Centre name: Sancta Maria House
Centre ID: OSV-0001813
Centre county: Limerick
Type of centre: Health Act 2004 Section 39 Assistance
Registered provider: St Joseph's Foundation
Provider Nominee: Catherine O'Connell
Lead inspector: Mary Moore
Support inspector(s): None
Type of inspection: Unannounced
Number of residents on the date of inspection: 6
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.
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**

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<tbody>
<tr>
<td>24 October 2016 09:15</td>
<td>24 October 2016 18:30</td>
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<tr>
<td>26 October 2016 08:45</td>
<td>26 October 2016 16:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
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<th>Outcome 05: Social Care Needs</th>
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**Summary of findings from this inspection**

**Background to the inspection:**
This inspection was the second inspection of the centre by the Health Information and Quality Authority (HIQA) and was undertaken to monitor ongoing compliance with regulatory requirements. The last inspection of the centre was undertaken on 22 September 2014; that inspection was a registration inspection.

**How we gathered our evidence:**
Prior to the inspection the inspector reviewed the information held by HIQA including the previous inspection findings and notifications submitted in the interim.

The inspector was on site in the centre for two days and during that time the inspector observed the delivery of supports to residents and interactions between staff and residents. The inspector met with the frontline staff on duty, with the recently appointed person in charge, the residential coordinator, the manager for adult services and the provider’s nominated representative.

The inspector met with five of the six residents living in the centre; one resident was on leave at home with family.
The inspector reviewed and discussed records including fire safety and health and safety records, staff related records and records pertaining to supports delivered to the residents living in the house.

Description of the service:
The inspector saw that, as outlined in the document titled the statement of purpose, residential services were provided to six adult residents in a purpose built single storey residence conveniently located in the busy local village.

Overall findings:
The overall inspection findings raised concerns in relation to the governance of the centre and the monitoring of the quality and safety of care and supports provided to residents.

While there was evidence of protective action taken by the provider in response to alleged breaches in the quality and safety of care and supports provided to residents, those concerning allegations and their investigation had not been notified to HIQA as required by Regulation 31(1)(f). There was evidence that residents may not have been safeguarded from these alleged breaches in a timely manner due to failings in reporting procedures and responsibilities.

Failings were identified in evacuation procedures as a robust evacuation plan specific to the current needs of each resident was not in place.

There was an overreliance on relief and agency staff that was not in keeping with the assessed needs and the support required by residents for the management of behaviours of concern.

Residents spoken with requested an explanation of the role and function of HIQA. Further to this explanation resident feedback was provided as to what was good about the centre and what was not so good; alleged incidents that were clearly still of concern to them but not on-going at the time of this inspection. The inspector was told that “things were okay now” in the house. Residents also spoke of how they enjoyed their personal space and belongings, going to the day service and other activities, receiving visitors and going home.

Over the two days, the inspector observed the routine of the house, staff - resident interactions and residents' general demeanour. Residents clearly had pride and a sense of ownership over the house and their personal space. Residents willingly participated in routines such as household duties, were comfortable with the staff on duty and reported that these staff were nice to them. Observed staff behaviours were appropriate and respectful of residents. The provider’s nominated representative was clearly known to the residents and his presence in the house was welcomed by them.

Based on the verbal feedback of these inspection findings there was evidence of the provider’s commitment to regulatory requirements and the provision of safe, quality services to residents in that;
- governance structures were revised and amended to support the consistent
monitoring of the quality and safety of the care and services provided to residents - the required notification and supporting evidence of action taken by the provider to safeguard residents was submitted to HIQA.
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 05: Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Each resident had a plan of support.

The plan was based on the outcome of an assessment of the resident’s holistic needs; where a need was identified a plan of support was put in place. Overall, plans were seen to be kept under review with updates to reflect changes in needs, however, deficits in review and update, particularly in relation to healthcare related supports were identified. For example, the inspector saw records of needs in the daily file that were not included in the support plan; these needs included a current wound and a concern in relation to weight loss. Staff spoken with were aware of these needs and described the monitoring interventions in place but there was insufficient detail in the daily file or the support plan to guide supports and care such as the required frequency of body weights or the current wound management plan. A vision support plan was not updated to reflect the findings from recent referral and review.

