<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Hollybank</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001921</td>
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<tr>
<td>Centre county:</td>
<td>Co. Dublin</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 38 Arrangement</td>
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<tr>
<td>Registered provider:</td>
<td>Peamount Healthcare</td>
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<tr>
<td>Provider Nominee:</td>
<td>Suzanne Corcoran</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Anna Doyle</td>
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<tr>
<td>Support inspector(s):</td>
<td>Michael Keating; Conan O’Hara</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>18</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
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<tr>
<th>From</th>
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<tr>
<td>22 February 2017 08:00</td>
<td>22 February 2017 19:10</td>
</tr>
<tr>
<td>23 February 2017 09:10</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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<thead>
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<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<td>Outcome 02: Communication</td>
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<td>Outcome 03: Family and personal relationships and links with the community</td>
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<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: General Welfare and Development</td>
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<td>Outcome 11: Healthcare Needs</td>
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<td>Outcome 12: Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

Background to the inspection:
This was the second inspection of this designated centre as a standalone centre. Prior to the last inspection the centre had been part of a larger designated centre. The inspection was announced and was carried out over two days. The purpose of the inspection was to follow up on actions from the last inspection completed in June 2016 and to inform a registration decision. Three inspectors were present on the first day of the inspection and two were present on the second day of the inspection.

Since the last inspection the provider had attended a meeting in HIQA's Dublin Office
to discuss the findings of the last inspection and to provide reassurances to HIQA that the actions identified would be implemented.

Description of the Service:
This centre is operated by Peamount Healthcare and is situated on a campus based setting in County Dublin. The unit is primarily divided into two areas and provides care to both female and male residents with intellectual disabilities; who require additional supports in areas such as; mobility issues, behaviours that challenge and dementia care.

In addition, the centre also provides short term respite to residents from other areas of the campus with increased short term medical needs. One bedroom in the centre is used for palliative care for residents who may require this support; both from the centre and from other centre’s on the campus.

However, at the time of this inspection there was no respite been provided in the centre, as a number of residents had been transferred into a section of this centre in order to facilitate major reconfiguration works in another centre on the campus.

This section of the centre was closed at this inspection and supports to residents were provided from the staff and the person in charge of the other centre from which the residents had transferred from. To accommodate this transfer residents residing in this centre were required to move bedrooms. Care is nursing led in the centre and health care assistants support the nursing staff in their role. Four waking night staff were available in the centre.

How we gathered evidence:
Over the course of this inspection, inspectors met all of the residents living in the centre with the exception of two residents who were not present on either days of the inspection. Inspectors spoke to a number of residents informally and one resident requested to meet with inspectors. They expressed that they were happy living in the centre and described it as their home.

Some of the residents were unable to express their views on the quality of services in the centre but inspectors observed mealtimes, reviewed personal plans and observed interactions between staff and residents.

One resident’s questionnaire and a number of family questionnaires were received. The views expressed in these along with the views of family members met at the inspection are included in the body of the report.

The person in charge was present throughout the inspection. In addition, staff were met formally and documents were reviewed including risk assessments, staff rotas and financial records. Since the last inspection a new person representing the provider had been appointed to Peamount Healthcare. They were met, along with another person participating in the management of the centre on the first day of the inspection. They attended the feedback meeting along with the person in charge and a clinic nurse manager for the centre.
Overall judgment of our findings:
The inspectors found that improvements had been made since the last inspection and that while a lot of the actions from the last inspection had been implemented, significant improvements were still required under workforce, safe and suitable premises and residents rights in the centre. All of these outcomes were found to be in major non compliance with the regulations. Moderate non compliances were found under social care, healthcare, health and safety, safe guarding and documentation. Three outcomes were found to be substantially complaint. All of the other outcomes were found compliant.

Examples of good practices found at the inspection included; care being provided in a respectful manner and time was afforded to residents during care delivery. Regular meetings were being held in the centre and the person in charge had protected time in order to have oversight in the centre. The action plan at the end of this report outlines the improvements needed.
**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:**

Overall, inspectors found the actions identified in the previous inspection were addressed. However, improvements were required in relation to consultation with residents, privacy and dignity practices and resident’s finances.

Staff members were observed to treat residents with dignity and respect. However, inspectors found that some practices in place did not ensure that each resident’s privacy was respected.

For example, the entrance to the centre was unlocked, a sign on the front door requested visitors to seek a member of staff when in the foyer of the centre. However, staff were not always present here and visitors could potentially walk into any area of the centre including bedroom areas. This was discussed with the person in charge and was addressed before leaving the centre.

Other practices which required review; included walking aids were marked with hospital personal information stickers, falls bracelets in place to alert staff to residents who were at risk of falls were hospital style bracelets. Staff only signs were also in place in some areas of the centre.

