

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St. Anne's Residential Services - Group J
Centre ID:	OSV-0005158
Centre county:	Tipperary
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Simon Balfe
Lead inspector:	Geraldine Ryan
Support inspector(s):	Louisa Power
Type of inspection	Unannounced
Number of residents on the date of inspection:	10
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
05 July 2016 08:30	05 July 2016 17:00
06 July 2016 08:45	06 July 2016 16:00

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 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 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this designated centre, the purpose of which was to follow up and monitor compliance with the 19 actions generated by the inspection carried out on 2 December 2015.

Description of the service

The designated centre comprises two houses (or 'Units') located in the community. The centre accommodates five residents in each Unit and mainly provides a service for residents with a moderate to severe intellectual disability, autism, a physical or sensory disability and with behaviours that challenge.

How we gathered our evidence

Inspectors met residents who lived in each Unit and with staff (day duty and night duty), the provider representative, the clinical nurse manager three (CNM3) and the house manager. The person in charge was not present for the two days of

inspection. At the end of the inspection, a feedback meeting was convened with the provider representative and two CNM3s. Inspectors observed staff practices and interactions between residents and staff, reviewed documentation such as residents' personal plans and healthcare plans, risk assessments, incidents record, medication management documentation and staff training records.

Overall judgment of our findings

Overall, inspectors observed positive interactions between residents and staff. Inspectors found that in Unit A, the rights, dignity and quality of life of the residents accommodated there were enhanced. Residents led active lives and were consulted and involved in how the centre was run. The house was clean, homely and residents stated that they were happy living there. Personal care plans were resident specific, up to date and completed in consultation with the residents.

However, significant non-compliances were identified in Unit B, one which resulted in the issuing of an immediate action plan on the first day of inspection, in relation to the health, safety and risk assessment of one resident. There was evidence that a resident was not enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximize his/her independence or access education/skills training. Furthermore, there was evidence that key recommendations from an assessment carried out by an external specialist for this resident in 2010 were not implemented. This issue was highlighted in the inspection of 2 December 2015. The provider's response to the immediate action plan issued on 5 July 2016 was satisfactory; complete with actions assigned to identified staff and dates specified for the completion of actions.

Inspectors found that a number of areas have yet to be satisfactorily addressed in Unit B in order to ensure that residents were provided with a safe, quality service. These areas included:

Outcome 1: residents' rights and dignity in relation to where residents chose to live; unsecure storage of confidential information

Outcome 2: communication processes not in place for non verbal residents and respective care plans not updated accordingly

Outcome 5: inadequate implementation and updating of residents' personal plans and goals which impacted on residents' opportunities to experience social inclusion, education and participation

Outcome 6: inadequate communal and private space; insufficient seating in the dining room and sitting room

Outcome 7: poor housekeeping practices; lack of awareness in relation to the prevention of infection (supply of paper hand towels; cleaning of floor mops)

Outcome 8: no investigation into a number of alleged allegations of abuse; some staff demonstrated a lack of understanding of what constituted restraint or restrictive practices; guidelines on the provision of intimate care to residents; review of

residents' behavioural care plans

Outcome 9: failure to submit to the Chief Inspector the required notifications in relation restraint

Outcome 10: not ensuring that a resident was supported to access education and life skills as recommended by a specialist in September 2010

Outcome 11: some health care interventions were not supported by written documentation from allied professionals. Some care planning was generic and not dated or signed off by relevant staff; poor oversight of food cooking/cooling and reheating practices

Outcome 12: unsafe medication management practices

Outcome 14: inadequate auditing of the quality of care by the provider and inadequate supervision in the centre

Outcome 17: staff training; not all staff had attended relevant/mandatory training; no clarification with regard to the training agency staff had attended.

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:

Two of three actions generated from the inspection of 2 December 2015 were completed. At the previous inspection, it had been identified that a number of residents were not facilitated to vote. The required action had been satisfactorily implemented. A voting record form had been developed and completed with each resident which recorded his/her wish in relation to voting and identified any requirement to assist residents to register to vote. Residents with whom an inspector spoke confirmed that they had been facilitated to vote in line with their wishes.

At the previous inspection, it had been identified that there was no nominated person to ensure the complaints procedure was correctly implemented. Inspectors saw that the required action had been satisfactorily implemented.

At the previous inspection, it had been identified that language used in a hospital information booklet did not promote the resident's privacy and dignity. The required action had not been satisfactorily implemented. There was evidence that information documented in residents' hospital passports was not up to date and inaccurate; terminology used was inappropriate:

- one resident's passport did not reference challenging behaviour but did state that two staff were required to support him at all times and that both staff have therapeutic management of aggression and violence training (TMAV)
- one resident's passport did not have the correct next of kin contact details
- one resident's passport did not have the correct contact details for the centre
- one resident's passport contained incorrect information regarding a resident's personal

history. This matter is actioned under outcome 5.

On perusal of same, the provider representative and the CNM3 concurred with this finding.

On this inspection there was evidence that three residents out of five accommodated in Unit B were not involved in or consulted in their multidisciplinary meetings.

While staff stated that residents' views were always sought there was little evidence that the residents' views were acted upon; for example; noted documented in three residents' PCPs, residents had stated that they wanted to live elsewhere. Also, on this inspection, one resident voiced this to an inspector on three different occasions. From review of the residents' personal plans there was documented evidence that the residents expressed this wish, but there was no evidence to indicate that a plan was in place to facilitate or accommodate the residents' wishes. Residents were not provided with the opportunity to participate in decisions about their care or where they would like to live.

