quality and care of services being provided.

There was no supervision in place for staff. This had been an action from the last inspection. Staff meetings were not held regularly in the centre. For example since the last inspection in Jan 2016 inspectors found, that in two of the locations only one staff meeting had been held. The person in charge did however outline their plans to hold staff meetings every four weeks in the centre and that supervision would be implemented initially every four to six weeks for staff.

An annual review was available in the centre, and an unannounced quality and safety review had been completed in the centre in April 2016. However the annual review did not contain the views of residents or family members on the services provided. This had

been an action from the last inspection.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge had only recently been appointed to the centre and had not been absent from the designated centre for more than 28 days. Inspectors found that there were satisfactory arrangements in place to cover any absences of the person in charge and the provider was aware of the requirements to notify HIQA in the event of the person in charge being absent.

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):
No actions were required from the previous inspection.

Findings:
Overall inspectors found that there was an appropriate skill mix in the centre to meet residents' needs.

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:
Inspectors found that the actions from the last inspection had not been fully addressed and that there were insufficient staff at certain times during the day in order to meet the assessed needs of residents.

Since the last inspection the provider had undertaken to conduct a review of the skill mix and staffing in the centre. A copy of this was not available to inspectors and inspectors were informed that staffing levels remained unchanged since the last inspection.

Inspectors found that residents were left unsupervised in apartments during the day. There were some measures in place such as the use of emergency alarms to support residents should they require assistance from staff. Residents were familiar with the alarms in all locations with the exception of one area where two residents who shared an apartment could not use the emergency alarm. One of the control measures in place to support these residents, required one staff to be in this apartment at all times.

However inspectors found that there were times during the day when other residents' needs may not be met due to this control measure being in place. For example one resident spoken to stated that in order for them to access supports around personal hygiene that they were required to phone the staff on duty and as a last resort contact an emergency response system that made contact with the reception in Peamount campus who would then contact staff in the designated centre.

Inspectors were not satisfied that these arrangements were meeting residents assessed needs in a timely and dignified manner. In response inspectors contacted the provider to discuss their concerns. The provider was asked to provide additional staffing until residents supports needs were adequately assessed. The provider submitted written confirmation to inspectors at the feedback meeting assuring inspectors that supports would be in place to ensure that all residents' needs could be met in the centre.

There was a planned and actual rota in the centre. Staff had not received training on some residents assessed medical needs. For example the management of diabetes. This had been an action from the last inspection.

No volunteers were employed in the centre. However personal assistants were employed by residents from an external agency. Inspectors requested confirmation that appropriate Garda Síochana vetting procedures and mandatory training was completed for these staff. However, there was no verification that one staff member had completed this. In addition cleaning staff were employed in the centre and were in locations unsupervised with residents over the course of the inspection. There were no records on file to support that vetting had been completed for these staff.

Personnel files were not viewed at this inspection as this had been completed as part of the last inspection of the centre in January 2016 and no issues were noted.

Judgment:
Non Compliant - Major

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

Theme:
Use of Information

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

Findings:
Overall, inspectors found that some improvements were required in relation to records and documentation.

Inspectors found that not all residents' records were kept in line with Schedule 3. Some residents' records reviewed were partially completed and weren't up to date for example residents communication passports were found to contain out dated information and residents activity trackers were found to contain significant gaps. In addition, records of incidents and accidents were not stored on-site. The inspector reviewed the directory of residents which contained the information required by Schedule 3.

Inspectors found that the records kept in the designated centre were in accordance with Schedule 4.

Inspectors found that not all the policies and procedures as required by Schedule 5 of the regulations were in place. There was no policy on access to education, training and development in the centre and three policies were in draft form: the prevention, detection and response to abuse policy, staff training and development policy and provision of information to residents' policy.

A resident's guide was maintained in the centre which included all information required under Regulation 20. An up to date insurance policy was in place for the centre.

