Health Information and Quality Authority
Regulation Directorate

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Prosper Fingal Residential Respite Service 1</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001860</td>
</tr>
<tr>
<td>Centre county:</td>
<td>Co. Dublin</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>Prosper Fingal Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Pat Reen</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Vahey</td>
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<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>7</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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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 1 day(s).

The inspection took place over the following dates and times
From: 15 February 2017 11:00
To: 15 February 2017 22:10

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

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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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Summary of findings from this inspection

Background to the inspection.
This was the third inspection of the designated centre the purpose of which was to monitor ongoing regulatory compliances. The centre was previously inspected in November 2014. Ten outcomes were inspected against on this inspection.

How the inspector gathered evidence.
The inspection took place over one day and was facilitated by the person in charge. The inspector spoke to four residents and also two staff members. The inspector also observed staff providing support to resident for social activities and during a mealtime. Records such as personal plans, fire safety records, contracts of care, risk assessments, incident records, complaints log and staff training records were also reviewed. A record of policies was reviewed post inspection along with audits which had been conducted in the preceding year.

Description of the service.
The centre provided respite services to approximately 80 residents and the centre could accommodate up to seven residents at any one time. The centre was located in a suburban town close to a range of local amenities. Public transport as well as a
centre bus were available. The centre had produced a statement of purpose which outlined the aim of the centre was to provide residential respite which was short term, in a safe and comfortable home, in response to individual's and carers' needs. The inspector found the centre met the aim as set out in the statement of purpose.

Overall judgement of findings.
Overall the inspector found residents received a good standard of care and support during their stay in respite services and residents expressed they were happy with the services provided. Good practice was identified in the management of complaints and in healthcare needs. Sufficient resources were made available to meet the needs of the residents such as adequate staffing, a large well maintained premises and a centre bus and residents were supported to access meaningful activities of their preference in the community. Some improvement was required in medication management practices in the centre.

Moderate non compliances were identified in five outcomes inspected against as follows;
- Outcome 5 - relating to out of date assessments of need and personal plans,
- Outcome 7 - relating to fire drills, risk management and the follow up to adverse incidents,
- Outcome 8 - relating to staff knowledge of safeguarding, the use of restrictive practice and behaviour support planning,
- Outcome 14 - relating to inadequate support for the house lead, auditing systems and lines of accountability were not consistently clear,
- Outcome 18 - relating to policies and procedures.

The reasons for these finding are explained in the body of the report, and the regulations that are not being met in the action plan at the end of the report.
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation
Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Individualised Supports and Care

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

Findings:
The inspector found there had been improvements in the management of complaints and the policy on managing resident's finances has been updated. The action relating to use of audio monitors was inspected under Outcome 8.

The inspector reviewed records of complaints and compliments in the centre. Complaints had been recorded and actions to resolve these concerns were documented and agreed with the complainant and the person in charge. The inspector found complaints had been promptly and appropriately responded to. Records of compliments regarding the centre were also maintained.

The inspector reviewed the policy on the management of residents' finances which had been reviewed since the last inspection. The inspector found the policy guided practice and records were maintained of monies received and spent on behalf of residents while using the respite service.

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 inspector found written agreements were in place for residents. These agreements outlined the services to be provided and the fees to be charged to residents. Written agreements had been developed into an accessible format and were signed by residents, their representatives and the person in charge.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that residents' needs were met in accordance with their assessed needs and plans however, most assessments and plans were out of date and were not subject to review.

Each resident's social, personal and health care needs had been assessed and were documented in personal plans such as person centred plans, health care plans, personal goals and personal care plans. However, the inspector found these assessments and plans had not been reviewed annually and in some cases for a number of years. The person in charge informed the inspector it was the responsibility of day service staff to assess residents' needs and develop plans however, the inspector found these were not completed in accordance with the timeframe specified in the Regulations.