There was evidence that a resident was not enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximize his/her independence or access education/skills training. Furthermore, there was evidence that key recommendations from an assessment carried out by an external specialist for this resident in 2010 were not implemented. This was highlighted in the inspection of 2 December 2015.

The centre's information governance did not protect residents' privacy in that confidential and sensitive information pertaining to residents was not securely stored. This information was stored in folders and boxes in the staff bedroom/office where, during both days of inspection, residents were observed accessing freely to retrieve personal belongings.

Inspectors sought the residents' permission to be in their home and view documentation. Two residents asked that inspectors not access their bedrooms and this request was respected.

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:

Residents in the centre had diverse communication needs; some residents did not communicate verbally. A communication plan of care was developed for each resident and staff informed inspectors that the plan of care was updated regularly in line with residents' needs. Inspectors observed that staff did facilitate residents to communicate using signs, gestures and expressions; staff were observed to understand this communication. However, in Unit B, inspectors noted that plans of care for residents who did not communicate verbally were limited and were not updated to reflect the most up to date recommendations from the speech and language therapist; for example; while the speech and language therapist recommended enhancing a resident's signs to maximise communication, this was not evident. The training matrix and staff confirmed that training had not been provided in communication and a manual sign system used as a communication tool (LÁMH).

Judgment:

Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

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

Findings:

At the previous inspection, it had been identified that the residents' contract of care did not adequately outline the actual services to be provided, the fees and additional costs to be levied. Inspectors reviewed a sample of contracts and saw that the actions required had been satisfactorily implemented.

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):

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

Findings:

Inspectors evidenced that the four actions generated from the previous inspection were not completed in a satisfactory manner. These non-compliances were in relation to incompatibility of residents accommodated in the centre; personal care plans (PCPs), annual reviews and information contained in hospital passports. However, the person in charge's response to the action plan from the inspection of 2 December 2015 indicated that the four actions were completed by 30 June 2016.

Inspectors reviewed six of the residents' PCPs. On perusal of residents' PCPs in Unit B, it was difficult to retrieve relevant and up to date and accurate information. Information was not collated in an organised manner to ensure staff had access to the most up to date guidance. While there was evidence of multidisciplinary involvement, the care plans did not address the assessed needs identified. There was evidence from the sample reviewed that PCP re-evaluation was not multidisciplinary.

Inspectors reviewed multidisciplinary goal setting forms, listing eight disciplines (physiotherapy, psychology, nursing, speech and language therapy (SALT), occupational therapy (OT), psychiatry, neurologist and other). However, while signed off by the person in charge, there was no information recorded in five of the eight disciplines; there was no evidence of consultation with the resident; there was no information to indicate that the three documented goals were actioned, by whom and by when.

Inspectors evidenced 'manager's responsibility sheets' post MDT meetings and these were observed as blank.

While the sample of residents' PCPs reviewed had evidence of an annual review meeting in the previous 12 months, it was not evident that the review tracked the progress of the residents' goals or if the resident was involved in the annual review.

It has been previously identified that the designated centre did not meet the assessed needs of all residents due to inappropriate placement, the number of residents in the centre, the incompatibility of some residents living together and the unsuitable space

provided by the premises. In Unit B, the contents of a resident's psychology report viewed by inspectors clearly indicated that the number of residents accommodated in the house should be reduced to three residents instead of five. Minutes of MDT meetings, referencing Unit B, contained statements referencing that the number of residents should be reduced, however no time bound action plan complete with an identified person responsible for the progressing this matter was evident. For example: the psychology report for one resident accommodated in Unit B, dated November 2015, stated that 'if the number of residents was reduced to three, it would provide increased opportunities for the resident to have more individual staff time for activities' and that the resident would 'benefit from sharing a house with service users who are more able than himself for appropriate role models'.

Inspectors noted documented in this resident's PCP that the resident 'appears to enjoy living with four other gentlemen'; this was contrary to what the resident stated to an inspector.

There was further documented evidence of negative interactions between a number of residents living in the house. While staff levels had been increased, it was to ensure that there were periods of separation for residents to alleviate potential situations. This was confirmed by staff, where it was stated that they would take a resident out for a walk to prevent two residents meeting.

No resident who expressed a wish/goal to move to different accommodation had a plan in place to facilitate or accommodate this or to achieve this goal.

Residents accommodated in Unit A had comprehensive PCPs capturing the assessed needs and goals of the residents.

For a number of plans reviewed in Unit B, detailed information was not evident or available in relation to what was important to each resident, how best to support the resident achieve their goals, what arrangements needed to be put in place to help the resident achieve a goal and who was responsible to support the resident and by when. The association between a resident's assessed needs, their personal plan and their goals was not evident. Some residents' goals included 'a pampering day, 'going to a hotel overnight', 'attend cookery classes', 'would like to live independently', it was not clear who was responsible to action these and by when. In addition, it was not demonstrated how the effectiveness of the personal plan was evaluated. For example, an intervention for one resident stated that he/she required supervision at all times. However, noted in another assessment under education and training, it clearly stated that the resident could go to the shop on his/her own and did not require to be accompanied by staff.

In Unit B, the need for 2:1 staffing to help regulate a resident's responsive behaviour had been facilitated in July 2015. However, there was no evidence that this arrangement had been reviewed or if there was a current requirement for this. Noted in an MDT meeting held on 15 December 2015, it was noted that 'the resident said he did not want two staff' and had submitted a complaint in relation to this. There was no evidence that this was addressed with the resident in a satisfactory manner and this information was not in the PCP.

In Unit B, there was evidence that residents' personal/family circumstances had recently changed, however, there was no information in the residents' PCPs with regard to the supports the residents may require or facilitating access to therapeutic supports; for example; bereavement support.

