## Centre Information

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Anne’s Residential Services - Group N</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005163</td>
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<tr>
<td>Centre county:</td>
<td>Tipperary</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Daughters of Charity Disability Support Services Ltd</td>
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<tr>
<td>Provider Nominee:</td>
<td>Simon Balfe</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>5</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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</table>
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: 03 November 2016 16:00 03 November 2016 18:00
04 November 2016 09:00 04 November 2016 15:00

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

<table>
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<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
<th>Outcome 04: Admissions and Contract for the Provision of Services</th>
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<tr>
<td>Outcome 05: Social Care Needs</td>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 12. Medication Management</td>
<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection
Background to the inspection:
This was the third inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 5 May 2015 and the second on 17 August 2015. The purpose of this inspection was to follow-up on the high level of non-compliance identified at the previous inspection, where six of the 18 outcomes were at the level of major non-compliance with a further seven at the level of moderate non-compliance.

Description of the service:
The centre comprised a house located in a rural village on the border between Tipperary and Offaly. On the day of inspection the centre was providing care and support to five residents, four men and one woman. All of the residents attended either work or a day service. Many of the residents in this centre were very involved in local community activities including, going to mass, shopping locally and going to music and zumba sessions during the week.
Since the previous inspection one resident had been discharged from the centre. There was evidence that this had been planned carefully, with the resident fully involved in the process and provided with all relevant information. While the resident had been discharged from the centre they were still part of the wider St Anne’s community with one resident saying that they “go and see them every month”.

How we gathered our evidence:
Inspectors met and spoke with all five residents who currently lived in this centre. Inspectors also met the person in charge of the centre, staff and the residential services manager. Inspectors observed staff practices and interactions with residents and reviewed residents’ personal plans, training records, meeting minutes and the complaints log.

Overall judgment of our findings:
At the previous inspection, six of 18 outcomes were at the level of major non-compliance. Of the six outcomes where failings had been indentified these had been now addressed completely in two of the outcomes namely, inappropriate placement of one resident (outcome 5) and notification of incidents (outcome 9). However, some improvement was still required in relation to:
• risk assessment and fire safety (outcome 7)
• practices and the documentation to support residents to manage their behaviours (outcome 8)
• records management (outcome 18)
• staffing (outcome 17).

At the last inspection a further seven outcomes had been at the level of moderate non-compliance. Issues identified had been remedied in relation to protection of residents’ finances (outcome 1), updating of statement of purpose (outcome 13), medication management (outcome 12) and the updating of policies relating to protecting residents (outcome 4). However, some improvement was still required in relation to:
• comprehensive educational assessment (outcome 10)
• healthcare (outcome 11)

At previous inspections, the arrangements in relation to the person in charge were not satisfactory due to the extensive remit of the person in charge. This resulted in insufficient oversight of the quality and safety of care and support provided in the centre. On this inspection the remit of the role of the person in charge remained unchanged from the previous inspection as there was still a remit for four designated centres. However, there was a new person in charge at the time of the inspection being inducted into the centre and was being mentored in relation to her new role. The new person in charge fulfilled the criteria of person in charge in terms of background and experience and said that she had committed to completing a management qualification.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The failing identified on the previous inspection in relation to residents’ finances had been adequately addressed.

On the last inspection the process for managing residents' finances was not transparent and in particular, in documentation seen, there had been reference to the transfer of money out of one resident’s day-to-day expenses marked as an “IOU St Anne’s “.

Since the last inspection St Anne’s Service had arranged a review of the management of residents' funds by an external financial auditor. This review that included all residents' financial accounts across all of St Anne’s residential services was completed in April 2016. The recommendations from this review included the requirement for monthly preparation and review of bank account totals for each resident. On this inspection there was a monthly finance reconciliation submitted to the residential service manager for review. This included personal bank account statements.

There were adequate systems in place to safeguard residents’ day-to-day money. All receipt dockets were signed by two staff. The totals were kept in a separate cash book.

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 issued identified on the previous inspection in relation to the admission policy had been rectified.

**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:**
Each resident’s wellbeing and welfare was maintained. In addition, there was evidence that residents were supported in transition between services.

Since the last inspection one resident had been discharged in accordance with the centre policy for admissions including transfers and discharge. This discharge had taken place in response to this resident’s changing needs that had been highlighted in the previous two inspection reports. There was evidence that the proposed move had been planned carefully, with the resident fully involved in the process and provided with all relevant information. While the resident had been discharged from the designated centre they were still part of the wider St Anne’s community with other residents still visiting and seeing how “they were getting on in the new place”. 
In relation to residents’ assessed needs there were person centred planning folders available in an easy to read format in words and pictures. There were separate assessments of residents’ healthcare needs and social care needs in the personal planning process.