The person in charge had recently identified the need for and had brought to the attention of the provider the requirement for structured nursing support and guidance in the service. These inspection findings would support this request as, while no deficits in practice were identified, there was a risk for deficits to develop in the absence of support plans that provided clear guidance.

The support plan incorporated the personal plan and each resident’s personal goals and objectives. These were reviewed and agreed annually; reviews were recorded with participation from residents and their families. However, the reviews seen were dated 2015 and dealt only with the practical supports required on a daily basis by residents.
rather than their personal goals and objectives. It was therefore not evident how personal goals were identified and agreed. Some goals lacked a development focus and were again linked to daily routines or wellbeing such as going for walks with staff. The records for progressing goals did not always convey whether goals had been met or not and if not why not. For example, a record seen by the inspector stated that one resident wanted to be able to lock their personal wardrobe; the inspector saw that the resident did not have this facility at the time of this inspection.

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

Findings:
There was evidence of measures to promote and protect the health and safety of residents and staff, however, the provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire.

The inspector saw a safety statement and a risk management policy; the latter informed the identification of hazards, the assessment and management of risk and the management of any accidents, incidents and adverse events.

There was an up-to-date centre specific risk register. The log of risks was dated January 2016 and individual risks were dated as reviewed in July 2016. The register included a range of environmental and work- related risk assessments, resident specific risk assessments and the risks as specifically required by Regulation 26(1)(c). The identified hazards and assessment of risk largely reflected the assessed needs of residents as described by staff spoken with. However, a full review of the risk assessments was required to ensure that all risks were correctly identified, assessed and managed and that the progress of the implementation of any additional controls was monitored. For example, while there was a support plan for the accumulation and stockpiling of specific items by residents, the risk posed in the event of heat and fire had not been identified. There was an open staffing risk with a risk rating of 25 (high) dated July 2016 with an additional control for an additional care staff.

The inspector saw that the premises was serviced by an automated fire detection system, emergency lighting, fire doors and compartments and prominently located fire fighting equipment. The fire register was well maintained and certificates were in place for the inspection and testing of fire safety measures at the prescribed intervals. Staff
also undertook and recorded daily, weekly and monthly inspection of these fire safety measures.

A diagrammatic evacuation plan was prominently displayed in the centre. Escape routes were seen to be clearly indicated and unobstructed. However, there were residual manual key locks on final exit doors; staff said that they had the key to the main front door on them at all times. However, while staff said that the other two doors were never locked and the inspector saw that the doors were unlocked, staff spoken with did not know if there were keys for these locks or why the locks were still in place.

Door wedges and furniture were seen to be used to hold open two fire doors; a bedroom door and the staff office. This practice was noted on an internal health and safety audit completed in July 2015. The provider was requested to review one fire door to confirm its integrity; a slight warp was noted when the door was closed and the gap between the floor and the door required review to ensure it was within recommended guidance.

Personal emergency evacuation plans (PEEPS) were in place for each resident; the plans seen were dated as reviewed in February 2016. Staff said and there was documentary evidence that staff undertook regular simulated fire drills with residents.

However, the provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire. On reviewing the records of three simulated drills undertaken in July, August and October 2016, the inspector saw that while staff had recorded an adequate evacuation time, they had failed to evacuate one resident who was recorded as having “refused” to leave the building. Staff spoken with confirmed this and their reliance on the closing of fire doors for preserving resident safety and life as recorded on the most recent fire drill report. Staff also said that the resident could decide to open fire doors if left unaccompanied in the building in the event of fire. The PEEP did not adequately address the findings of the most recent fire drills or adequate measures to be taken to ensure the safe evacuation of the resident, particularly if the resident refused to leave the compartment where the fire was located.

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):
No actions were required from the previous inspection.

Findings:
There were measures in place to protect residents from harm and abuse; these included organisational and national policies and procedures, designated persons, and staff training. However, based on the evidence available to the inspector these measures had failed to protect residents from harm and abuse in a timely manner.

In the course of general conversation with residents and subsequently staff, the inspector was advised of alleged behaviours and incidents in the centre in early 2016 that constituted, if upheld, emotional, psychological, institutional and physical abuse of residents. These allegations had not been notified to the Chief Inspector and were first brought to the attention of the inspector by a resident.