There was no evidence that residents' personal plans were made available to them in an accessible format.

A number of hospital passports required review e.g.

- one resident's passport did not reference challenging behaviour but did state that two staff required to support him at all times and the both staff required therapeutic management of aggression and violence training (TMAV)
- one resident's passport did not have correct next of kin contact details
- one resident's passport did not have the correct contact details for the centre
- one resident's passport contained incorrect information regarding a resident's personal history.

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):

No actions were required from the previous inspection.

Findings:

This outcome was reviewed so far as inspectors noted that there was inadequate communal space in Unit B; for example; if five residents and three or four staff were in Unit B at any one time, there was only seating for six persons at the dining table; and for only five persons, at any one time, in the sitting room. This was brought to the attention of senior management.

Facilities for occupation and recreation were inadequate in Unit B. Other than the resident's bedroom, residents did not have space to be on their own or entertain visitors. The rooms available were the communal sitting room and the kitchen/dining room.

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:

The action from the last inspection was not completed in a satisfactory manner. It was not evident that staff had the appropriate training in responding to emergencies including incidents of choking or when a resident with a diagnosis of diabetes suffers a hypoglycaemic episode.

The training consisted of one slide (of a total of 69 slides) on the topic of hypoglycaemia in residents who have diabetes.

The staff training matrix indicated that not all relevant staff had attended training on responding to a resident experiencing an episode of choking. However, the provider's response to the action plan generated by the inspection carried out on 2 December 2015 stated that the training had been completed by 9 December 2015.

A number of gaps were noted in the staff training matrix:

- two staff had not completed hand hygiene and staff were unable to demonstrate that agency staff had completed training
- two staff had not completed manual handling – both scheduled for 12/07/16
- three staff required refresher fire training and staff were unable to demonstrate that all agency staff had completed training
- three staff had not completed food safety training and staff were unable to demonstrate that agency staff had completed training. This matter is actioned under outcome 17: Workforce.

Individualised risk assessments were not updated to reflect most contemporaneous information; for example; one resident's risk assessment referred to a transfer to another specialist facility, however while this was ruled out at a MDT on 15/12/15, there was no evidence that the assessment was updated to capture the interventions required to ensure the continued living arrangements and safety of the resident and other residents.

Staff informed inspectors that some residents went home at weekends with their weekend supply of prescribed medication secured in a locked pouch. However, no resident had a risk assessment carried out in relation to this matter. Furthermore,

inspectors noted documented that, due to a resident's inability to open a locked carrier pouch containing his/her medication, a resident did not have his medication over the weekend. On further exploration, it surmised that the resident's family did not supervise the administration of the resident's medication and that the resident self administered medication. It was also noted up to this time, staff were of the opinion that the resident's family supervised the medication administration. No assessment had been carried out for this resident in relation to the resident's ability to self administer medications/or not.

A resident with particular behaviours did not have a risk assessment in place to aid staff to mitigate the risks associated with the behaviours.

From a review of a number of assessments carried out by a speech and language therapist, a number of residents were considered to have a risk of choking when eating. In one house, a folder of comprehensive information was available to guide and inform staff on residents' nutritional intake and specific guidance on how each resident was to be served their meals. However, no information in relation to this was available to staff in the second house where a number of residents had particular dietary requirements accompanied with information on how food was to be served.

The standard of cleanliness in one of the two houses was of a high standard. However, the standard of hygiene and cleanliness in one of the two houses was of a poor standard; for example;

- no evidence of deep cleaning of the centre. Flooring was stained.
- a refuse bin located in the kitchen was stained and unclean
- one resident's shower doors, frame and surround were unclean
- shelving in the kitchen was grimy
- some kitchen drawers required cleaning.

Cleaning schedules reviewed had numerous gaps in the record sheets: for example: the cleaning schedule was not filled in for the four days in July 2016 and three days in June 2016. It was noted on the cleaning schedule that the floor mops were to be washed three times a week. Cleaning schedules evidenced that this was not occurring and furthermore staff had different approaches to cleaning of the mops; some staff soaked the mops in bleach and replaced when mops appeared frayed; other staff washed mops in the washing machine. On the days of inspection, three wet mops were hanging in the utility room.

Fire safety was reviewed in detail in the inspection of 2 December 2015. On this inspection, staff spoken to were knowledgeable in relation to fire safety and of a safe place to relocate in the event of an evacuation. However a fire extinguisher located in the kitchen had a sticker on it stating that it was 'to be replaced'. Staff had no knowledge of this. This matter was attended to on the first day of inspection and a new fire extinguisher put in place.

Gaps were noted in the record of the temperature of the food fridge in the kitchen. The temperature was not recorded for three days in July 2016; four days in June 2016; three days in May 2016.

The records of cooking/cooling /reheating records were not maintained in a consistent manner; for example; there was no evidence that the temperature of food was recorded between the following dates:

- 30 May 2016 to 2 June 2016
- 8 June 2016 to 12 June 2016
- 12 June 2016 to 18 June 2016
- 18 June to 2 July 2016.

On the first day of inspection, there was no available paper hand towel in the kitchen, in the downstairs bathroom or the staff en suite. Staff reported that the paper hand towel supply 'had run out'. This was addressed during the inspection.

Recommendations from an OT assessment carried out for a resident in May 2016, included placing carpet on the stairs and the installation of hand rails in the shower room/on stairs would assist his/her mobility. This had not been addressed and there was no evidence of a plan to address same.

Cords attached to window blinds were not secured in a safe manner on some windows.