In relation to healthcare needs the personal file contained the “healthcare plans of care” for residents including all relevant healthcare needs for each resident. There was evidence that these healthcare plans were taking into account changes in circumstances and new developments.

In relation to the social care needs of residents, there were specific assessments and plans in relation to community inclusion and social needs. Many of the residents in this centre were very involved in local activities including, going to mass, shopping locally and going to music and zumba sessions during the week.

The residential personal plans also had the annual person centred planning meeting. The most recent planning meeting for most residents had only recently taken place and so they were not available in a typed/easy-to-read format. This planning meeting developed resident goals for the year. In the records seen by inspectors the goals were person centred, appropriate and were realistic. Goals included:
- spending a night away
- up-skilling on computers
- attending music festivals
- increasing family contact

There was evidence of some multi-disciplinary input into the reviews of personal plans. However, as all planning meetings had been typed up it was not clear if not all required healthcare expertise was always available at the person centred planning meeting.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
Improvement was still required in relation to the process for risk assessment and “fire stopping” measures.
As on the previous two inspections the doors throughout the centre were not fire doors. The absence of fire doors meant adequate measures were not provided to protect the means of escape and to prevent the spread of fire and smoke throughout the building. As a result of this, residents were at serious risk should a fire occur in the building. This was discussed with the person in charge who said they would obtain, from a suitably competent person, assurance in relation to the fire safety arrangements in the centre.

As on the last inspection the identification of hazards and management of risks required improvement in particular:

- an occupational therapist in July 2015 had identified the doors throughout the premises as a hazard to residents as they were “fast closing” with the potential for injuring residents. Staff confirmed that this had not been risk assessed since the last inspection. The doors were observed by the inspector to close quickly and residents who required assistance while mobilising were at risk of injury
- in relation to the hazard resident falls, while screening for the risk of falls had been completed, the system did not identify whether a risk assessment is required.

On the last inspection improvement was required in relation to the personal emergency evacuation plans of residents as they did not adequately account for the mobility and cognitive understanding of each resident. On this inspection each resident had a personal emergency evacuation plan that outlined the level of mobility and assistance that each resident required.

**Judgment:**
Non Compliant - Moderate

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**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:**
Practices and the documentation of the management of behaviours that challenge required improvement.

Residents who required support to manage their behaviour had care support plans in
place. However, as on the last inspection improvement was required to behaviour support plans as they did not provide adequate guidance for staff. In some cases staff were directed to adhere to a “behaviour management plan”. However, in one case the plan had not been updated since January 2011. There were recommendations on file from a psychiatrist in July 2016 stating that the resident should have support from a psychology. The risk assessment in relation to this hazard had been completed in October 2016, was designated a “low risk” and did not reference the recommendation for psychology input.

In other cases the behaviour support plan had been completed by a staff member who did not have a qualification in the area of behaviour support. The most recent annual review of the safety and quality of care and support provided in the centre also highlighted the lack of clinical psychology support available to residents.

The service provider was obliged to notify HIQA on a quarterly basis of any occasion on which restraint was used (such as physical, environmental or chemical). HIQA was notified in October 2016 that one resident had a sensor mat in place as a restraint. This mat alerted staff if the resident decided to get out of bed at night. The inspector was told that this restraint had been approved by the service restrictive interventions review committee. However, documentation was not obviously available in the resident’s healthcare file.

The inspector queried the choice of language used in one section of the person centred planning documentation which did not promote residents' dignity. This was discussed with the assistant chief executive officer who outlined that she would review these issues.

**Judgment:**
Non Compliant - Moderate

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**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:**

It is a requirement that all serious adverse incidents were reported to HIQA within three working days of the incident. Since the last inspection a record of all incidents occurring had been maintained and all notifications had been sent to HIQA as required.
### 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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
It could not be demonstrated that each resident had a comprehensive assessment of their social and personal development needs.

At the previous inspection, a comprehensive assessment of residents’ training, education and personal development needs had not been completed for all residents. Similarly on this inspection a comprehensive assessment of training and personal development needs was not in place for all residents. For example, one resident’s epilepsy care plan also contained a form relating to “my education, training and development”. However, this form was not fully completed and had not been signed or dated. In addition, a review of the resident’s day service had been recommended as part of a psychology referral. However, there was no indication as to why the day service placement was inadequate.

**Judgment:**
Substantially Compliant

### Outcome 11. Healthcare Needs

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

**Theme:**
Health and Development

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

**Findings:**
Residents were supported on an individual basis to achieve and enjoy the best possible health.
The person in charge outlined that residents had the option of attending a general practitioner (GP) of their own choice. The inspector reviewed a sample of resident healthcare files and found evidence of regular GP reviews. The GPs requested review of residents’ healthcare needs by consultant specialists as required, for example in the area of skin care.

