

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Waxwing 1
Centre ID:	OSV-0004843
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Brothers of Charity Services Limerick
Provider Nominee:	Norma Bagge
Lead inspector:	Mary Moore
Support inspector(s):	Noelle Neville
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
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 un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 July 2016 11:30	19 July 2016 19:30
20 July 2016 08:45	20 July 2016 18:00

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 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 10. General Welfare and Development
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This inspection was the third inspection of the centre by the Health Information and Quality Authority (HIQA). The last inspection was announced and was undertaken on 14 September 2015. Those inspection findings were not satisfactory. Given the significant non-compliance evidenced on that inspection, the provider was requested to attend a meeting with HIQA on 16 October in its head office at which the non-compliance was discussed and the provider was issued with a warning letter as part of HIQA's escalation procedure. A further meeting with the provider was requested and held on 15 December to discuss the response received to the action plan. While elements of the action plan were not agreed with HIQA, overall the provider did outline appropriate actions to be taken to address to failings identified.

How we gathered our evidence

This inspection was unannounced. The inspection was facilitated by the area manager and the acting person in charge. The head of community residential services and the nominated provider attended the verbal feedback at the conclusion of the inspection. Inspectors met and spoke with frontline staff. Inspectors reviewed records including complaint records, fire safety and health and safety records, records of reviews and audits, records pertaining to residents and staff related records.

Inspectors met and spoke with residents when they returned from the day service on the first day of inspection and in the morning and evening of the second day of inspection. Each resident communicated with the inspectors in the manner that was suited to their needs. Inspectors found residents to be engaged and content, residents demonstrated their comfort with the presence of the inspectors in their home and engaged freely with inspectors and with the staff on duty.

Residents spoke of their ongoing family contact, social outings they had enjoyed and planned holidays and family events. Residents clearly took pride in their personal appearance and showed inspectors recently purchased personal items. One resident eagerly introduced inspectors to the recently acquired cat.

Description of the service

The premises was a domestic type single storey premises. It was well maintained, homely and welcoming in presentation. The premises was situated in a small residential development in a rural location where transport was required to access all amenities. Inspectors saw that a vehicle was available to staff and residents and staff confirmed that plans were almost finalised for the provision of a vehicle more suited to the needs of the residents.

The statement of purpose and function stated that the provider provided residential services to residents identified as requiring increased supports due to personal health requirements and increasing age. Residential services were provided to six adult females with a diverse range of needs.

Overall Findings

Given the failure to act on the findings of a fire safety report commissioned by the provider in October 2015 and the deficits identified by inspectors in the providers own systems an immediate action plan was issued to the provider. Inspectors were not satisfied that effective fire safety management systems were in place in the centre. In relation to regulation 28 (1), the provider was requested to provide reassurance to HIQA within three working days that the registered provider would ensure that effective fire safety management systems were in place in the centre.

The provider responded within the specified timeframe and stated that following further consultation with the fire safety engineer, the latter had confirmed that remedial work carried out in early 2016 had significantly improved the safety of the premises. Further works were required in order to resolve some outstanding issues but no funding was available for the additional works.

The provider stated that the monitoring of fire safety controls would be implemented in the centre and that these controls would include the servicing and maintenance of fire safety equipment, regular fire drills and further fire safety training for staff.

The incidence of medicines management errors had decreased. However, having reviewed medicines error records, four were of note as all related to the non-administration of prescribed medication by staff; on at least one occasion medicines were signed as administered but were not administered. It was of concern to inspectors that records seen indicated that medicines management training had not been provided to over 50% of staff working in the centre; this was not disputed at verbal feedback.

There was evidence that staff welcomed complaints; that residents did complain, that their complaints were listened to and that action was taken to resolve the matters complained of. However, there was a requirement for further improvement to demonstrate that there was an effective complaints procedure in place that was consistently implemented by staff.

Overall however, improvement on the previous inspection findings was evidenced as were actions to be taken by the provider as committed to in the response to the previous action plan.

The quality of life and outcomes for residents had been enhanced by the consistent provision of additional staffing resources and constructive input into their care and supports from the multi-disciplinary team.

Arrangements for the management of the centre were enhanced by the presence of a supernumerary person in charge who was based in the centre.

There was noted improvement in supporting residents to communicate effectively and in preventing and managing behaviours that had the capacity to challenge others.

Records created by staff were noted to be respectful in tone, content and in the language used and overall and on balance were reflective of residents needs.

Of the 14 Outcomes reviewed and reported on by inspectors the provider was judged to be compliant in seven and in substantial compliance with two, in moderate non-compliance with three and in major non-compliance with two; Outcomes 7 and 12, health and safety and medicines management; these two outcomes were also judged previously as in major non-compliance. The findings to support these judgements are presented in the relevant outcome in the body of the report.

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

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

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

Findings:

Inspectors met with all residents on both days of inspection. Each resident appeared to be happy and engaged openly with inspectors, some chatted while others engaged and communicated with inspectors in the manner that was unique to them.