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:

There was evidence that the health, safety and absence of assessment of a particular risk associated with a resident was of a significant concern. An immediate action plan was issued to the provider representative in respect of this matter. The evidence indicated that the resident was not assisted, supported to develop the knowledge, self awareness, understanding and skills needed for self care and protection nor was there a risk assessment undertaken to ascertain the impact and the controls required to ensure this resident's safety and quality of life.

Four of five actions generated from the most recent inspection were not completed in a satisfactory manner. One action pertaining to a ward of court matter was completed.

The four actions not completed in a satisfactory manner pertained to:

- residents' access to psychology
- restrictive practices (decision making, implementation and review)
- implementation of specialist recommendations generated from a resident's review in 2010
- guidelines for each resident on the provision of intimate care to residents.

There was evidence that there were ongoing issues for residents to access to psychology. A timescale submitted by the provider for the completion of this action was 26 February 2016 however, this has not occurred. Inspectors evidenced that residents' behaviour support plans were not adequate. Many were not reviewed in consultation with the psychologist: for example: one resident who may require TMAV/chemical restraint, a resident who exhibited aggressive behaviours towards staff, a resident who had autism and a resident who exhibited particular behaviours.

The matter of restrictive practices was highlighted in the inspection on 2 December 2015. Inspectors evidenced that one resident was administered a chemical restraint twice in one day. However, it was not clear that all efforts were used to alleviate a situation before a chemical restraint was used. From a perusal of medication management documentation, an inspector noted that the resident had not received prescribed medication the previous day. This was discussed with senior management on day one of the inspection.

The behaviour support plans available did not guide staff in the use of chemical restraint in line with the psychiatrist recommendations; for example: the reactive strategies described in one resident's behaviour support plan, was limited to TMAV; even though chemical restraint was prescribed and used.

Intimate care plans were not complete: for example: one resident's care plan outlined the interventions in relation to shaving due to restricted access to shaving equipment following an incident on 25/05/15 where they ran a finger along the razor blade and cut their finger. No other intimate care activities outlined. One resident's care plan had particular detail on intimate care however there was no evidence that this care path was followed when the resident's key worker was off duty.

One resident with significant behaviours had a behaviour support plan last updated 31/03/14. Inspectors noted that a number of the documented antecedents to this resident's behaviour were associated with other residents living in the centre.

Furthermore, robust arrangements were not in place to ensure that all disclosures of incidents, allegations or suspicions of abuse were appropriately investigated and responded to in line with the centre's policy, national guidance and legislation. Inspectors reviewed three residents recorded as having the potential to 'make inaccurate statements'. The substantive matters of these alleged allegations were not investigated. This was brought to the attention of senior management.

A review of the incidents log evidenced incidents of peer to peer negative interaction. Staff reported that certain residents did not 'get on' with one another. However, this information did not guide the residents' behaviour care plans. Staff reported that they would take a resident out for a walk so that particular residents did not engage with one another. Another resident's assessment dated 16/02/2015 stated that the resident exhibited behaviours which had caused 'major concerns' to other residents. The control measure implemented to address this was 'extra staff' and for 'staff to read policies'. No further guidance was available to staff on how to de-escalate a situation.

The provider representative was unable to demonstrate that agency staff had completed safeguarding or training in challenging behaviours.

Judgment:

Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

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

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

Findings:

At the previous inspection, incidents of chemical restraint were not notified to the chief inspector as required. The action required had not been satisfactorily implemented.

While there was a log of all accidents and incidents, some were not reported to the Authority within the three day time period as necessary. The quarterly notification submitted for the centre for the period 1 January to 31 March 2016 outlined that chemical restraint in the form of 'as required' psychotropic medicines had been administered to one resident on two occasions. However, an inspector reviewed incident forms and medication administration records for this period which indicated that 'as required' psychotropic medicine(s) had been administered to the resident on four occasions (11 January 2016, 12 January 2016, 15 January 2016 and 24 March 2016).

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:

Inspectors found that the implementation of care planning was inconsistent; with good practices evidenced in Unit A and significant failings identified in residents' care plans in Unit B. There was little evidence to indicate that residents' care planning guided and informed the care to be given to a resident.

Each resident had access to a general practitioner (GP).

Residents had access to specialist care in psychiatry, occupational therapy, speech and language therapy (SALT), physiotherapy, dental and optical services. Where residents had access to a clinical nurse specialist (CNS) in nutrition, it was evident that the CNS met with the staff with a resultant diet sheet produced. However, there was no evidence that the resident was assessed by or consulted by the CNS.

A comprehensive folder pertaining to residents' dietary requirements was available in Unit A. However, in Unit B, none of the dietary residents' dietary requirements were available to staff, particularly agency or relief staff.

There was evidence that residents had access to physiotherapy and follow-on recommendations documented. However on review there was evidence that a resident had been reviewed by a physiotherapist on 23 September 2015. The physiotherapist set out a specific programme of daily exercises for the resident. However, noted in an MDT meeting held on 9 March 2016 (six months later), it emerged that residential staff were under the impression that the day service staff were facilitating the resident's exercises with him/her, but this was not the case and resulted in the resident not being supported to avail of his physiotherapy programme. While a risk assessment was devised on 11 November 2015 in relation to the resident and the physiotherapy programme; noted on the assessment was that the person responsible for actioning this was 'off sick'; there was no evidence that an alternative person was identified to action this matter and no further update was evident. The frequency and effectiveness of another resident's physiotherapy programme had not been recorded.

Communication plans for residents in Unit B required review to ensure they contained guidance for residents who communicated in a non verbal manner and used LÁMH signs and for residents who may used a picture time table. Specific guidance from a SALT review carried out on 27 November 2015 and 3 December 2015 had not been included in another resident's communication care plan in Unit B.