There was evidence that residents were referred for support as required by allied health professionals including speech and language therapy and physiotherapy. There were clear and up-to-date guidance available to staff following any such review. In healthcare, information relating to one resident there was reference to a referral to an occupational therapist in November 2015 for sensory processing review. Staff had completed an additional sensory processing checklist in June 2016 but it was not clear if the resident had been seen by the occupational therapist as recommended.

There was a policy and guidelines for the monitoring and documentation of residents’ nutritional intake. The inspector found that residents were referred for dietetic review as required and residents had nutrition care plans as required.

**Judgment:**
Substantially Compliant

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**Outcome 12. Medication Management**

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

**Theme:**
Health and Development

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

**Findings:**
The issues identified on the previous inspection in relation to transcription practices had been rectified.

**Judgment:**
Compliant

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**Outcome 13: Statement of Purpose**

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

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

### Findings:
There was a written statement of purpose that accurately described the service provided in the centre.

The statement of purpose described the service and facilities provided to residents, the management and staffing and the arrangements for residents’ wellbeing and safety. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre.

### Judgment:
Compliant

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

### Theme:
Leadership, Governance and Management

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

### Findings:
Some improvement was required to address the non-compliance identified over the course of the three inspections of this centre.

At the previous inspection, six of 18 outcomes were at the level of major non-compliance. Of the six outcomes where failings had been identified these had been now addressed completely in two of the outcomes namely, inappropriate placement of one resident (outcome 5) and notification of incidents (outcome 9). However, some improvement was still required in relation to:
- risk assessment and fire safety (outcome 7)
- practices and the documentation to support residents to manage their behaviours (outcome 8)
• records management (outcome 18)
• staffing (outcome 17).

At the last inspection a further seven outcomes had been at the level of moderate non-compliance. Issues identified had been remedied in relation to protection of residents’ finances (outcome 1), updating of statement of purpose (outcome 13), medication management (outcome 12) and the updating of policies relating to protecting residents (outcome 4). However, some improvement was still required in relation to:
• comprehensive educational assessment (outcome 10)
• healthcare (outcome 11)

At previous inspections, the arrangements in relation to the person in charge were not satisfactory due to the extensive remit of the person in charge. This resulted in insufficient oversight of the quality and safety of care and support provided in the centre. On this inspection the remit of the role of the person in charge remained unchanged from the previous inspection as there was still a remit for four designated centres. However, there was a new person in charge at the time of the inspection being inducted into the centre and was being mentored in relation to her new role. The new person in charge fulfilled the criteria of person in charge in terms of background and experience and said that she had committed to completing a management qualification.

There was also a house manager who was part-time (17.5 hours per week). She worked the remainder of the week in another centre 10 kilometers away.

Since the previous inspection a new residential services manager had been appointed to the service in February 2016. In addition the “link” nursing manager who had been in post at the time of the previous inspection had also been replaced. The inspector was informed that the current nursing manager was in post on secondment from another service.

The provider had completed an annual review on 28 October 2016 of the safety and quality of care and support provided in the centre. This was found to be comprehensive.

Judgment:
Substantially 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:
Based on the assessed needs of residents, there were sufficient staff with the right qualifications and experience to meet those needs. However, the annual review did identify that there were times when three “non-drivers” were on duty and so residents may not be able to go to planned activities.

On the last two inspections it was found that the unavailability of transport limited the activities the residents could undertake at the weekend. One of the issues highlighted in the most recent annual review of the safety and quality of care and support provided in the centre was that transport was available at all times. However, the annual review did identify that there were times when three “non-drivers” were on duty and so residents may not be able to go to planned activities.

Since the last inspection records indicated that all staff had completed relevant training. In addition, the St Anne’s service had supported four staff to complete a certificate in intellectual disability practice.

Judgment:
Substantially Compliant

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

Theme:
Use of Information

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

Findings:
Since the previous inspection all required policies procedures and guidelines were available. In addition, the residents’ guide and the directory of residents had been updated.
As on the previous two inspections it was found that appointment cards for outpatient review by consultant specialists and allied health professionals were filed loosely in residents’ healthcare files. This filing method could not guarantee the confidentiality of residents’ personal information or ensure that appointments would be kept.

**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:**

Kieran Murphy
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 report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0005163</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>03 and 04 November 2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>20 December 2016</td>
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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 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As on the last inspection the identification of hazards and management of risks required improvement.

1. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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 PIC and CNM3 will complete an updated risk assessment on the fast closing doors throughout the centre. Where risks have been identified these will be addressed immediately by the service to prevent injury to service users. The PIC will review the falls screening tool completed on service users. Where a concern has been identified the PIC will complete the required risk assessment and update the care plan accordingly.