House meetings were held regularly as a forum for residents to discuss various matters. Records indicated that residents engaged with and contributed to this process. A new house meeting template had been developed and included items for discussion such as safeguarding, activities, meals, fire safety and evacuation plan and any other business. Inspectors noted that the template was well laid out, however, it was not being used to its full potential. For example, some discussions led to items which could have been recorded as actions but were not. In addition, it was not always recorded by staff that actions had been followed up on from the previous meetings. These findings concur with the findings of an unannounced provider visit conducted on 11 July 2016 which also found that there was a lack of evidence of the follow up on issues raised at house meetings.

There was a policy on the management of complaints and an easy read version of this policy and easy read complaints card were available to residents. There was evidence that staff welcomed complaints; that residents did complain, that their complaints were listened to and that action was taken to resolve the matters complained of. However, there was a requirement for further improvement to demonstrate that there was an effective complaints procedure in place that was consistently implemented by staff.

Inspectors reviewed the centre's local issue book in which records began in February 2016. There were four local issues recorded, resolved to the satisfaction of the person raising the issue and signed by staff. There was also an informal complaints book in the centre in which records also began in February 2016. However, of the five complaints recorded, two remained unresolved, one since 22 February 2016 and the other since 11 March 2016. Other records seen by inspectors also made references to "complaints" and inspectors were not reassured that the complaint records seen were a complete and accurate record of all complaints made. It was noted in the provider's unannounced visits conducted in March and July 2016 that the provider had on both occasions raised queries as to the number of issues logged given the complexity of issues in the centre and the level of ability of some residents in the designated centre to self-advocate. The provider's unannounced visits also concluded that it was unclear if complaints that could not be resolved locally had been escalated as required by the provider's complaint management policy.

Inspectors reviewed a sample of residents' finances. There was an organisational policy on the handling of the personal assets of adult individuals who use the services dated February 2016. The acting person in charge confirmed that the organisation was in the process of rolling out a new system of maintaining residents' finances and of the six residents in the centre, one resident had this new system in place.

In the sample of finances checked, it was noted that ledger balances matched the balance held. The acting person in charge confirmed that the ledger was signed by one staff and receipts by two staff. However, some receipts reviewed by inspectors were still only signed by one staff member. The acting person in charge said that she was meeting staff to re-iterate the importance of double signatures. Inspectors were told that the person in charge conducted a random check on residents' finances, there was an annual audit and the area manager also conducted random audits.

There were no discrepancies found by inspectors in the sample of finances reviewed, there was evidence of the purpose for which monies were used and that residents benefited from these expenditures. However, based on records reviewed and staff spoken with, inspectors formed the view that decision-making, the process, management, documentation trail and oversight particularly of larger expenditure required review to demonstrate transparency and accountability. A specific example was given at verbal feedback of the purchase of furniture/equipment and how it was not clearly evidenced how need was ascertained, how ownership by the resident was demonstrated and safeguarded and how a resident was reimbursed by the provider where equipment required following MDT review was purchased using residents personal finances.

Inspectors reviewed a large representative sample of records created by staff in relation to residents. The records seen were respectful in tone, content and in the language used.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication

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

Theme:

Individualised Supports and Care

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

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

Findings:

The action from the previous inspection was completed. Inspectors reviewed a sample of communication assessments and plans for residents. Inspectors saw that the plans were individualised to each resident, differentiated between comprehension and expressive ability and set out the strategies used by residents to communicate such as gestures, pointing to objects, single words and facial expressions. There was evidence to support that these residents had regular speech and language therapy review.

Recommendations from these reviews were seen to be implemented and included in the completion of communication passports, profiles and dictionaries. The use of assistive technology was discussed at one residents' MDT (multi-disciplinary team) meeting in November 2015 and it was confirmed that assessments to date would not indicate a need for this.

Staff spoken with confirmed that they were comfortable communicating with residents in the centre and that they had used the communication passports and dictionaries when they first started working in the centre so as to familiarise themselves with each residents means of communication. Residents however continued to take their communication passports and diaries with them when leaving the centre, for example when going to the day service.

Staff confirmed that education on communicating effectively with residents had been provided to them, included input from the psychologist on communication and its role in both triggering and preventing behaviours that challenged.

Judgment:

Compliant

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

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

As evidenced at the time of the last inspection staff maintained a log of family contact which demonstrated that residents had regular contact with family where possible including phone calls and visits. There were no restrictions on visits if this was the expressed preference of the resident. Where residents required support to facilitate ongoing contact with family and peers there were measures in place to facilitate this.

As appropriate family members were invited to and did attend the review of personal plans.

The importance of ongoing family contact and social engagement to residents was demonstrated in their conversations with inspectors. Residents spoke of the support they received from their siblings, of their inclusion in family events and celebrations and of planned outings and holidays with family and peers.

Each resident had access to off-site structured day supports/services from Monday to Friday. Each resident had a visual activity planner that reflected their participation in activities in the day service and in the wider community. Inspectors reviewed records which indicated that staff in the centre facilitated activity within the wider community such as shopping, cinema and dining out at weekends.