Staff spoken with said that they had brought their concerns to the attention of a line manager, but that no action was taken and that the alleged abuse continued for an undetermined period following the complaints made by them. Staff said that they were instructed not to question the direction of staff that were senior to them. Staff said that they believed that their concerns were never brought to the attention of senior management. In April 2016, staff did bring the concerns directly to the attention of the designated person and protective measures to safeguard residents were taken by the provider with immediate effect.

This alleged reporting failure and the impact it had on staff exercising their responsibilities to safeguard residents and be facilitated to raise further concerns if necessary as to the quality and safety of the care and supports provided to residents was of concern to the inspector. Reporting procedures and responsibilities required further clarification with both staff and residents to prevent reoccurrence and ensure that residents were safeguarded from abuse at all times.

Residents did present with behaviours that were of concern and that posed a risk to other residents and staff; the inspector observed these behaviours while in the centre. Staff spoken with had good knowledge of residents, behaviours, known triggers and interventions. Staff were observed to manage exhibited behaviours therapeutically and with positive results. Staff said that there was increased awareness in the house of the impact of behaviours on everyone living in the centre and the requirement to support and safeguard all residents. There was a very recently devised behaviour support plan for implementation. The plan was evidence based and based on the functional analysis of behaviours between August and September 2016. There was a clear implementation plan and timeframes (November 2016) upon which the success of the plan was dependent.

However, at the time of this inspection, records seen and the inspector's observations confirmed that the behaviours of concern and risk (the assessed risk to others of some behaviours was high) continued. Core elements of the behavioural support plan were not implemented; specifically in relation to meaningful engagement, the alleviation of boredom, the provision of positive behaviour support plans for all residents and
ultimately the provision of regular, completely familiar and consistent staff.

Staff had identified practices that were restrictive. These included environmental restrictions such as locked bedroom doors, the central storage of residents’ personal toiletries and restricted access to some food stuffs. There was a rationale for these practices, the safeguarding of residents personal space and property; residents spoken with clearly wished to protect their personal space and property. However, there were no formal procedures for the identification, sanction and ongoing review of restrictive practices to ensure that they were justified, a last resort and not open to misuse or abuse.

While no concerning patterns of use were identified by the inspector, the inspector did not see a protocol to guide staff decision making in the administration of medicines prescribed on a p.r.n basis (a medicine administered only as required). Staff spoken with confirmed there was no protocol. For example, one resident had two such prescribed medicines which were, based on the records seen, administered interchangeably by staff.

**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):**
No actions were required from the previous inspection.

**Findings:**
All adverse events that had allegedly occurred in the centre had not been notified to the Chief Inspector. This included alleged safeguarding concerns that should have been notified within three days of their alleged occurrence in early 2016 but were only brought to the attention of the inspector on inspection. The required notification was submitted retrospectively.

**Judgment:**
Non Compliant - Major

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

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

**Findings:**
Overall, while there may have been documentary deficits, having observed practice and having spoken with staff the inspector was satisfied that, arrangements were in place to support residents to maintain their health and well-being.

The person in charge confirmed that residents attended their choice of general practitioner (GP). There was documentary evidence that staff monitored resident well being and sought medical review and treatment as and when necessary. There was evidence of other actions taken by staff to monitor and maintain well being such as regular monitoring of body weight, of vital signs (pulse, temperature, blood-pressure), blood-profiling, monitoring of blood glucose levels and referral to the acute hospital services as necessary. There was evidence that staff supported residents while in hospital.

There was evidence of formal communication between day support and residential staff when the former had input in to healthcare needs such as requesting GP or nursing review.

As appropriate to their needs there was documentary evidence that residents had access to the required supports including psychiatry, psychology, social work, speech and language therapy, occupational therapy, dental care, chiropody and diabetic services including retinal screening.

Staff spoken with were familiar with residents, their healthcare needs and the supports required to maintain resident well being.

Staff were seen to freshly prepare meals that residents said they enjoyed. Staff were observed to implement speech and language recommendations including supervision at mealtimes.