Written correspondence was maintained between day service staff and the centre, in
relation to residents' care and support needs and the inspector found this contributed to
the plan for residents' stay in respite. For example, interventions to work on residents'
personal goals, such as cooking a meal. There was evidence that the assessment and
recommendations made by allied healthcare professionals contributed to the
development of personal plans.

Residents were involved in the development of personal plans and plans were available
in an accessible format. Arrangements were in place to meet the needs of the residents
as set out in the plans. Meaningful activities were planned with residents at residents'
meetings and records confirmed these activities were facilitated, for example, going to a
restaurant, going to the cinema, bowling and shopping. The inspector spoke to three
residents who told the inspector they enjoyed staying in the centre and participating in a
range of community activities.

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

**Findings:**
The inspector found there were systems in place to promote the health and safety of
residents, visitors and staff however, improvement was required in fire drills, incident
management and in some risk management plans.

Suitable fire equipment was provided throughout the centre including a fire alarm with
break glass units, fire extinguishers and emergency lighting. All fire equipment had been
serviced within the last year. Fire doors were fitted throughout the centre and fire doors
had self-closure devices fitted. There were adequate means of escape including an
external stairs from the first floor to the rear garden and all exits were unobstructed on
the day of inspection. Daily and weekly checks of fire precautions such as the fire
alarms, exits, emergency lighting and door releases were completed.

The inspector reviewed records of fire drills for the preceding year. Fire evacuation drills
had been completed on a monthly basis however, the inspector found some drills had
not been completed in a timely manner. In some instances the rationale for this was
documented and a plan to address this was identified and implemented however, this
was not consistently the case. For example, a drill which took ten minutes to complete
did not have any rationale as to the reasons and there was no follow up action to
address this issue. The inspector found the detail contained on fire drill records was
basic, for example, did not records the names of residents participating in order to ensure that residents availing of the service had an opportunity to participate in a drill, and to inform personal emergency evacuation plans if appropriate.

Staff had received training in fire safety. The inspector spoke to a staff member who was knowledgeable on the evacuation procedure in the centre.

There were policies and procedures relating to health and safety including incident management and food safety. There was also an up-to-date safety statement. The person in charge completed an annual health and safety audit and actions were developed where required. A monthly hazard identifying check was also completed by the team lead and actions were also developed. Evidence was available on the day of inspection to confirm actions had been implemented for example; maintenance issues had been attended to. An annual check of all electrical equipment in the centre had also been completed. Policies and procedures relating to incidents where a resident goes missing had recently been developed and were due to be signed off in the near future.

Satisfactory infection control measures were in place with suitable hand washing facilities and personal protective equipment provided.

There was a risk management policy and risk management plans were developed for the risks as specified in Regulation 26. Centre specific risk assessment had been developed, for example, medication management, lone working, fire and carbon monoxide and these assessments outlined the measures to control identified risks. However, the inspector found individual risk assessments were not developed for known risks such as challenging behaviour.

The inspector reviewed records of incidents for a one year period. Incidents were recorded by staff and reported to the person in charge. Where required actions were identified to prevent reoccurrence however, the inspector found these were not always implemented. For example, a known risk was not identified on a personal plan following an adverse incident and the measures to control this risk were not specified. In addition, a review of an independent skills programme was recommended following an adverse incident in November 2016 however, this was yet to be completed on the day of inspection.

**Judgment:**
Non Compliant - Moderate

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

Findings:
The inspector found systems were in place to safeguard residents however, improvement was required in staff knowledge on safeguarding. Practices identified as restrictive had not been applied as such, and improvement was required to ensure up-to-date information on residents' behaviour support needs was available.

While there was a national policy available on safeguarding, this policy was not centre specific. Although all staff had up-to-date training in safeguarding, improvement was required in staff knowledge on the types of abuse and on the response to an allegation, suspicion or disclosure of abuse. There was a designated person appointed to deal with safeguarding concerns and the inspector found safeguarding concerns had been promptly responded to and were proceeding as per the national policy. Staff members were observed to interact respectfully with residents and support residents in a dignified and caring manner. The inspector spoke to a number of residents who stated they felt safe in the centre.