Judgment:
Non Compliant - Moderate

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Peamount Healthcare ID Community Based Service
Centre ID:	OSV-0003504
Date of Inspection:	18 August 2016
Date of response:	10 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 is failing to comply with a regulatory requirement in the following respect:
Intimate Care Plans did not adequately guide staff to ensure that residents' privacy and dignity was respected.

One resident stated that new staff required more training in respecting rights to privacy.

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

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

Please state the actions you have taken or are planning to take:
1. Intimate care plans will be reviewed and updated to guide staff in ensuring that the privacy and dignity of all residents is respected. 30 November 2016 and ongoing.
2. As part of their induction training, the importance of upholding the residents' rights to privacy and dignity in all respects will be emphasised to all new staff members. 03 October 2016 and ongoing.

Proposed Timescale: 30/11/2016

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The interim measures introduced to safeguard residents were not effective.

The finance policy did not guide practice in terms of residents rights.

Two residents were paying for additional staff supports in the centre and there was no clear rationale why they were paying for this.

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

Please state the actions you have taken or are planning to take:
1. The PIC will introduce a more robust interim system for managing the residents' finances that ensures transparent and accurate records are maintained to ensure residents' finances are safeguarded until the recommendations in the report from the external auditors have been received and implemented. 31 October 2016 and ongoing.
2. The policy on the management of residents' finances will be updated to ensure that it guides practice on upholding the rights of residents to manage their financial affairs. 30 November 2016.
3. These arrangements have been assessed individually, with each resident, with the support of the Social Work team. For one resident, they will cease paying for the additional support and the support will be provided by the staff team from now on. For the other resident, the additional support that they are paying for is in addition to their assessed needs and the resident has indicated their preference to continue paying for this additional service. 17 October 2016.

Proposed Timescale: 30/11/2016

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One resident was not satisfied with the outcome of a complaint.

3. Action Required:
Under Regulation 34 (2) (e) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
The Social Worker met with the resident subsequent to the inspection and the outcome of the meeting was that the resident was satisfied with the outcome of the complaint. Measures have been put in place to ensure that concerns are fully addressed in a timely manner in the future and the residents satisfaction rating with the outcome will be recorded as part of the complaints process. If unsatisfied, residents will be advised and guided through the appeals process in line with the centre's complaints policy.

Proposed Timescale: 31/08/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

The is failing to comply with a regulatory requirement in the following respect:
Residents were not supported at all times to communicate in accordance to their needs and wishes.

Communication passports were out of date.

Two communication passports were not easily accessible

A resident was not able to identify activities in an activity schedule that was displayed in their bedroom and did not like a lot of the activities contained in this schedule.

4. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
1. All out of date communication passports will be reviewed and updated, and subsequently reviewed on a regular basis.
2. Communication passports will be stored in an accessible location.
3. The activity schedule will be reviewed and updated with the resident so that it supports them to communicate in accordance with their needs and wishes.

Proposed Timescale: 31/10/2016

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no contracts for the provision of services for each resident.

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

Please state the actions you have taken or are planning to take:
Contracts of care will be provided for each resident in the centre.

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no contracts for the provision of services that outlined the fees or additional fees being charged.

Residents were not aware of a rent supplement that they were in receipt of.

6. Action Required:
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident's assessed needs and the statement of purpose.

Please state the actions you have taken or are planning to take:
1. All fees or additional fees will be included in the Contract of Care issued to each resident.
2. All residents will be made aware that they are in receipt of a rent supplement, and that it is paid directly into their bank account, which they can subsequently access with their ATM cards at any time.

Proposed Timescale: 14/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no admission policy in place in the centre that included transfers, discharges and the temporary absence of residents in the centre.

7. Action Required:
Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

Please state the actions you have taken or are planning to take:
An Admission Policy will be introduced which includes transfers, discharges and the temporary absence of residents in the centre.

Proposed Timescale: 30/11/2016

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:
A comprehensive assessment of need had not been completed for all residents in the centre to include all social care needs, healthcare needs and activities of daily living needs.