In Unit B, inspectors noted that a residents' mobility care plan had not been updated with specific recommendations from the OT dated 13 April 2016. The OT guidance included; use a banister; appropriate footwear; verbal prompts to mobilise slowly; fitting of carpet to stairs: to date the carpet on the stairs and a banister/hand rail had not been fitted.

Input from a psychologist was required for some residents. This was an ongoing issue for the centre and the organisation is continuing its efforts to recruit two psychologists. The provider in response stated that in the interim the centre will continue to receive support from the senior psychologist from another part of the organisation.

The potential impact for residents accommodated in Unit B, was that it could not always be demonstrated that the least restrictive practice was in place or that residents had appropriate supportive behavioural plans to guide staff on the management of a resident who may exhibit a responsive behaviour.

In Unit B, inspectors noted in a letter dated 15 December 2015 that the 'feasibility of a resident attending a stress management course' was to be discussed with a psychologist. There was no evidence that this was progressed. The resident concerned exhibited responsive behaviours. Inspectors reviewed the resident's risk assessment and noted that while interventions/guidance were documented, including regular review of the behaviours care plan however, this regular review was not happening.

Clinical assessments required review so as to ensure that the assessed needs of the residents were captured. For example, in Unit B:

- a resident with a noted weight loss did not have a suitable assessment completed
- a resident's continence assessment was not informative in relation to the matters staff needed to know in order to attend to the resident's specific needs on a daily basis. While the key worker assigned to this resident was very informed as to how to manage this matter, the keyworker was not clear on what happened when he/she was not on duty.

In Unit B, residents' falls risk assessments required review to ensure that they included recommendations from the OT or physiotherapy. A resident's care plan had not been updated following the resident sustaining a fall at an external venue on 20 June 2016.

Generally, in Unit B, care plans were not comprehensive; the stated specific need/ability to be supported was vague; the intervention described was not resident specific and while a review of the outcome was dated and information pertinent to a resident's change in circumstance was not captured.

In Unit B, a resident with cardiac issues had no care plan to guide staff on the expected care in the event of an exacerbation of symptoms.

Residents, in Unit B, with particular dietary requirements did not have a care plan to guide staff. There was no evidence in care plans to guide staff what to do in the event of a resident experiencing an episode of choking or how food should be presented in order to mitigate against such an incident.

While staff in Unit B demonstrated knowledge of the residents, written documentation did not reflect the daily requirements of the residents.

Vital signs (blood pressure, temperature, pulse, weight) were recorded.

In both Units, staff were observed encouraging/assisting residents to carry out tasks independently; for example; make tea. A small number of residents prepared their own breakfast.

Judgment:

Non Compliant - Moderate

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:

This outcome was examined by a medicines management inspector.

At the previous inspection, it had been identified that an incident had occurred where a resident had not received insulin as prescribed and this had led to a judgment of major non-compliance due to the potentially catastrophic impact on the resident. The actions required from the previous inspection had not been satisfactorily implemented. The inspector saw that on two occasions, 4 July 2016 and 26 June 2016, the medication administration record indicated that the resident's regular insulin had not been administered and no reason was recorded for this omission. Staff with whom the inspector spoke were unable to confirm if the insulin had been administered as prescribed. Due to the potentially catastrophic impact of omitted doses of insulin for this resident, the inspector judged this to be a level of major non compliance.

The inspector reviewed a sample of incident forms and saw that medication related errors were identified, reported on an incident form and there were arrangements in place for investigating incidents. In one service Unit, six medication related incidents had been reported since 1 January 2016. The inspector noted that the appropriate immediate response had been taken following each incident. The incident form indicated that the incidents were reported to a clinical nurse manager. A review of each incident was undertaken by the clinical nurse manager and individual recommendations were made. The inspector noted that the recommendations made had been implemented. However, the inspector noted that four of the incidents were of a similar nature. A

review of medication incidents was not undertaken on a regular basis to ensure that a multifactorial and systems-based analysis was undertaken to identify trends and to prevent recurrence of medication-related incidents.

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:
Two actions generated by the inspection of 2 December 2015 were not completed in a satisfactory manner.

One action was in relation to the lines of accountability and responsibility required to ensure cohesive management and overview of care practices. There remains a clear lack of clarity in the roles of members of management; the person in charge reported to the CNM3 however the person in charge had delegated the review and completion of residents' care plans to the CNM3 and the key worker. The house manager was not included in the review.

It is the regulatory responsibility of the person in charge to ensure that the residents' care plans meet the assessed needs of the residents. However, as evidenced throughout this inspection report, such personal care plans were significantly inadequate; guide supports or clinical practice and did not reflect changes in need and circumstances of residents.

In addition, adequate systems to monitor the service had not been implemented since the last inspection:

- audits were not completed in any area since November 2015
- only one audit was completed in 2015 and this was completed by staff within the centre (related to PCP completion). There was evidence that an audit had been carried out by the pharmacist. However, PCP completion and infection control audits were last completed in 2015.

The provider's response to the action plan generated from the most recent inspection carried out on 2 December 2015 stated that the CNM3, the person in charge and the provider representative would continue to audit and monitor practices in the centre. The date submitted by the provider for the completion of this action was 29 February 2016. However, on this inspection records reviewed indicated there was no evidence of any audit being carried out since November 2015.

In the provider's response to the action plan generated from the inspection of 12 December 2015, the person in charge was the identified person to audit the quality of intimate care guidelines and by 31 January 2016. However there was no evidence of this audit.

While there was evidence of staff meetings, the records evidenced that the areas of discussion concentrated on the residents and exhibited behaviours that may challenge. There was no clear evidence that; for example; incidents/errors/complaints/risk management/health and safety were reviewed or learning from same disseminated.