Overall a restraint free environment was promoted. However, the inspector found the use of audio monitors which had been identified as a restrictive practice by the provider nominee, had not been applied in accordance with best practice. One resident had a support plan in place however; there was no support plan available for another resident for the use of these audio monitors. Evidence was not available on the alternative measures tried, or the plan to reduce these practices and there was no corresponding risk management plans developed for these practices. The use of bedrails for a resident was for safety purposes and as such not for restrictive purposes.

Behaviour support plans had been developed for residents outlining behaviours of concern and strategies to prevent or respond to these identified behaviours. Multidisciplinary team members had been involved in the development of these plans and while some plans had been reviewed, the inspector identified one plan had not been reviewed for over three years.

Intimate care plan were in place for residents and were detailed in order to guide practice and to ensure residents' privacy and dignity was maintained.

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):**

**Findings:**
The inspector found residents' healthcare needs were met.

The inspector reviewed a number of healthcare plans and records. The provider had put satisfactory arrangements in place to meet the healthcare needs of the residents, considering their scope of responsibility and the type of services provided in the centre. While a number of healthcare plans were out-of-date, the plans in place guided practice and were in accordance with the recommendations made by allied healthcare professionals. For example, mobility plans developed by a physiotherapist, a sensory plan developed by an occupational therapist and nutritional plans developed by a speech and language therapist. Residents accessed multidisciplinary team members mainly through Prosper Fingal day services and where required these allied healthcare professionals attended the centre to assess residents' needs specific to the centre.

The inspector found plans were implemented, for example, the inspector observed health care interventions such as nutritional plans being implemented in accordance with speech and language recommendations. Records were maintained of interventions and observations such as fluid charts and epilepsy seizures records.

Residents choose their preference of meals at a weekly residents' meeting and food was prepared in the centre. The inspector reviewed records of meals offered to residents and found the food was varied and nutritious. Residents told the inspector they had a good choice of food when staying in the centre. There was ample supply of fresh food and snacks available and the inspector observed residents were facilitated to choose snacks as they so wished. A mealtime was observed to be a positive and social time for residents.

**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:
The inspector found most medication management procedures were in line with national guidelines. Improvements were required in practices for checking controlled medication and in plans to guide the administration of emergency epilepsy medication.

There were some controlled medications in use in the centre and medication stocks were checked on receipt, on discharge of the resident from the centre and on administration of these medications. However, the inspector found these controlled medications had not been checked at change of shift, in line with An Bord Altrainais guidelines on medication management.

There was an up-to-date medication management policy. Secure storage was available for medication. The medication press was found to be small and inappropriately fitted above a radiator however; the person in charge outlined a plan to improve this arrangement. Medication management plans formed part of personal plans and outlined the individual support a resident required to manage their own medication.

Medication prescription and administration sheets were complete and medication had been administered to residents as prescribed. PRN (as required) medication stated the circumstances under which medication should be administered and were subject to review. However, the inspector found a PRN (as required) medication prescription which clearly stated the circumstances when an emergency epilepsy medication should be administered, was in conflict with some of the details set out in a corresponding epilepsy management plan. However, the inspector identified staff did use the prescription as a reference for the administration this medication, and as such this reduced the potential risk for error.

Medications were administered by registered nurses in the centre. Medications were supplied by residents' individual pharmacists and medication were counted on admission and discharge of residents to and from the centre.

A medication management audit had been completed in November 2016 and included auditing of areas such as storage, administration, policies, medication management plans and training. Actions had been developed to identified issues however, the inspector found the content and outcome of this audit had not been made available to the person in charge until the day of inspection. This is discussed under Outcome 14.