8. Action Required:
Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The needs of the residents will be assessed comprehensively using a Multi-Disciplinary Team approach. Regular review meetings with the residents, their key workers and residents' representatives will inform the person centred planning process.

All personal plans will reflect these identified needs and required supports.

Proposed Timescale: 30/11/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no support plans for some residents assessed needs.

There was no structured plan in place to ensure that residents were supported with independent living skills as appropriate to their needs in the centre.

9. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
Each resident will have a support plan which will identify their assessed needs and the appropriate supports required to meet those assessed needs.

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:
Some resident's plans had not been reviewed yearly or as their needs changed.

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

Please state the actions you have taken or are planning to take:
Residents plans will be reviewed:
• If there is a change in needs or circumstance.
• Every three months at a Multi-Disciplinary Team (MDT) meeting.
• Annually.

Proposed Timescale: 31/10/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents representatives had not received a copy of their families personal plan for eight months after the request was made.

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

Please state the actions you have taken or are planning to take:
The resident will be consulted about this, and pending their permission, the requested information will be shared with the representative.

Proposed Timescale: 31/10/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
The kitchens in the two semi detached houses require modernisation

12. Action Required:
Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

Please state the actions you have taken or are planning to take:
Both kitchens have had the old wooden units removed, and these have been replaced with modern units, plus new appliances and cooking implements.

Proposed Timescale: 06/10/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Equipment was stored in the centre that was no longer in use. For example
- a stair chair was in place in one of the locations,
- equipment for personal care that was no longer required was stored in residents bathrooms.

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

Please state the actions you have taken or are planning to take:
1. The stair chair will be removed.
2. This piece of equipment has been removed.

Proposed Timescale: 14/10/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
The systems in place regarding risk identification, assessment and review required improvements as outlined in the report.

14. 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:
All identified risks within the centre will be regularly assessed, reviewed and appropriate actions taken to minimise the risks, prior to risks being escalated to an organisational level.

Proposed Timescale: 06/10/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
It was not evident that the outcomes of the review of incidents and accidents were being appropriately fed back to staff.

Staff had not completed risk assessment training. This had been part of the action plan from the last inspection.

15. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
1. The review of incidents and accidents will also include the identification of preventative actions to reduce further risk, and the communication of this information back to the staff team and other relevant parties.
2. All staff members will be provided with risk assessment training.

Proposed Timescale: 30/11/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
The cleanliness of some areas in the centre were found to need improvement as noted in the body of the report.

16. 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:
A new cleaning contract has been secured with a different service provider. The effectiveness of the new cleaning service will be reviewed regularly to assess its effectiveness.

Proposed Timescale: 06/10/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
There were not adequate arrangements in place for evacuating all persons in the designated centre and bringing them to safe locations.

17. 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:
Personal emergency evacuation plans will be updated to ensure that:
• The supports required for each resident are in line with their assessed needs and documented.
• Residents have a documented safe location to go to if they were unable to re-enter the centre.

Proposed Timescale: 30/11/2016

Theme: Effective Services

The is failing to comply with a regulatory requirement in the following respect:
Not all staff had received fire training.

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

Please state the actions you have taken or are planning to take:
All staff members will be provided with fire training.

Proposed Timescale: 31/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records around the use of two restrictive practices in the centre.

19. 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:
All restrictive practices will be identified, assessed and documented in the respective residents' care plans.

Proposed Timescale: 31/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had completed training in safeguarding vulnerable adults.

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

Please state the actions you have taken or are planning to take:
All active staff members have now received training in safeguarding vulnerable adults.

Proposed Timescale: 29/09/2016

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:
Two restrictive practices had not been reported to HIQA.

21. 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:
1. These restrictive practices have now been notified to the Chief Inspector by the Person in Charge. 06 October 2016.
2. The Person in Charge will give notice to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure was used. Ongoing.

Proposed Timescale: 06/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A notification had not been submitted regarding an unexplained absence of a resident in the centre.

22. Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

Please state the actions you have taken or are planning to take:
1. This absence has now been notified to the Chief Inspector by the Person in Charge. 06 October 2016.
2. The Person in Charge will give notice to the Chief Inspector within 3 working days of any future occurrence. Ongoing.

Proposed Timescale: 06/10/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of abuse had not been notified to HIQA.

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

Please state the actions you have taken or are planning to take:
1. This allegation has now been notified to the Chief Inspector by the Person in Charge. 09 September 2016.
2. The Person in Charge will give notice to the Chief Inspector within 3 working days of any future occurrence. Ongoing.

Proposed Timescale: 09/09/2016

Outcome 10. General Welfare and Development

Theme: Health and Development

The is failing to comply with a regulatory requirement in the following respect:
It was not evident that residents were provided opportunities to participate in activities in accordance with their interests.

One resident stated that they were very lonely in the centre.

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

Please state the actions you have taken or are planning to take:
1. Residents will be provided with opportunities to participate in activities, in accordance with their interests and wishes. 10 October and ongoing.
2. This resident will be consulted to assess whether there are additional supports that can be put in place to provide them with more meaningful activities, according to their interests. 31 October 2016.

Proposed Timescale: 31/10/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some resident's plans had not been updated since 2013.

There were no support plans in place for some residents assessed needs.

25. 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:
1. These plans will be updated and subsequently reviewed: 31 October 2016 and ongoing.
• If there is a change in needs or circumstance.
• Every three months at a Multi-Disciplinary Team (MDT) meeting.
• Annually.
2. All residents' assessed needs will be identified, and a support plan put in place for each identified need. 30 November 2016 and ongoing.

Proposed Timescale: 30/11/2016

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:** Some of the information contained in residents risk assessments on self administration of medication was contradictory and did not guide practice. **26. Action Required:** Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability. **Please state the actions you have taken or are planning to take:** The risk assessment on self-administration of medication will be reviewed and standardised so that there is no contradictory information contained in it, and that it guides practice around encouraging residents to take responsibility for their medication, in accordance with their wishes and ability.
Proposed Timescale: 31/10/2016
Theme: Health and Development **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** The medication policy for the centre was only in draft format. One medication press in the centre was too small to store all of the medications. **27. Action Required:** Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident. **Please state the actions you have taken or are planning to take:** 1. The medication management policy and all associated Standard Operating procedures (SOPs) will be updated. 2. This medication press will be assessed as to its suitability and a bigger press, or suitable alternative solution for storing the resident's medication will be put in place, in accordance with the resident's preferences.
Proposed Timescale: 30/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medications that had been prescribed for residents and was stored in residents medication presses had not been rewritten on the prescription sheet.

Not all prescribed PRN medications had indications for use recorded on the prescription sheet.

Some PRN medications were not clearly labelled.

There were two PRN protocols in place for some medications with differing information recorded on them.

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

Please state the actions you have taken or are planning to take:
1. These medications were removed from the residents' medication presses immediately. The following day, the affected kardexes were amended, and the medications returned to the resident's medication presses.
2. All PRN medications will have their indications for use recorded on the prescription sheet.
3. All PRN medications will be clearly labelled.
4. A single, clear protocol will be put in place to ensure that it guides practice in the use of PRN medications.

Proposed Timescale: 31/10/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The audit system in place for the receipt of medication into the centre was not consistently recorded.

The system in place for the review of medication errors in the centre was not effective so as to ensure that learning from the review was implemented into practice.

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

Please state the actions you have taken or are planning to take:
1. The system in place for recording the receipt of medication into the centre will be reviewed to ensure that it is effective and that consistent, accurate recording is taking place. 30 November 2016
2. The management of medication errors has been reviewed and additional processes have been put in place to ensure that there is positive learning and changes to practice. 03 October 2016 and ongoing.

Proposed Timescale: 30/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not completed refresher training in the administration of medication.

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

Please state the actions you have taken or are planning to take:
Refresher Safe Administration of Medication (SAM) training will be provided to all staff members who require it.