A new provider representative had commenced employment with the organisation in April 2016. The provider representative outlined improvements to ensure the delivery of quality and safe care to residents. This included regular quality assurance meetings with persons in charge and the CNM3s where all had the opportunity to present a progress report and raise any issues from their centres.

Judgment:

Non Compliant - Major

Outcome 17: Workforce

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

Theme:

Responsive Workforce

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

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

Findings:

The action from the inspection on 2 December 2015 was in relation to staff requiring additional supports and training to enhance their competencies. This action was not completed in a satisfactory manner.

A review of the staff training matrix and on discussion with staff in one house confirmed that training had not been provided in communication and LÁMH signs, where a resident used this method of communication.

The provider's response to the action plan generated by the inspection carried out on 2 December 2015 stated that the training had been completed by 9 December 2015. However, on this inspection, a review of the staff training matrix indicated that not all relevant staff had attended training on responding to a resident experiencing an episode of choking.

A number of gaps were noted in the staff training matrix:

- two staff had not completed hand hygiene and the provider representative was unable to demonstrate that agency staff had completed training
- two staff had not completed manual handling – both scheduled for 12/07/16
- three staff require refresher fire training and staff on the days of inspection were unable to demonstrate that all agency staff had completed training
- three staff had not completed food safety training and staff on the days of inspection were unable to demonstrate that agency staff had completed training.

The PIC was not included in the staff roster. Staff were not sure where the PIC was based but had a contact number for 'senior cover'.

The current supervisory arrangements included that a house manager covered the two houses. This included a night duty shift once a fortnight. The hours the house manager worked were divided between the houses. However, on review it emerged that when the house manager was on duty, the overall day duty hours for one house was reduced. Inspectors, based on evidence gathered from the two days of inspection, were of the opinion that oversight, governance and management of one of the houses was inadequate resulting in poor outcomes for the residents.

A staff nurse was rostered 24 hours per week to the centre. However, inspectors were of the opinion based on evidence from the two days of inspection that the division of hours was not proportionate to the assessed needs of residents. A staff nurse was assigned to one house for 20 hours and four hours to the second house. There was no evidence that the allocation of hours was assessed to ensure that the residents' complex needs were effectively met.

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:

Geraldine Ryan
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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 report¹

Centre name:	St. Anne's Residential Services - Group J
Centre ID:	OSV-0005158
Date of Inspection:	05 July 2016
Date of response:	28 July 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:

Confidential and sensitive information pertaining to residents was not securely stored.

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

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

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:

An appropriate storage facility has been identified in House B. This will ensure that all service users confidential and sensitive information pertaining to each service user is securely stored.

Proposed Timescale: 31/08/2016

Theme: Individualised Supports and Care

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

Not ensuring that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support.

2. Action Required:

Under Regulation 09 (2) (a) you are required to: Ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability, participates in and consents, with supports where necessary, to decisions about his or her care and support

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

Each service user will attend their future MDT and PCP meetings if they wish. All decisions made or communicated by service users will be supported and documented. The appropriate structures will be put in place for each service user to support them.

Proposed Timescale: 31/10/2016

Theme: Individualised Supports and Care

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

Resident were not provided with the opportunity to participate in decisions about their care or where they would like to live.

3. Action Required:

Under Regulation 13 (1) you are required to: Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

An assessment of need is to be completed on all five service users. This will include the service user, family members where appropriate, advocate and MDT. Meetings have been scheduled with family members to discuss the possibility of service users moving

to alternative accommodation / service provider. While awaiting to find suitable accommodation the service users will be supported by the PIC, Home Manager and staff team to learn daily life skills. Commenced August 1st 2016

Proposed Timescale: 01/08/2016

Outcome 02: Communication

Theme: Individualised Supports and Care

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

Plans of care for residents who did not communicate verbally were limited and were not updated to reflect the most up to date recommendations from the speech and language therapist.

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:

Recommendations from the speech and language therapist will be incorporated into the service users care plan. Training will be provided to staff in communication and Lamh.

Proposed Timescale: 26/08/2016

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 no evidence that residents' personal plans were made available in an accessible form, to the resident and, where appropriate to, his/her representative.

5. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

The PIC and House Manager will work with the staff teams and individual service users to ensure that all personal plans are up to date, person focused and in an accessible format to each individual. They will have set time frames for achievements, named responsible person, review dates for each goal and monitoring of progress. The PIC and House Manager will complete six monthly audits on the personal plans to monitor their standard and progress.

Proposed Timescale: 01/11/2016

Theme: Effective Services

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

Not ensuring that residents' personal plans were updated if there was a change in needs or circumstances. Personal plans were not kept under regular review.

6. 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:

The PIC will work with the House Manager and staff team in ensuring the personal plans will be a 'live document' and updated accordingly. The PIC and House Manager will carry out monthly audits to ensure the relevant information is implemented and recommendations are adhered to. To commence Friday 30th September 2016

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

The annual reviews of some residents' personal care plans were not multidisciplinary.

7. Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

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

The Organisation has secured a Psychologist for two days a week who will commence the second week in September 2016. Once started they will have input into the MDT as required. The PIC will ensure all MDT goals are in SMART format, specific, measurable, achievable, realistic and timed. The PIC will audit these on a three monthly basis. Any recommendations or official reports from members of the MDT will be incorporated into a specific part of the Care Plan.

Proposed Timescale: 01/11/2016

Theme: Effective Services

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

Not ensuring that residents were suited to living together in this environment and that all residents' needs could be met within this environment.

8. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

A Teleconference meeting was held on Tuesday 26th July with members of the MDT and representatives from two HSE areas, HSE Midlands and HSE Midwest to discuss the inappropriate placement of the five service users. An assessment of need is to be completed on all five service users. This will include the service user, family members where appropriate, advocate and MDT. Meetings have been scheduled with family members to discuss the possibility of service users moving to alternative accommodation / service provider.

The HSE Midlands have committed to commence the process of moving one service user to the Birr area in line with his and family wishes.

The HSE Midwest have committed to the assessment of another service user with a view to an alternative placement with an alternative provider.

Safeguarding meetings were held on Wednesday 27th July for all five service users. An interim safeguarding plan was completed on all five service users. Actions to be carried out are a review of all relevant risk assessments, behavioural support plans / guidelines. To complete a structured daily planner which will assign staff to individual service users.

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:

Not ensuring that a review of a resident's personal care plan was done in consultation with the resident.

9. 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:

Each service user will attend their future MDT and PCP meetings if they wish. All decisions made or communicated by them will be supported and documented.

Proposed Timescale: 28/10/2016

Theme: Effective Services

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

Not ensuring that residents' personal plan reviews assessed the effectiveness of each plan and took into account changes in circumstances and new developments.

10. Action Required:

Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

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

The PIC will work with the House Manager and staff team in ensuring the personal plans will be a 'live document' and updated accordingly. The PIC will ensure all PCP goals are in SMART format, specific, measurable, achievable, realistic and timed. The PIC and House Manager will carry out monthly audits to ensure the relevant information is implemented and recommendations are adhered to.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

For a number of plans reviewed, detailed information was not evident or available in relation to what was important to each resident, how best to support the resident achieve their goals, what arrangements needed to be put in place to help the resident achieve a goal and who was responsible to support the resident and by when.

11. Action Required:

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

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

The PIC, House Manager and staff team will work with the individual service user in ensuring their personal plans are presented in SMART format and ensuring there are realistic goals set. Each goal will identify a designated staff and time frame to help achieve same. The PIC and House Manager will carry out monthly audits to ensure the goals are being achieved.

Proposed Timescale: 30/09/2016

Theme: Effective Services

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

A number of residents' hospital passports required review to ensure that relevant and crucial information was available in the event of residents requiring transfer to acute care.

12. Action Required:

Under Regulation 25 (1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre to the person taking responsibility for the care, support and wellbeing of the resident at the receiving designated centre, hospital or other place.

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

All service users hospital passports will be reviewed and updated to provide relevant information regarding the service user. This will be overseen by the PIC and House Manager.

Proposed Timescale: 05/08/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

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

Not providing adequate private and communal space for residents accommodated in Unit B.

13. Action Required:

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

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

An assessment of need is to be completed on all five service users in house B. This will include the service user, family members where appropriate, advocate and MDT. Meetings have been scheduled with family members to discuss the possibility of service users moving to alternative accommodation / service provider. A full review of the service users activities will be carried out. An activity planner will be put in place for each service user based on their likes and dislikes. This will help reduce the number of service users in communal areas at any one time.

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:

Not having robust systems in place for the assessment, management and on going review of risk.

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:

The CNM 3 and Health and Safety officer will carry out a risk assessments audit in line with the safety statements and care plans. All staff that require up to date training have been book in for same.

Proposed Timescale: 16/09/2016

Theme: Effective Services

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

Cleaning schedules reviewed had numerous gaps in the record sheets.

Cleaning schedules evidenced that floor mops were not washed three times a week. Staff had different approaches to cleaning of the mops; some staff soaked the mops in bleach and replaced when mops appeared frayed; other staff washed mops in the washing machine.

Insufficient supply of paper hand towel resulting in no provision of paper towel in the kitchen, residents' bathroom and staff en suite.

15. 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:

New cleaning logs have been devised to provide more structure to recording of cleaning schedules. Mops will be washed three times a week in the washing machine.

A fortnightly audit will be carried out by the PIC or House Manager to ensure good practices are being adhered to and the right quantity of supplies are available.

Commenced Friday 12th August 2016

Proposed Timescale: 12/08/2016

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:

Not ensuring that the process for decision making, implementing and reviewing restrictive practices was robust.

16. Action Required:

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

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

Each service user will have a full review of their care plan carried out to include restrictive practices at the appropriate stage with the MDT and behavioural management plans. The Organisation has secured a Psychologist for two days a week who will commence the second week in September.

The PIC will give a weekly update at the Governance and Quality meetings on any incidents that have happened the previous week to include, medication errors or peer to peer negative interaction. The PIC is required to bring supporting evidence of what actions have been taken to ensure the safety of all service users and what has been put in place to elevate future incidents.

Proposed Timescale: 28/10/2016

Theme: Safe Services

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

Not all staff had up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

17. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

All staff have received training in Managing Challenging Behaviour. The PIC and House Manager will meet with all the staff in the house and review each service user. This will include developing appropriate risk assessments and completing individualised behavioural management protocols / guidelines for each service user in the house.

Proposed Timescale: 28/10/2016

Theme: Safe Services

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

Not all staff had received training in the management of behaviour that is challenging including de-escalation and intervention techniques

18. Action Required:

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

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

Training in management of behaviours that challenge including de-escalation and intervention training has been provided for all staff.

Proposed Timescale: Completed

Theme: Safe Services

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

Residents did not have access to psychological assessment.

19. Action Required:

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

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

The Organisation has secured a Psychologist for two days a week. The Psychologist is to commence the second week in September.

Proposed Timescale: 28/10/2016

Theme: Safe Services

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

Inspectors reviewed three residents recorded as having the potential to 'make inaccurate statements'. The substantive matters of these alleged allegations were not investigated.