Judgment:
Substantially 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:**
The inspector found overall the management systems had ensured the service provided was safe and effective however, appropriate supports were not in place to support the team lead in their management functions. In addition, improvement was required in the auditing of the services provided.

There was a house lead appointed to the centre who was also identified as a person participating in management. The role of the house lead was discussed with the person in charge who outlined this staff was responsible for the day to day planning and operation of the centre. The house lead also had responsibility for supervision of staff, health and safety and for dealing with maintenance issues. The actions identified in audits also confirmed the house lead had responsibility for a number of areas of service provision. The house lead had limited protected time allocated to them and over a five month period had been allocated a total of 35.5 hours. The person in charge stated the likelihood was the house lead did not have enough protected time.

There was a defined management structure however, the lines of accountability for some aspects of care and support required clarification and improvement. The person in charge outlined day staff were responsible for developing and reviewing residents' assessment of need and personal plans however, a number of these reviewed on the day of inspection were out-of-date. In addition, the follow up to an adverse incident, documented the day service staff were required to follow up. There was no documentary evidence of this follow up action being completed and when the person in charge contacted day service they stated they had not completed this action as the issue had arisen in the respite centre.

Staff reported to the house lead who in turn reported to the person in charge. The person in charge was employed on a full time basis and had responsibility for three designated centres comprising four units. The person in charge was supported in her role by the house lead. The person in charge reported to the operations manager who in turn reported to the chief executive officer.

The provider had visited the centre and carried out an unannounced visit in November 2016 and had also delegated responsibility for further unannounced visits on specific aspects of service provision such as person centred goal planning, medication management and health and safety. The inspector found some of these audits had been carried out a number of months ago however, the audits were not made available to the person in charge until she requested them to inform this inspection. However, the inspector did find while there was no specified timeframe for completion of actions in
some of these audits, most actions had been completed. In addition, the inspector found the audit system for personal plans was not robust and focused only on the personal goals for residents and the issue of out-of-date assessments of need and personal plans had not been identified as an issue.

An annual review of the quality and safety of care and support had been completed in January 2017 for the year 2016. Residents and relatives views had been sought as part of the six monthly unannounced visit, the outcome of which had contributed to the annual review.

Judgment:
Non Compliant - Moderate

<table>
<thead>
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<th>Outcome 17: Workforce</th>
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<tr>
<td>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.</td>
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Theme:
Responsive Workforce

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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</table>

Findings:
The inspector found there were sufficient staff with the right skills and qualifications to meet the needs of the residents.

The centre was staffed by nursing staff and care staff and there were sufficient numbers on duty to meet the needs of the residents at all times. Where increased support needs were identified for some residents, the number of residents availing of the respite service was reduced. A nurse was on duty at all times in the centre.

The inspector reviewed actual and planned rosters and found staff had been effectively deployed to ensure adequate support for residents. Vacancies arising from absences were filled by regular relief staff. The inspector observed staff interacting and providing support in a caring and kind manner.

The inspector reviewed a sample of four staff training records and staff had completed mandatory training. One staff required refresher training in behavioural support however, there was plan to facilitate this training in the coming months. Additional training had been provided to staff specific to residents' needs such as feeding, eating, drinking and swallowing training and training in the administration of emergency epilepsy medication.
Informal supervision was facilitated by the house lead at approximately fortnightly intervals. Records were not available on the day of inspection. The person in charge facilitated an annual performance review with each staff member and the inspector reviewed a sample of these records. The inspector found the performance review was of good quality and facilitated improvements and changes of practice where required.

**Judgment:**
Compliant

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**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

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

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

**Findings:**

The inspector found a number of policies had not been reviewed within the time frame specified by the Regulations. These included the following:

- the provision of personal intimate care
- the provision of behavioural support
- communication with residents
- recruitment and selection of staff
- staff training and development
- the creation, access to, retention of, maintenance of and destruction of records
- health and safety policies including food safety and manual handling.