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):

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

Findings:

The action from the previous inspection had been satisfactorily completed. Inspectors reviewed a sample of contracts for the provision of services for residents and noted that they were in place, signed by the resident and/or their representative and the area manager. However, it was noted that the frequency of the charge for services was unclear in some contracts and some information (not required by the regulations) required updating to reflect changes in the centre. This was discussed at verbal feedback. The contract advised residents of the services included in the fee and what

residents were personally responsible for funding such as clothing, personal effects, toiletries, private medical expenses and leisure activities.

Judgment:
Compliant

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

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

Findings:

Based on the representative sample of residents' plans, My Profile My Plan, seen, improvement was noted in both the relevance and presentation of these plans. Based on staff description of residents, their strengths, needs, daily routine and overall well-being, inspectors were satisfied that overall and on balance the plan was an accurate representation of the resident and their required supports.

Staff said and there was documentary evidence that since that last inspection each resident had had a multi-disciplinary (MDT) review. The records of these reviews indicated that they were truly multi-disciplinary with good and meaningful MDT representation and input. Actions further to these reviews and responsible persons were clearly identified.

Significant and meaningful progress was noted in the process for establishing and progressing individual goals and objectives with residents. Goals were informed by the completion of an information gathering booklet and a person centred planning meeting. Records of these meetings reflected resident, family and MDT input.

There was a clear process for monitoring the progress and achievement of personal goals, any barriers were identified and there was evidence of action taken to either address these barriers or amend the goal. For example hearing loss had been identified as a barrier to progress for one resident and there was clear evidence that action had and was being taken to address this.

Aspects of the MPMP were available to the resident in an accessible format, that is, pictorial and photographic cues. On speaking with residents it was clear that the plan was implemented as residents spoke of social outings and completed and planned holidays. One resident had requested to obtain a cat. This had been supported in a planned manner and in consultation with the other residents.

There was evidence in practice of the implementation of the plan including MDT recommendations and positive outcomes for residents particularly in relation to their overall quality of life and therapeutic responses to behaviours that challenged.

Since the last inspection the quality of the MPMP process had been the subject of review by the area manager and by the provider's own review process. There were lingering challenges as evidenced on this inspection. There was some evidence of unsigned and undated alterations and obliteration of text. It was difficult to establish and verify that referrals, reviews and MDT recommendations were followed up on and integrated into the MPMP. Current and previous plans were both retained in the folder, for example eating, drinking and swallowing plans. The area manager said that these difficulties were noted and a new template for the MPMP was to be piloted.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

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

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

Findings:

An immediate action plan was issued to the provider in relation to regulation 28 (1), 'the registered provider shall ensure that effective fire safety management systems are in place'. Inspectors were not satisfied that effective fire safety management systems were in place in the centre.

A fire safety survey conducted at the request of the provider in October 2015 identified serious failings in fire safety measures. These defects included no evidence of installation/maintenance certificates for fire safety equipment to the required legislative standard, fire doors not closing fully against the frame when activated, and deficits that compromised the effectiveness of fire door sets. The report stated that the required remedial works were urgently required. However, inspectors were told that the deficits identified were substantially not addressed at the time of this inspection. Inspectors saw that works had not been completed as intumescent strips on door sets were still painted

over and bedroom doors did not fully close when released as identified in the report.

In addition the area manager confirmed that certificates of inspection and testing at the prescribed intervals on an ongoing basis of the fire alarm and emergency lighting systems were not available to inspectors as these fire safety measures had not been inspected and tested.

It was also noted by inspectors from records in the centre that there were deficiencies in the weekly checks to be carried out by staff of fire safety measures, with only 23 checks recorded since August 2014. Inspectors also found 20 days during 2016 on which the integrated fire detection system to be checked daily was not recorded as checked. It was reported by staff in the fire alarm log book nine times since January 2016 that the fire doors did not close fully during system testing. In addition, this issue was recorded in three of the seven fire evacuation drills conducted and was noted to be reported to senior management.

Training records indicated that four out of 11 staff employed required fire training or refresher training. The person in charge said that this training was scheduled for August 2016.

Inspectors did see that fire evacuation drills were taking place regularly and actions including individual resident assessment had been taken to improve on the evacuation times achieved; action taken included the use of an assistive evacuation device. Records seen indicated that there were seven simulated drills during 2016. The duration of evacuation was noted to be less than two minutes for each drill. The provider's review of the service in March 2016 stated that the provider was satisfied as to the accuracy of the reports as they were overseen by the person in charge and the area manager.

There were personal emergency evacuation plans (PEEPs) in place for each resident, most recently reviewed on 10 July 2016. The PEEP included details on the resident's awareness of the procedure, methods of assistance, equipment provided, egress procedure and safe route. All residents in the centre required verbal prompting and guiding by staff.

There was evidence that fire extinguishers were serviced in February 2016. There was an emergency plan in place in the centre dated December 2015.

The risk register was reviewed by inspectors: the register contained open risks, closed risks, records of restrictive practices and local operational risk management procedures. Deficits were identified in systems for the identification, assessment and ongoing review of risks. There were two open risk assessments with a residual risk rating of 25, being the most serious rating. One of these risk assessments was in relation to a night-time evacuation dated September 2015, reviewed 1 June 2016 and due review again on 1 July 2016. During the feedback meeting, inspectors were informed that this risk assessment's residual rating had been reduced to 16, however there was no evidence of this reviewed and updated risk assessment in the centre or of the controls that had been identified to support the reduced risk rating given these inspection findings. The other risk assessment dated November 2015 related to the fire report recommendations not being implemented to date; the assessment was dated as reviewed 14 July 2016.