20. 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:

Any statements or accusations of inaccurate nature will be recorded and reported to the designated officer. All accusations will be reviewed at a preliminary meeting as per National Policy. Detailed safeguarding plans will be devised for all service users

Proposed Timescale: 27/07/2016

Theme: Safe Services

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

Not ensuring that the recommendations from a specialist assessment carried out in September 2010 outlining vital supports, safeguarding supervisory requirements and interventions pertinent to a resident, were implemented.

21. Action Required:

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

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

One service user requires a Forensic Psychologist assessment. The service user will be brought to their appointment in Kilkenny. We are awaiting a date and time to be confirmed. In the interim previous recommendations around life skills teaching will commence. These skills will help provide them with the necessary skills for daily living. These will be reviewed monthly to assess their progress. August 1st 2016 for skills teaching.

Proposed Timescale: 01/08/2016

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:

Some incidents were not reported to the Authority within the three day time period as necessary.

22. Action Required:

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

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

The PIC and House Manager are aware of the regulatory requirements to submit some incidents within the three day time period. The PIC will provide a written report to the inspector at the end of Q3 to include any omission from previous quarter.

Proposed Timescale: 31/07/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

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

Residents' access to psychology was limited.

23. Action Required:

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

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

The Organisation has secured a Psychologist for two days a week. The Psychologist will commence the second week in September 2016

Proposed Timescale: 28/10/2016

Theme: Health and Development

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

Not ensuring appropriate health care for each resident, having regard to each resident's personal plan.

24. Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

All Care Plans will be reviewed to include appropriate healthcare as per recommendations and identify input from each service user.

Proposed Timescale: 28/10/2016

Theme: Health and Development

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

Not ensuring that food is stored in hygienic conditions. The kitchen and presses in one house require deep cleaning.

25. Action Required:

Under Regulation 18 (1) (b) you are required to: Ensure there is adequate provision, so far as reasonable and practicable, for residents to store food in hygienic conditions.

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

A deep clean of the kitchen and utility area including presses, shelves and drawers will be carried out. New cleaning logs have been devised to provide more structure to recording of food storage and cleaning schedules.

A fortnightly audit will be carried out by the PIC or House Manager to ensure good practices are being adhered to as per hygiene guidelines.

Proposed Timescale: 06/08/2016

Theme: Health and Development

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

Cooking/cooling and reheating temperatures of food were not monitored in a consistent manner.

26. Action Required:

Under Regulation 18 (2) (a) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

Each service user will be provided with adequate food and drink of their choice which are properly and safely prepared and served. Temperatures will be monitored as per food safety guidelines. A fortnightly audit will be carried out by the PIC or House Manager to ensure good practices are being adhered to and food safety guidelines are being met. Commenced 25th July 2016 and ongoing

Proposed Timescale: 25/07/2016

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:

It could not be confirmed that a resident had received insulin as prescribed.

A review of medication incidents was not undertaken on a regular basis to ensure that a multifactorial and systems-based analysis was undertaken to identify trends and to prevent recurrence of medication-related incidents.

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:

Rosters reviewed to establish staff on duty of time of incident. Identified staff omitted to record that service user self-administered insulin on one occasion. Service user away with host family second occasion. Drug errors completed for incidents in question. These will be reviewed by the local drugs and therapeutic committee. Any actions identified following review will be carried out by PIC. A monthly audit of all Kardex's will be carried out by the PIC and results reviewed by the drugs and therapeutic where appropriate.

Proposed Timescale: 29/07/2016

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:

Not ensuring that where a person is appointed as a person in charge of more than one designated centre, that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

28. Action Required:

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

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

The Person in Charge is appointed to three designated centres. They have a direct link with a CNM3 who provides support and mentorship to them. There are weekly Governance and Management meetings which they attend. The focus of these meetings is to give support and guidance to the PIC's and evaluate how they are managing and auditing their designated centres. The CNM3 will have individual supervision meetings monthly with the PIC.

Proposed Timescale: 29/07/2016

Theme: Leadership, Governance and Management

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

Not putting management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

29. 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:

There are weekly Governance and Management meetings which the PIC attends. The focus of these meetings is to give support and guidance to the PIC's and evaluate how they are managing and auditing their designated centres. A House Manager meeting was held on the 27th July 2016 and the importance of their role was highlighted. Going forward the PIC and house managers within their areas will be met every two months by the Registered Provider.

Proposed Timescale: 29/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

The PIC was not included on the staff roster.

30. Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

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

The PIC is supernumerary. They have three designated centres. The PIC will inform the House Manager where they are throughout the week. The PIC commenced emailing out a roster stating where they will be throughout the week. The PIC is contactable by phone while on duty.

Proposed Timescale: 29/07/2016

Theme: Responsive Workforce

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

Not ensuring that staff had access to appropriate training, including refresher training, as part of a continuous professional development programme.

31. Action Required:

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

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

All staff have now been re book into the training they require. The PIC and House Manager will ensure that all training for staff is maintained and up to date and where training is not available in service the Nominee Provider will ensure that it is sourced externally. There is an up to date monitoring system in place to identify immediately if staff are absent or missing from training.

Proposed Timescale: 29/07/2016

Theme: Responsive Workforce

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

Not ensuring that staff were appropriately supervised.

32. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

The PIC attends weekly Governance and Quality meetings. Every two months the Nominee Provider will meet with the PIC and House manager. The PIC and House Manager have the support of the CNM 3. The House Manager will meet with the staff and commence individual supervision meetings. A more detailed and structured handover will commence where staff are identified for specific tasks throughout the day. Commenced 5th August 2016

Proposed Timescale: 05/08/2016