**Judgment:**
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):
No actions were required from the previous inspection.

Findings:
There was evidence of good medicines management practice.

The inspector saw policies and procedures signed as reviewed in September 2016 governing the management of medicines.

Medicines were supplied in a compliance aid by a community pharmacy on an individual resident basis. Medicines were seen to be securely stored.

There was a refrigerator specifically for the storage of medicines; staff monitored its temperature daily.

Each resident was seen to have a signed and dated prescription and a corresponding administration record. Prescription records were current and legible, the maximum daily dosage of medicines prescribed on a p.r.n basis (a medicine administered only if required) was stated; discontinued medicines were signed and dated as such.

The medicines administration record completed by staff was seen to reflect the instructions of the prescription. The inspector saw that staff respected a resident’s right to refuse medicine but also supported the resident to make a good and informed decision.

Residents were not participating in the management of their medicines; there were clinical records in place supporting this decision.

Systems were in place for reporting and managing medicines related incidents. The person in charge said and there was documentary evidence that these were analysed to establish any patterns and contributing factors, and any remedial actions required to promote safe medicines management.

Other systems to support the safety of medicines management practice included the checking of medicines delivered and the return of unused and unwanted medicines to the pharmacy; there were itemised, signed and verified records of the latter. There was a monthly audit of the administration and stock balance of medicines administered on a p.r.n basis.

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):**
No actions were required from the previous inspection.

**Findings:**
Prior to the conclusion of this inspection and immediately following its conclusion, the provider confirmed the review of, and amendment to, the overall governance structure and the person in charge arrangements. These changes were made to support effectiveness in monitoring and ensuring the quality and safety of the supports and services provided to residents. The inspection findings did not support the effectiveness of the existing structures or the robustness of the providers systems of review. For example, while unannounced visits to the centre were frequent, four were noted to last approximately 15 minutes; reports were not available from all reviews.

The person in charge was recruited to the role in August 2016, was suitably qualified in disability social care studies and had established experience in the sector as a social care worker. While this was her first person in charge role, the inspector found that the person in charge had a sound understanding of her role and responsibilities including her regulatory responsibilities.

There was documentary evidence that the person in charge had exercised her responsibilities and had met with the senior management team on 14 October 2016 to discuss issues of concern to her; minutes were available to the inspector. Issues raised included the working arrangements of the person in charge and how they were not conducive to the administration and operational management of the centre; other issues included failings identified by this HIQA inspection such as staffing and the management of behaviours of concern. The person in charge described the meeting as positive and responsive. The minutes of this meeting included definitive actions, responsible persons, timeframes and a review date.

The provider submitted an explicit, internally agreed action plan to HIQA outlining the actions taken with immediate effect and or to be completed by the 8 November 2016 in relation to governance. The plan clearly outlined roles, responsibilities and reporting relationships. Actions included the appointment of two additional nominated providers; the presence and availability of the residential coordinators from 08:00hrs to 20:00hrs to correspond to the hours when both staff and residents were present in the centre; an agreed schedule of both announced and unannounced reviews to be completed by year end; the use of HIQA templates for the completion of all reviews and defined responsibilities for the submission of required notifications to HIQA.

Prior to the conclusion of the inspection, the provider confirmed that the working
arrangements of the person in charge had been reviewed and would not include a requirement to work sleepover duties as a member of the frontline team.

As the provider submitted a comprehensive action plan for the governance of the centre, this Outcome is judged compliant on that basis.

**Judgment:**
Compliant

**Outcome 17: Workforce**

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

**Theme:**
Responsive Workforce

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

**Findings:**
There was evidence from staff spoken with, records seen and the inspectors own observations that there was an overreliance on relief and agency staff. There was evidence that this arrangement was not consistent with the supports required by residents.

Staff described the staffing levels to the inspector. Two staff were on duty from 07:00hrs until residents left for the day service at approximately 08:30hrs. One staff remained in the house to provide support for one resident; once the remaining residents returned in the evening there was two staff on duty until 21:00hrs. From 21:00hrs to 07:00hrs there was one staff on duty and this was a sleepover arrangement from 11:00hrs. Staff spoken with raised no concern as to the adequacy of the night-time sleepover arrangement.