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:

Given the altered governance arrangements as described below in Outcome 14, the person in charge was now based in the centre. The acting person in charge said that this facilitated consistent contact with residents and the supervision of care and supports. Further measures in place to protect residents included policies and procedures, staff training, access to a designated safeguarding person and regular discussion with residents at the residents meetings on safeguarding and complaints.

Training records indicated that all staff had training on safeguarding adult service users and staff spoken with were clear on the provider's reporting policies and procedures.

There was evidence that the provider did exercise its responsibilities in relation to any alleged, suspected or reported abuse, took protective measures in line with policy and submitted the required notifications to the Authority.

As necessary residents had safeguarding plans that outlined for staff the actions to be taken to support and protect residents from harm and abuse. There was documentary evidence that the plan was reviewed in consultation with the designated person.

However, at the time of the last inspection while there was evidence of investigation and reported measures taken by the provider including enhanced security in services accessed by residents in response to suspected abuse, it was clear on speaking with staff and reviewing records at that time that they (staff) and family members had ongoing safeguarding concerns for residents. Based on the information available to inspectors from staff it was difficult for inspectors to be reassured that these concerns were not justified. This was discussed at that time in detail with the management team of the centre including the provider nominee. The provider nominee agreed with the concerns held and gave a commitment that further action would be taken by the

provider to re-visit certain safeguarding matters and investigations so as to reassure the provider, staff, relatives and the Authority as to the robustness of all investigations, safeguarding measures and to identify any learning required for the protection of all residents.

However, while there was evidence of some action taken in the intervening period this matter was not satisfactorily resolved so as to provide reassurance that the matter had been appropriately investigated and responded to.

Residents did present with behaviours that challenged and improvement was found in how residents were supported by staff so as to prevent and manage behaviours.

Records indicated and staff spoken with confirmed that they had attended training on responding to behaviours that challenged and the management of actual and potential aggression. However, as more appropriate to the needs of these particular resident's inspectors also saw and staff confirmed that staff had received support from the multi-disciplinary team on core areas such as communication and the impact on behaviour of communication seen as somehow inappropriate by residents though perhaps not intended to be. There was documentary evidence that any concerns raised by residents in this regard were respected and acted on by the provider, measures were taken to support staff learning and there was noted improvement by the MDT team in the quality of staff therapeutic responses.

Residents were seen to have explicit positive behaviour support plans developed in conjunction with the MDT team. The plans were clear and simple, identified triggers for behaviours and how staff were to respond. Residents as necessary had support from psychology, psychiatry and the behaviour support team. Inspectors saw practical and documentary evidence of the implementation of therapeutic supports that were known but not implemented at the time of the last inspection and the obvious comfort and reassurance residents gained from these interventions.

There was some lack of clarity as to the requirement for further input from the behaviour support team. However, the acting person in charge said that she was aware of this and was following up on this with the team.

Environmental restrictive practices were in place such as restricted access to cooking utensils. There was a rationale for their use, the safety of the resident and they were subject to review so as to justify their ongoing requirement.

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):

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

Findings:

Based on the records seen by inspectors the action from the previous inspection with regard to notification to HIQA of all injuries to a resident was completed.

The centre's accident and incident records were reviewed. Inspectors noted that there were 22 incidents and three accidents in the centre since October 2015. All incidents and accidents appeared to have been followed up on appropriately, were signed off on by staff and notified to the Chief Inspector where necessary.

Judgment:

Compliant

Outcome 10. General Welfare and Development

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

Theme:

Health and Development

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

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

Findings:

Based on these inspection findings inspectors were satisfied that there was recognition, a meaningful process and supports to ensure that residents general welfare and developmental needs were met.

This was a process that was individualised to each resident, their particular needs and abilities and was reflected in the personal planning process (PCP). As discussed in Outcome 5 the identification of person goals and objectives was based on assessment and discussion with each resident. Agreed goals reflected social inclusion and integration, learning new skills such as literacy and numeracy and enjoying new experiences.

Each resident had daily access to structured day services at a pace that suited their needs and abilities and enjoyed activities such as swimming, music, art, attended the library and advocacy meetings, exercise and relaxation programmes. There was evidence that residents were supported to attend ongoing learning programmes and had MDT support and assessment to evaluate skills and ability for example in financial management.

Within the centre there was documentary evidence that staff offered residents further opportunities for activities and engagement such as social trips, meeting with family and friends and supporting residents to choose and purchase personal items and clothing.

Where a resident declined an activity this was respected and documented.

Residents spoken with confirmed the above. Staff spoken with said that the increased and consistently maintained staffing resources enabled staff to support residents and their PCP and residents had benefited positively from this.

Judgment:
Compliant

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

Having spoken with staff and reviewed records inspectors were satisfied that staff monitored resident well-being and took action as appropriate.