The policy on access to education, training and development was not available and the policy on monitoring and documentation of nutritional intake was at draft stage. The policy on the prevention, detection and response to abuse was not centre specific.

**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:

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Prosper Fingal Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001860</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>15 February 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>06 April 2017</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:

Personal plans had not been subject to a minimum of an annual review. Some plans had not been reviewed for a number of years.

1. Action Required:
Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
1. All PCPs and Support Plans will be reviewed on an annual basis and updated as required. Day Service managers will be responsible for ensuring these reviews take place. The exception will be Support Plans which are Respite specific (e.g. intimate care, medication) for which the PIC will be responsible.
2. Every Day Service (as the referring source to the Respite Service) will maintain a spreadsheet of PCPs and Support Plans required for Respite users and this spreadsheet will be used by Day Services to ensure plans are reviewed, at a minimum, on an annual basis or more frequently if required.
3. The review process will commence with those presenting for Respite being given priority in the order that they are due to avail of the Respite Service.

Proposed Timescale: 1, 2, and 3 to commence April 2017

Proposed Timescale: 30/04/2017
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Documentary evidence was not available to confirm residents had an annual review of their social, personal and health care needs.

2. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
1. All assessments will be reviewed on an annual basis and updated as required. Day Service managers will be responsible for ensuring these reviews take place. The exception will be supports which are Respite specific (e.g. intimate care, medication) for which the PIC will be responsible.
2. Every Day Service (as the referring source to the Respite Service) will maintain a spreadsheet of assessment of social, personal and health care needs required for Respite users and this spreadsheet will be used by Day Services to ensure assessments are reviewed, at a minimum, on an annual basis or more frequently if required.
3. The review process will commence with those presenting for Respite being given priority in the order that they are due to avail of the Respite Service.

Proposed Timescale: 1, 2, and 3 to commence April 2017

Proposed Timescale: 30/04/2017
**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:
The follow up actions identified in response to some adverse incidents involving residents had not been implemented.

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

Please state the actions you have taken or are planning to take:
1. PIC to ensure Respite staff liaise with Day Services regarding any follow up action/s identified in response to an adverse incident in Respite that is the responsibility of the Day Service to undertake. This liaison must continue to action/s completion.
2. Company Safety Officer to re-issue instructions to Day Service Manager and key workers in relation to following up on actions requested of them, arising from adverse incidents within the Respite Service.

Proposed Timescale:
1. April 2017
2. April 2017

**Proposed Timescale:** 30/04/2017

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some identified risks did not have a corresponding risk management plan developed.

4. **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:
Broaden our current Risk Management process to include risk assessment for all identified risks.

Proposed Timescale: July 2017

**Proposed Timescale:** 31/07/2017
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Records of fire drills indicated on occasions, residents were not evacuated in a timely manner. The documentation in relation to drills was not detailed, did not record the names of residents participating in drills. Where evacuation of the premises was lengthy, the reasons were not consistently recorded and the follow up measures to reduce the risk were not always identified or implemented.

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:**
1. PIC to remind Respite staff to attach ‘Evacuation Roll Call’ to all future ‘HSC 9 Record of Emergency Evacuation Drill’.
2. PIC to re-instruct Respite staff on completing Fire Drill records, including the importance of consistently recording rationale and follow up action/s should drill not be completed in a timely manner. PIC responsible for ensuring the identified follow up actions are carried out to completion.

Proposed Timescale:
1. Completed February 23rd 2017
2. Completed February 23rd 2017

**Proposed Timescale:** 23/02/2017

**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:**
A behaviour support plan had not been reviewed for a number of years.

6. **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:**
PIC will liaise with Day Services to ensure that the Behaviour Support Plan of the resident concerned is reviewed and re-issued to all relevant stakeholders.