However, all staff spoken with confirmed that there was an overreliance on relief and agency staff. Staff associated this lack of continuity in supports with heightened anxiety for and amongst residents and an escalation in behaviours of concern. Records seen including safeguarding records, audits, risk assessments and behaviour support plans all referenced the negative impact on residents when they experienced a lack of continuity of staff; these recorded impacts included confusion, emotional upset and an intensification of behaviours. There was an explicit internal requirement for “completely familiar and regular staff”.

However, this was not in place at the time of this inspection. Approximately 10 different
staff were listed as providing supports on a relief or agency basis. Over the course of this inspection the inspector met with one relief and two agency staff. Staff described patterns of irregular input into the service such as a few shifts or having last worked in the centre a few weeks prior to this inspection; two staff on duty together had never previously met each other.

The inspector saw that a service level agreement was in place between the provider and staffing agencies.

Staff files were available for the purpose of inspection. The sample reviewed was well presented and contained all of the documents required by Schedule 2.

Staff training records were maintained and made available for inspection. The records seen included regular, relief and agency staff. Training records indicated that mandatory training requirements in safeguarding, fire safety, manual handling and behaviours that challenged were met and or refresher training was scheduled. Additional training provided to staff included first aid, infection prevention and control, communicating using manual signing, supporting residents who experienced seizure activity and an introduction to HIQA for frontline staff.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001813</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>24 and 26 October 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 05: Social Care Needs

Theme: Effective Services

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

Deficits in review and update particularly in relation to healthcare related supports were identified. There was a risk for deficits to develop in practice in the absence of support plans that provided clear guidance.

1. Action Required:

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
Under Regulation 05 (6) (c) and (d) the Person in Charge will ensure that all support plans relating to the medical needs of the residents will be updated to reflect the current medical needs of the residents. The Person in Charge is currently reviewing all residents plans currently in place and will ensure that any new support plans required will be developed with the relevant input from multi-disciplinary team members.
Administration procedures within the centre have been amended to enhance clarity and appropriate transfer of information in relation to residents support needs. This review will also address the deficits in relation to goals and the development and progression of same.

Proposed Timescale:
Review and updating of support plans relating to medical needs have commenced and will be completed by 13th January 2017.

Review of all residents plans will be completed by February 28th 2017

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

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was not evident how personal goals were identified and agreed. Some goals lacked a development focus and were linked to daily routines; the records for progressing goals did not always convey whether goals had been met or not and if not why not.

2. **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:**
Under Regulation 05 (7) the Person in Charge will ensure that a comprehensive review of all residents plans including review & updating of all goals will be carried out. This will involve a consultation process with residents, their families and relevant multi-disciplinary team members. A keyworking system operating within the centre has been reviewed within the centre and communication logs have been put in place to identify how decisions on goals are reached. As well as the yearly requirement to review all residents personal plans, all plans will be informally reviewed on an ongoing basis by keyworkers and at least quarterly by the person in charge.
### 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:**

1. The risk posed in the event of heat/fire by a stockpile of combustible material had not been identified.

2. There was an open risk with a risk rating of 25 (high) dated July 2016 with an additional control for an additional care staff.

**3. Action Required:**

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

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

Under Regulation 26 (1) (a) the Registered Provider will ensure that the risk management policy includes hazard identification and assessment of risks throughout the residence.

A risk assessment has been completed to reflect the risk of a resident stockpiling combustible material in relation to an event of fire or heat.

A support plan has been put in place to support the resident to manage his requirement for these items and to reduce this hazard.

The open risk with a high risk rating (25) has been addressed by the introduction of an extra staff as per the control. The current risk rating is ‘monitor’ and the risk will be reviewed at least quarterly or more frequently as required.

**Proposed Timescale:** Completed by 22 November 2016 and ongoing review of risk.

**Proposed Timescale:** 22/11/2016

**Theme:** Effective Services

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

1. There were residual redundant manual key locks on two final exit doors.

2. Fire doors were wedged open.

3. One fire door required review to confirm its integrity.

**4. Action Required:**

Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.
Please state the actions you have taken or are planning to take:
The Registered Provider to comply with Regulation 28 (2) (b)(ii) will ensure that adequate arrangements for reviewing fire precautions are in place.
The redundant manual key locks found by the inspector on two exit doors have been removed.
New door closure systems have been installed and wedges removed. One resident remains non-compliant regarding having his door closed and a support plan to support him around issue is being implemented.
Any necessary maintenance / upgrading of fire doors have been completed.