Residents presented with a range of evolving needs some related to advancing age; inspectors were satisfied that staff were aware of these needs.

The acting person in charge confirmed that residents had access to supportive General Practitioner (GP) services. Records seen by inspectors indicated that staff facilitated timely medical review and treatment for residents including out-of-hours medical review. In addition there was a process for formal annual medical review. There was documentary evidence that residents were facilitated to participate in individual health screening, national screening programmes and annual influenza vaccination.

Residents also had access as required to other healthcare professionals/services including dental, optical, chiropody, behaviour therapist, psychiatry, psychology,

neurology, memory clinic, dietician, occupational therapy and speech and language therapy. The acting person in charge confirmed that since the last inspection each resident had had a full MDT review; four follow-up reviews had taken place in the week prior to this inspection but these reports were awaited.

Residents did present with health care related issues and support plans specific to these were in place. Those seen reflected residents assessed needs and had been updated to reflect any changes. Evidence of the implementation by staff of required interventions was seen and included the monitoring and recording of body weight (those seen were stable), eating, drinking and swallowing interventions including modified diet and assistive utensils, and bowel management plans.

However, while no deficits in care were identified on this inspection and there was clear evidence of the MDT approach to care and supports, it was difficult and time consuming to retrieve, verify and establish information from the documentation seen to ensure that care was as recommended, was effectively communicated and implemented. This is addressed as a failing in Outcome 5.

Judgment:
Compliant

Outcome 12. Medication Management

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

Theme:
Health and Development

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

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

Findings:

Improvement was noted in medicines management; however, it was of concern to inspectors given the concerning failings identified at the time of the last inspection and the judgement of major non-compliance, that six staff were identified as not having had medicines management training.

Medicines were supplied to the centre on a monthly basis by a community pharmacy in a compliance aid or in their original containers, for example medicines administered on a p.r.n. basis (as required). Medicines were seen to be supplied on an individualised resident basis and were clearly labelled. A medicines identifier was supplied and the content of each individual compliance aid compartment was identified for staff by the pharmacist. Medicines were seen to be securely stored.

Each resident had a legible prescription record that was seen to reflect the medicines supplied and the instructions of the compliance aid. Staff said that the prescription record accompanied the resident to each clinical review so that any changes could be made contemporaneously by the prescriber. Discontinued medicines were signed and dated as such. The prescribing and use of night sedation had been reviewed, discontinued or altered since the last inspection.

However, the maximum daily dosage of medicines required on a p.r.n. basis was not always stated.

Based on the records seen the incidence of medicines management related errors had decreased. Having reviewed these records, four were of note as all related to the non-administration of prescribed medication by staff to residents; on at least one of these occasions medicines were signed as administered but were not administered. The last of these errors was recorded as having occurred in February 2016.

The area manager said that these errors had been addressed by her with staff. However, it was of concern that medicines management training had not been provided to over 50% of staff working in the centre.

Staff continued to sign for the administration of the "blister pack" only and not for each individual medicine as identified on the prescription. Again, the inspector was not satisfied as to the robustness of this practice in terms of reinforcing staff accountability to adhere to the seven rights of medication administration as outlined in the provider's own medicines management policy dated May 2016.

As outlined in the provider's response to the action plan medicines management had been the subject of audit since the last inspection. Audit records were available for the purpose of inspection. Overall these were detailed, did identify deficits and the required actions. Based on the records seen however, the audit did not reflect the February medicines management errors.

Judgment:
Non Compliant - Major

Outcome 14: Governance and Management

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

Theme:
Leadership, Governance and Management

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

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

Findings:

As committed to in the provider's response to the last action plan the provider had reviewed the governance arrangements of this centre.

There was a clear management structure consisting of the person in charge, the area manager, the head of community residential services and the nominated provider.

Based on the concerning findings of the previous two inspections the provider had made positive alterations to the working arrangements of the person in charge. The person in charge was on leave at the time of this inspection but the acting person in charge confirmed that the role of person in charge/acting person in charge was fulltime, was based on site in the centre and was present in the centre eight days over each fortnight. The acting person in charge did not work as a member of the frontline team and did not work any sleepover shifts. The acting person in charge continued to participate in the on-call rota operated by the provider. The acting person in charge said that the provider had amended the on-call system so that it now included an on-call support. The on-call support was directed by the person in charge and provided whatever practical support and assistance was required in a centre in response to an on-call and not the person in charge as had previously been the case. This allowed the person in charge to attend to both the on-call and the person in charge duties.

The acting person in charge said that while only recently appointed she believed these working arrangements were conducive to exercising her role and responsibilities.

The area manager and the nominated provider confirmed for the inspectors that there were no plans to alter these enhanced working arrangements of the person in charge.

Staff said that the acting person in charge was accessible and supportive. The acting person in charge said that she had access to the area manager as needed and they also met formally on a weekly basis.

The area manager said that since the last inspection by HIQA the centre was subjected to a focussed solution based process of review; there was evidence of this. Reports were available of the review of resident's personal plans, medicines management and health and safety measures. Reports were available of the monitoring and review of the safety and quality of the supports and services provided to residents by the provider as required by Regulation 23; the nominated provider participated directly in these reviews.