Proposed Timescale: 30/11/2016

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 for the centre required improvements:
- The floor plans of the rooms in the designated centre including their room sizes were not clear.
- The whole time equivalents employed in the centre was not correct and did not include the use of personal assistants for some residents.
- The organisational structure for the designated centre was not included.
- The PPIM's listed on the document were not consistent with what had been notified to HIQA.
- Not all services being provided from the centre were included. For example staff from the centre assisted residents in another location managed by Peamount for periods during the day and week.

31. 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:
1. Updated floor plans have been added to the Statement of Purpose....
2. The whole time equivalents have been updated and the use of personal assistants has been included in the Statement of Purpose.
3. The organisational structure for the designated centre has been included in the Statement of Purpose.
4. The PPIM information in the Statement of Purpose has been updated.
5. The Statement of Purpose has been updated to reflect the support that is provided to residents at a location that is not part of the designated centre.

Proposed Timescale: 28/09/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review for the centre did not include the views of residents or their representatives.

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

Please state the actions you have taken or are planning to take:
The views of the residents and/or their representatives will be sought for all subsequent annual reviews of the designated centre.

Proposed Timescale: 28/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structures in place up to the appointment of the person in charge were not effective so as to ensure the effective delivery of supports to residents in the centre.

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

Please state the actions you have taken or are planning to take:
A new Person in Charge was appointed on July 18th 2016, to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Proposed Timescale: 18/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no supervision in place for staff in the centre.

Staff meetings were not being held regularly in the centre.

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

Please state the actions you have taken or are planning to take:
1. A supervision process has been initiated and communicated to all staff member in the designated centre, for commencement immediately. 21 September 2016 and ongoing.
2. Staff meetings have commenced in the designated centre as per a defined schedule. 29 August 2016 and ongoing.

Proposed Timescale: 21/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no records to confirm that staff employed from an external agency and staff who were employed form a cleaning company had Garda Síochána vetting completed.

35. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
1. A record of Garda vetting was sourced for the staff members employed by the external agency.
2. A new cleaning contract with a different cleaning company is now in place and Garda vetting has been sourced for the staff member from the cleaning company who has commenced work in the centre.

Proposed Timescale: 05/10/2016

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors were not satisfied that appropriate staff numbers were available in the centre in order to meet residents assessed needs.

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

Please state the actions you have taken or are planning to take:
1. Additional staffing has been put in place to meet the residents' assessed needs. Completed - 19 August 2016.
2. The provider has also engaged the services of an external consultant to conduct an extensive assessment of residents' needs and a workforce analysis to ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the Statement of Purpose, and the size and layout of the designated centre. 30 November 2016.

Proposed Timescale: 30/11/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received training in residents assessed needs.

There were no records to confirm that all staff employed from an outside agency had completed mandatory training.

37. 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:
1. A new process and associated documentation will be introduced which will guide staff members in the process of assessing residents' needs.
2. Records will be kept that show that all staff members employed from outside agencies have completed mandatory training.

Proposed Timescale: 30/11/2016

Outcome 18: Records and documentation

Theme: Use of Information

The is failing to comply with a regulatory requirement in the following respect:
Not all the policies and procedures as required by Schedule 5 of the regulations were in place.

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

Please state the actions you have taken or are planning to take:
All of the policies and procedures required by Schedule 5 of the regulations will be put in place.

Proposed Timescale: 30/11/2016

Theme: Use of Information

The is failing to comply with a regulatory requirement in the following respect:
Some records reviewed were partially completed and weren't up to date
- residents communication passports
- residents activity trackers
- records of incidents and accidents were not stored on-site.

39. 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:
1. All out of date communication passports will be reviewed and updated, and subsequently reviewed on a regular basis.
2. All residents' activity trackers will be reviewed and updated, and subsequently

reviewed on a regular basis. 3. A record of all incidents and accidents is now being stored in the designated centre in an incident register which was designed by the Person in Charge. All incidents and accidents since January 1st 2016 have also been retrospectively added to the incident register.
Proposed Timescale: 31/10/2016