Proposed Timescale: 31/12/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The absence of fire doors meant adequate measures were not provided to protect the means of escape and to prevent the spread of fire and smoke throughout the building. As a result of this, residents were at serious risk should a fire occur in the building. This was discussed with the person in charge who said they would obtain from a suitably competent person assurance in relation to the fire safety arrangements in the centre.

2. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The service enlisted an external fire consultant agency in February 2015 who completed a fire safety risk assessment. The works on the locks have been completed. The fire alarm and emergency lighting has been completed. All staff within the centre has received fire training and evacuation plans are posted in appropriate areas. The centre has all the required certification for electrical, fire alarm and emergency lightening. The mobility status for all service users has been updated. The works on the fire doors remain outstanding, costings have been submitted to the HSE.

Proposed Timescale: 28/02/2017

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:
The behaviour support plans had been developed without input from an appropriately trained and qualified professional. Therefore, the behaviour support plans did not provide appropriate guidance for staff to identify and alleviate the cause of residents’
behaviour that challenged. There was no review or oversight of these incidents by an appropriately trained and qualified professional.

### 3. 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:**
The behavioural support plans for all service users will be reviewed by members of the MDT. This will ensure that all relevant information is up to date and compliant with their individual needs. The PIC and CNM3 will discuss and give guidance to all staff in the centre on identifying and dealing with behaviours that challenge. Interviews for a Psychologist took place in early December. There was a successful candidate. They are currently being processed by HR and will commence in March 2107. The PIC will review all incidents on a weekly basis. The CNM3 will link with the PIC to review the incidents and identify any concerns. All incidents will be brought formally to the monthly Governance meetings to be discussed and reviewed.

**Proposed Timescale:** 31/01/2017

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### Outcome 10. General Welfare and Development

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A robust assessment was not in place to establish each resident's educational, employment or training goals

**4. Action Required:**
Under Regulation 13 (4) (a) you are required to: Ensure that residents are supported to access opportunities for education, training and employment.

**Please state the actions you have taken or are planning to take:**
The Person in Charge will review Care Plans and PCP's to ensure goals reflect training educational and development as per access to training and development policy DOCS070
The PIC will ensure that the keyworker will link with day services in relation to the setting and monitoring of goals.

**Proposed Timescale:** 28/02/2017

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### 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:
In healthcare information relating to one resident there was reference to a referral to an occupational therapist in November 2015 for sensory processing review. Staff had completed an additional sensory processing checklist in June 2016 but it was not clear if the resident had been seen by the occupational therapist as required.

5. 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:
A referral made to OT 16/11/15 for a sensory processing review an additional sensory processing checklist was sent to OT on 12/06/16. All documentation was sent to the Dublin service. An assessment will be carried out on the 26/01/2017

Proposed Timescale: 26/01/2017

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 all actions identified on the previous two inspections had been rectified.

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

Please state the actions you have taken or are planning to take:
The PIC and CNM3 will complete an updated risk assessment on the fast closing doors throughout the centre. Where risks have been identified these will be addressed immediately by the service to prevent injury to service users.
The PIC will review the falls screening tool completed on service users. Where a concern has been identified the PIC will complete the required risk assessment.

The behavioural support plans for all service users will be reviewed by members of the MDT. This will ensure that all relevant information is up to date and compliant with their individual needs. The PIC and CNM3 will discuss and give guidance to all staff in the centre on identifying and dealing with behaviours that challenge. Interviews for a Psychologist took place in early December. There was a successful candidate. They are currently being processed by HR and will commence in March 2107.
The PIC will review all incidents on a weekly basis. The CNM3 will link with the PIC to review the incidents and identify any concerns. All incidents will be brought formally to
the monthly Governance meetings to be discussed and reviewed.

**Proposed Timescale:** 28/02/2017

### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review did identify that there were times when three “non-drivers” were on duty and so residents may not be able to go to planned activities.

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

**Please state the actions you have taken or are planning to take:**
PIC to review roster and ensure driver always on the Roster.

The PIC and House Manager have reviewed the roster and an identified driver will be rostered to each shift. In the event where there is no driver available the PIC will link in with another centre to ensure that all activities will go ahead as planned.

**Proposed Timescale:** 19/12/2016

### Outcome 18: Records and documentation

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As on the previous two inspections it was found that appointment cards for outpatient review by consultant specialists and allied health professionals were filed loosely in residents’ healthcare files. This filing method could not guarantee the confidentiality of residents’ personal information or ensure that appointments would be kept.

**8. Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
All appointment cards will be kept in polly pockets within each individual service users file. Any appointments will be inputted into the diary in the centre and when the service user attends their appointment the can bring their appointments cards with them. Staff
will adhere DOCS 050 Records Management Policy.

**Proposed Timescale:** 19/12/2016