Records indicated that there had been four unannounced provider visits to the centre between November 2015 and July 2016. Having reviewed these reports, inspectors concluded that they did not provide adequate reassurance that the governance structure ensured that the quality and safety of care and services was consistent and that regulatory requirements were met. For example following the providers review of March 2016 and "given the nature of the findings" a meeting was convened between the head of community residential services and the area manager and the person in charge. In

July 2016 the provider noted ongoing "concerns regarding the standard of documentation and record management".

This HIQA inspection found improvements had been made, however, given that this was the third inspection of this centre, there were also concerning and unnecessary failings identified. These included fire safety failings that resulted in the issuing of an immediate action plan, an unresolved safeguarding matter, deficits in staff training and lack of adherence to the provider's policies on the management of resident's finances and the management of complaints.

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 provider had exercised its regulatory responsibility to notify the Chief Inspector of any change or proposed absence of the person in charge.

Arrangements were in place for the management of the centre in the absence of the person in charge. An acting person in charge had recently been recruited. The acting person in charge worked full-time, held relevant qualifications in social care and had recently completed studies in management.

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:

The area manager and the acting person in charge told inspectors that with the exception of the sleepover shift there were now two staff on duty in the centre at all times when the maximum number of residents were present in the centre. Inspectors were told that Monday to Friday there were two staff on duty from 17:30hrs to 22:30hrs and between 08:00hrs and 08:45hrs. There were times when there was one staff on duty, for example from 08:45hrs and 11:00hrs but there were only three residents in the house at this time and at the weekends between 09:00hrs and 11:00hrs.

Staff spoken with confirmed these increased staffing levels and that they were consistently maintained. Staff said that residents had benefited from these additional supports in terms of the time that staff could give to residents and ensuring that there was sufficient staff in place to manage behaviours that challenged. The reported staffing arrangements were as seen by inspectors.

Residents did get up at night-time; there was only one staff member on duty and this staff was on sleepover duty from 23:00hrs to 07:00hrs (these hours altered at the weekend). Some staff said that the sleepover arrangement did not meet residents' needs while other staff said that while they may have to get up to attend to residents it was not at a frequency that was problematic. In March 2016 the providers review stated that the area manager and the person in charge both agreed that waking night staff were required. However, at the time of this HIQA inspection the area manager and the acting person in charge told inspectors that they were both satisfied to state that the existing sleepover staffing arrangement was sufficient to meet residents' needs.

The acting person in charge and the area manager said that residents not sleeping at night tended to be cyclic and related to a specific issue. Measures had been taken to support night-time routines and healthy sleeping patterns such as the review of medicines and adherence to elimination and behaviour support plans. Staff maintained records of residents sleeping patterns and these were monitored by the person in charge and the area manager. Those seen by inspectors indicated that while residents did get up at night, the incidence and prevalence of this had improved.

The night- time staffing numbers and arrangements required on-going monitoring and action as necessary by the provider as it is the provider's responsibility as outlined in Regulation 15 (1) to ensure that staffing numbers and arrangements are suited to residents assessed and evolving needs. The nominated provider committed to this on-going monitoring at verbal feedback.

The area manager said and staff spoken with confirmed that a cohort of relief staff had been recruited to work only in the Waxwing group which consisted of three designated centres. Residents were clearly familiar with the staff on duty.

A sample of staff files was reviewed to establish their compliance with the requirements of schedule 2 of the regulations. The majority of the required documentation was in place. However, one staff employment history had no dates and therefore could not be verified as complete and one photographic evidence of identity was not legible.

The action from the previous inspection with regard to mandatory training was partially addressed. It was noted from training records that all staff had received manual handling, protection of vulnerable adults and MAPA (management of actual or potential aggression) training. Staff spoken with confirmed their attendance at this training. From the records viewed inspectors noted that staff also had a range of other training including medicines management, food safety, communication, eating, drinking and swallowing, car safety and training on the policy on handling personal assets; again staff spoken with confirmed this. However, deficits were identified in staff attendance at fire safety and medicines management training and these were addressed in the respective Outcomes.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

**Health Information and Quality Authority
Regulation Directorate**

Action Plan



Provider's response to inspection report¹

Centre name:	Waxwing 1
Centre ID:	OSV-0004843
Date of Inspection:	19 July 2016
Date of response:	22 September 2016

Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

The template for the residents' meetings was well laid out, however, it was not being used to its full potential. Some discussions led to items which could have been recorded as actions but were not. In addition, it was not always recorded by staff that actions had been followed up on from the previous meetings.

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

1. Action Required:

Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

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

- The Acting Person in Charge is supervising front line staff during house meetings to advice on how to appropriately document actions required and how to follow up or previously agreed actions in order to ensure the effectiveness of meetings and to track progress on actions.
- Acting Person in Charge is monitoring minutes of house meetings to ensure that minutes and actions are recorded appropriately.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

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

Based on records reviewed and staff spoken with, inspectors formed the view that decision-making, the process, management, documentation trail and oversight particularly of larger expenditure required review to demonstrate transparency and accountability in relation to transactions of residents finances.