Proposed Timescale: 16/12/2016
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to demonstrate that there were adequate arrangements in place for evacuating all residents in the event of a fire.

5. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
Under Regulation 28 (3) (d) the Registered Provider will ensure that adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations are in place.
All residents personal evacuation emergency plans have been reviewed and any extra controls required in the event of an evacuation are in place.

Proposed Timescale: 16/12/2016

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
1. There were no formal procedures for the identification, sanction and ongoing review of restrictive practices to ensure that they were justified, a last resort and not open to misuse or abuse.

2. There was no protocol to guide staff decision making in the administration of medicines prescribed on a p.r.n basis (a medicine administered only as required).

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

Please state the actions you have taken or are planning to take:
Under Regulation 07 (4) the Registered Provider will ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

The Registered Provider has requested an audit of any practice which may be restrictive in the centre and the result of this audit will be highlighted to the Restrictive Practice Committee for guidance on their appropriateness. Where a restrictive practice is deemed necessary its use and implementation will recorded and the restriction reviewed on a regular basis.

The residents psychiatrist has reviewed the residents kardex regarding the use of PRN medication and has given clarity in writing regarding its appropriate use. A support plan for the resident around the use of PRN medication for all residents will be implemented.

Proposed Timescale:
Drug kardex amended 10th November 2016.
PRN support plans/ protocols 13th January 2017

Proposed Timescale: 31/01/2017
Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a very recently devised behaviour support plan for implementation; however, core elements of the plan were not implemented.

7. 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:
Under Regulation 07 (3) the Person in Charge will ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his / her representative, and with the support of a psychologist the core elements of the residents positive behavioural support plans will be implemented and reviewed and staff will be supported to fully understand the purpose and importance of positive behavioural support plans. Regular staff meetings are held with the psychologist.
These plans will be review as part of the personal planning process.
Additional staff have been allocated to the centre, rosters are being reviewed to reflect skill mix and continuity of support.
Any deficiencies in the staffing requirements have been highlighted and recruitment processes are in place.

Proposed Timescale: Additional staff in place 5th December 2016.
Psychology input: Ongoing.
Recruitment: Permanent staff in place 28th February 2017

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<th>Proposed Timescale: 28/02/2017</th>
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<td>Theme: Safe Services</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Safeguarding measures had failed to protect residents from harm and abuse in a timely manner.

8. **Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
Under Regulation 08 (2) the Registered Provider will ensure that all residents are protected by providing refresher training for staff on safeguarding, including safeguarding on the agenda for all staff meetings and discussing safeguarding with residents at their residents meetings. Service users will also receive information and training on self advocacy.

| Proposed Timescale: 31/01/2017 |

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<th><strong>Outcome 09: Notification of Incidents</strong></th>
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<td><strong>Theme:</strong> Safe Services</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All adverse events that had allegedly occurred in the centre had not been notified to the Chief Inspector.

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

Please state the actions you have taken or are planning to take:
Under Regulation 31 (1) (f) the Person in Charge will ensure that any allegation, suspected or confirmed, abuse of any resident which may occur in the residence will be notified to the designated Chief Inspector. Procedures have been reviewed and
amended with regard to reporting of adverse events to ensure that the Person in Charge and the person within the organisation designated to submit reports are informed of all notifiable incidents within the required timeframe.

**Proposed Timescale:** 01/11/2016

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**Outcome 17: Workforce**  
**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was an overreliance on relief and agency staff. There was evidence that this arrangement was not consistent with the supports required by residents.

**10. Action Required:**  
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**  
Under Regulation 15 (3) the Registered Provider will ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.  
Any deficiencies in the staffing requirements have been highlighted and recruitment processes are in place.  
Existing vacancies currently filled by agency/relief staff will be regularised and filled on a permanent basis.  
Regular and familiar relief/agency staff will be employed as much as possible until the permanent filling of these vacancies.

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