Proposed Timescale: May 2017
**Proposed Timescale:** 31/05/2017  
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The use of audio monitors, identified as restrictive practices, had not been applied in accordance with best practice. There was no plan in place for the use of an audio monitor for one resident. There was no plan in place for the alternative measures tried or the plan to reduce this practice. Risk assessments were not in place for the use of these devices.

**7. 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:
1. An interdisciplinary review of the use of audio monitor was carried out incorporating clinician, PIC, key worker, family and individual concerned (to the greatest extent possible). Consensus was agreed on the use of audio monitor and Support Plan put in place.
2. Research is being undertaken into possible suitable alternative measures.

Proposed Timescale:  
1. Completed March 2017  
2. May 2017

**Proposed Timescale:** 31/05/2017  
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvement was required in staff knowledge of safeguarding as outlined in the body of the report.

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

Please state the actions you have taken or are planning to take:
PIC to schedule immediate Safeguarding Awareness ref: HSE Policy ‘Safeguarding Vulnerable Persons at Risk of Abuse’ refresher training to staff member concerned.

Proposed Timescale: Completed March 23rd 2017
**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:**
Controlled medications were not counted at the times when staff changed shift.

**9. Action Required:**
Under Regulation 29 (4) (d) 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 storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

**Please state the actions you have taken or are planning to take:**
PIC to instruct Nurses to check controlled drugs at change of shift in accordance with An Bord Altranais Guidelines.

Proposed Timescale: Completed February 23rd 2017

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**Proposed Timescale: 23/02/2017**

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The guidance set out in a plan for the administration of emergency epilepsy medication was in conflict with some of the instructions documented by the prescriber.

**10. 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:**
Management to instruct all staff that information contained on a Prescription sheet should not be duplicated on any Support Plan.

Proposed Timescale: March 2017

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**Proposed Timescale: 31/03/2017**
## 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:**
Auditing of the services provided required improvement to ensure the details and outcome of audits were promptly communicated to the person in charge and the staff team and to ensure some aspects of care and support were subject to review.

**11. 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:**
1. Quality and Standards to ensure audit reports are issued promptly to PIC.
2. Organisational audit tool for Personal Planning will be applied to Respite Service.

Proposed Timescale:
1. Within one month of each audit being conducted
2. June 2017

**Proposed Timescale:** 30/06/2017

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate support was not provided to the house lead. This staff member had minimal protected time allocated, given the scope of the service provided and the level of responsibility.

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

**Please state the actions you have taken or are planning to take:**
Registered Provider is committed to increasing the allocation of protected time to the House Lead to eight hours per week.

Proposed Timescale: May 2017

**Proposed Timescale:** 31/05/2017
**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improvement was required in lines of accountability for some areas of service provision.

13. **Action Required:**
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
Management to agree and re-clarify responsibilities of Respite Service and Day Service staff in terms of Personal Planning.

Proposed Timescale: May 2017

**Proposed Timescale:** 31/05/2017

**Outcome 18: Records and documentation**

**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some policies had not been developed and one policy was not centre specific.

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

**Please state the actions you have taken or are planning to take:**
1. Policies as per Schedule 5 of Health Act 2007 will be developed in line with Prosper Policy schedule as agreed with the Prosper Board of Management.
2. Include Designated Officer's mobile telephone number on the centre Safeguarding posters in addition to the existing Emergency Contact List in the staff office.
3. Centre specific guidance will be developed and issued to staff regarding reporting of safeguarding concerns, including during out-of-hours, in compliance with HSE National Policy on Safeguarding.

Note: Prosper have adopted, implemented and trained on the HSE National Policy on Safeguarding as required by the HSE Service Arrangement.

Proposed Timescale: 1. December 2017
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of policies were out of date and had not been reviewed at the interval as specified in the Regulations.

15. **Action Required:**
Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

**Please state the actions you have taken or are planning to take:**
The out-of-date policies as per Schedule 5 of the Health Act 2007 will be reviewed in line with the Regulations.

Proposed Timescale: To commence April 2017