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:

- A Personal Assets policy is in place that provides clear guidance in relation to oversight of Service User money.
- Following the inspection the Area Manager and Acting Person in Charge have reviewed all purchases made on behalf of residents over €250 in the last 12 months and documented the reasons for these purchases.
- The PIC will carry out monthly audit of accounts as per policy.
- Area Manager will audit a sample of accounts monthly.
- All purchases made in excess of €250 require approval from the PIC prior to being made, in accordance with local policy. This request will be made in writing on the appropriate documentation and a copy of the approval will be filed with the service user's financial information. This information has been communicated with staff in the designated centre by management and through training
- In instances where the service user does not have the capacity to make decisions in regards to large purchases, it is a requirement that this is approved at MDT, if it has not been a recommendation of a professional or a priority identified through the persons PCP.
- Where meaningful Service Users will co-sign transactions related to their purchases. Where this is not meaningful two staff will sign transactions.

Proposed Timescale: 30/09/2016

Theme: Individualised Supports and Care

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

Of the five complaints recorded, two remained unresolved, one since 22 February 2016 and the other since 11 March 2016. Other records seen by inspectors also made references to "complaints" and inspectors were not reassured that the complaint records seen were a complete and accurate record of all complaints made.

3. Action Required:

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

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

- PIC and Area Manager reviewed the informal complaints made by Service Users in the designated centre.
- The complaint made in March 2016 was resolved satisfactorily and this was clarified by the PIC on 11/08/16 in the house meeting where the complaint was discussed and the Service Users communicated their satisfaction with the resolution.
- In regards to the complaint made in February, the PIC met with the complainant to discuss the actions to date on 14/09/16. The complainant was happy that this complaint had been resolved satisfactorily. The PIC documented the complainant's response in an easy read format and the complainant signed to confirm that this was accurate. This has been filed with the complaint in the complaints log.
- There will be greater oversight of complaints in line with the procedure on the management of complaints by both the PIC and the Area Manager.

Proposed Timescale: 14/09/2016

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:

There was some evidence of unsigned and undated alterations and obliteration of text. It was difficult to establish and verify that referrals, reviews and MDT recommendations were followed up on and integrated into the MPMP.

4. Action Required:

Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

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

- PIC and Area Manager to discuss good practice in record keeping with all staff.
- Training will be provided to all staff in relation to record keeping. This training will be

completed by 11/10/2016.

- Updates on actions relating to MDT recommendations to be documented at all follow up MDT's minutes which is to be overseen and approved by the PIC.
- The implementation of the new version of My Profile My Plan to be piloted in the designated centre. This will be an opportunity to address and improve the standard of records for each resident.

Proposed Timescale: 30/11/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Deficits were identified in systems for the identification, assessment and ongoing review of risks. There were two open risk assessments with a residual risk rating of 25, being the most serious rating. One of these risk assessments was in relation to night-time evacuation dated September 2015, reviewed 1 June 2016 and due review 1 July 2016. During the feedback meeting, inspectors were informed that this risk assessment's residual rating had been reduced to 16, however there was no evidence of this reviewed and updated risk assessment in the centre or of the controls that had been identified to support the reduced risk rating given these inspection findings.

5. 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:

- On review of the risk relating to night time evacuation it was found that the rating was in fact 20 and had been calculated wrong. The risk was reviewed by the acting person in charge on 6/8/16. The risk has now been reduced to a 15. This risk is reviewed monthly as part of the monitoring process.
- The risk related to the implementation of the recommendations of the fire report is rated at 25. This risk has been escalated to the Director of Services and is maintained on the corporate risk register, in line with local procedures.
- A business case has been prepared sent to the HSE to request funding to implement the recommendations of the fire inspection report. Funding has not been approved and to date. The timeline on this action is difficult to determine. The HSE has advised that there is no funding for fire safety upgrade at this time.
- All other measures are being consistently implemented to ensure the safety of residents in the centre in relation to fire. This includes daily checks by staff, weekly checks by the acting Person in Charge as well as weekly tests of the fire alarm. Staff carry out drills monthly and the fire system and emergency lighting are now tested / serviced quarterly. The acting person in charge now reports weekly to the area manager on the fire safety measures being carried out in the centre.
- Required servicing and maintenance is up to date.

Proposed Timescale: 06/08/2016

Theme: Effective Services

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

A fire safety report conducted at the request of the provider in October 2015 identified serious failings in fire safety measures. The report stated that the required remedial works were urgently required. However, it was confirmed for inspectors that the deficits identified were substantially not addressed at the time of this inspection.

Certificates of inspection and testing at the prescribed intervals on an ongoing basis of the fire alarm and emergency lighting systems were not available to inspectors as these fire safety measures had not been inspected and tested.

There were deficiencies in the weekly checks to be carried out by staff of fire safety measures.

It was reported by staff in the fire alarm log book nine times since January 2016 that the fire doors did not close fully during system testing. In addition, this issue was recorded in three of the seven fire evacuation drills conducted and was noted to be reported to senior management.

Training records indicated that four out of 11 staff employed required fire training or refresher training.

6. Action Required:

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

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

- The fire alarm system was tested on 27/7/16. The certificate to confirm this is in the fire register in the centre. The emergency lighting system was tested on 2/8/16 and a certificate is on site to confirm this. These tests will continue to occur quarterly.
- The requirement for staff to carry out checks on the fire panel and fire exits was discussed with them both individually and at a team meeting with the acting PIC.
- The acting PIC reviews the fire register weekly to ensure checks are being carried out. These checks have consistently occurred since the inspection.
- Fire Consultants appointed 01/10/15 to review the premises.
- Following several visit to the premises a report was issued December 2015 which highlighted a number of deficiencies with regard to fire safety
- Remedial work was carried out in early 2016 which in the opinion of the Fire Safety Engineer have significantly improved the safety of the premises.
- However further works are still required in order to resolve some outstanding issues.
- The Area Manager has reported the problems relating to fire doors not closing fully to the Director of Services. A business case has been sent to the HSE to request funding to complete the remaining works as recommended in the fire inspection report. This includes works to remedy the fault with the fire doors. Funding has not been approved. The HSE has advised that there is no funding available at this time for Fire Safety upgrades. It is not possible to determine the timeline in respect to this matter.
- All other measures are being consistently carried out to ensure the safety of residents

in the centre in relation to fire. This includes daily checks by staff, weekly checks by the acting person in charge as well as weekly tests of the fire alarm. Staff carry out drills monthly and the fire system and emergency lighting are now tested / serviced quarterly. The acting person in charge now reports weekly to the area manager on the fire safety measures being carried out in the centre.

- The staff whose training was out of date completed training in fire safety on August 2nd 2016. The person in charge is scheduled to complete refresher training on September 27th 2016. All staff in the centre will then be up to date on fire safety training.

Proposed Timescale: 30/09/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

At the time of the last inspection while there was evidence of investigation and reported measures taken by the provider including enhanced security in services accessed by residents in response to suspected abuse, however, it was clear on speaking with staff and reviewing records at that time that they (staff) and family members had ongoing safeguarding concerns for residents. The provider nominee agreed with the concerns held and gave a commitment that further action would be taken by the provider to revisit certain safeguarding matters and investigations so as to reassure the provider, staff, relatives and the Authority as to the robustness of all investigations, safeguarding measures and to identify any learning required for the protection of all residents. However, while there was evidence of some action taken this matter was not satisfactorily resolved so as to provide reassurance that the matter had been appropriately investigated and responded to.

7. Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

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

- The Designated Officer met with the previous Designated Officer in order to fully understand the issues involved.
- The Designated Officer has written to the relevant person of the investigating body requesting a meeting with the Director of Services and the Designated Officer relating to this matter.

Proposed Timescale: 31/10/2016

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:

As outlined in the body of the report failings were identified in the management of medicines.

8. 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:

- New community medication policy in put in place since May 2016.
- Seven staff from the designated centre have attended training to date. The one remaining staff is scheduled to complete training on September 23/09/2016.
- PIC has commenced the review of current medical files in order to ensure accuracy of information held on site and efficient access to this information.
- The area manager and the PIC put structures in place to address specific medication errors. This included training and supervision of medicines administration practice.
- Monthly audits of medication by Area Manager continue. Area Manager to cross check local records and records maintained by herself for accuracy of information to ensure information is complete and comprehensive.

Proposed Timescale: 23/09/2016

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:

Records indicated that there had been four unannounced provider visits to the centre between November 2015 and July 2016. Having reviewed these reports, inspectors agreed that they did not provide adequate reassurance that the governance structure ensured that the quality and safety of care and services was consistent and that regulatory requirements were met.

While this HIQA inspection found improvements had been made, given that this was the third inspection of this centre, there were also concerning and unnecessary failings identified. These included fire safety failings that resulted in the issuing of an immediate action plan.

9. 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:

- At the time of the inspection a new PIC was working in the centre. This PIC remains supernumery and is based in the Designated Centre.
- The Area Manager and the PIC meet on a weekly basis.
- Monthly meetings between the PIC and staff in the designated centre take place. Issues such as complaints, medication management, record keeping safeguarding, activities relating to person centre plans for residents are on the agenda for these meetings.
- The PIC oversees the implementation of policies and procedures and supervises documentation and practices.
- The introduction of a policy relating to supervision and the associated training is planned for Monday, 26th September 2016. This procedure and training will support better governance and management of the designated centre.
- Regular visits to the centre from the Area manager which involves audits and observations of work practices in the centre.
- The implementation of action plans from internal unannounced inspections and HIQA inspections.
- The planned introduction of a refined documentation of the residents file in the designed centre will support better governance and management.
- 6 month unannounced inspection will review the status of actions outlined in this report.
- Oversight of actions will also be provided by the Head of Community Services as part of her management of the Area Manager.

Proposed Timescale: 31/10/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

One staff employment history had no dates and therefore could not be verified as complete and one photographic evidence of identity was not legible.

10. 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:

- Alternative photo identification and additional dates of employment were obtained for staff member the day after the inspection and their HR file has since been updated.

Proposed Timescale: 21/07/2016