Inspectors found that the residents were consulted with on a day to day informal basis and had a campus wide ‘Speak Up Group’ to discuss issues in the campus. However, there was no formal consultation with residents about how the centre is planned and run on a centre level.
For example, the centre had been recently restructured to accommodate five temporary residents from another designated centre to allow for maintenance works to be carried out. There was no evidence to show that residents were consulted regarding the restructuring of the centre.

The centre had a policy in place for the management of complaints and a user friendly, accessible version was available to the residents in the centre. Inspectors reviewed the complaints since the last inspection and found that they were managed and brought about changes.

However, the satisfaction of the complainant was not recorded on the complaints reviewed. Feedback from relatives stated that they felt complaints were not responded to appropriately.

The centre had an updated finance policy in place. Residents had their own bank account managed for them by Peamount Healthcare administration department. Staff then supported residents to access funds from this account for recreational use and this money was managed at unit level by staff. There was also evidence that finance audits were completed by members of staff from the finance department.

Inspectors reviewed a sample of residents’ financial records and inspectors found that a new recording system had recently been implemented at unit level. However, improvements were required to ensure the safeguarding of residents’ monies.

Inspectors found that unit accounts were not balanced weekly as per the finance policy, and that receipts of monies spent were not clearly recorded in the financial records in order to ensure transparency. One account reviewed showed a resident paid for a healthcare treatment in 2016. This was not in line with the contract of care.

This was highlighted to the person in charge and inspectors were assured that the resident would be reimbursed the monies by the finance department.

Inspectors found that some residents’ finances were being used to pay for additional staff supports (personal assistants) from an external agency provider. These fees were substantial and inspectors were informed that these staff supported residents to achieve social care activities.

Inspectors were unable to determine whether this service was in addition to the provider’s obligation to meet residents’ needs, as a recent staff review commissioned by the provider found that staffing levels were not adequate in the centre in order to meet residents social care needs. Inspectors also found this a failing at this inspection.

Judgment:
Non Compliant - Major

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions
are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
Overall, inspectors found that residents’ communication needs were met in the centre.

The centre had a policy in place on communication with residents.

Inspectors spoke with staff, observed their interactions with residents, and found that
staff were aware of the different communication needs of residents.

Each resident had a communication passport in place which provided a profile of the
resident, outlined their individual communication needs, how the resident
communicates, their preferences and things important to them. The passports had all
recently been reviewed.

The centre had recently introduced four communication stations in the centre. The
stations contained a communication folder and a sketch pad. The communication folders
included images to support residents communicate different needs including feelings,
time, pain, money, numbers, letters, clothes and activities.

The person in charge informed inspectors that the information contained in these folders
would be incorporated into residents’ communications plans in the future.

Residents had access to TV, newspapers, radio and the internet.

Judgment:
Compliant

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with
the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were supported to develop and maintain personal relationships with family and friends. Links with the wider community were also considered.

The centre had arrangements in place for each resident to receive visitors in private. The staff supported family members to visit on a regular basis and there were no restrictions on visitors to the centre. In addition, residents were supported to visit home for holidays. Residents had pictures of family members in the designated centre.

Families questionnaires submitted and families met indicated that they were broadly satisfied with the services provided in the centre. Records viewed indicated that families were encouraged to get involved in the lives of residents. Families were invited to attend meetings and be involved in the care planning and provision of care to residents.

Inspectors reviewed a sample of residents’ activities. Inspectors found that while there were examples of residents attending aquariums and concerts, overall residents had limited engagement in the community.

**Judgment:** Compliant

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**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 inspectors found that the actions from the last inspection were implemented as there was an admission policy in place and residents now had written service agreements in place.

There were policies and procedures in place for admissions to the centre, including the transfer, discharge and temporary absence of residents. However, while the statement of purpose of the centre outlined the criteria for respite admissions to the centre, some of this criteria was not included in the admission policy.

There were written contracts in place for residents outlining the services to be provided and the fees to be charged. The contracts had been sent to residents’ representatives where appropriate and some of them were yet to be returned to the person in charge.
There had been no new admissions to the centre since the last inspection. However, part of the centre was being used to accommodate residents from another designated centre, due to major renovation works that were being completed in that centre. Inspectors were informed that the person in charge did not have any oversight over the care and services being provided to the residents in this area.

**Judgment:**
Compliant

**Outcome 05: Social Care Needs**

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

**Theme:**
Effective Services

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

**Findings:**
The inspectors found that some of the actions from the last inspection had been implemented. However, improvements were still required so as to ensure that all residents social care needs were being met in the centre. Improvements were also required in the annual review for residents and personal plans.

Each resident had a personal plan in place that included an assessment of need for each resident. However, from a sample viewed the social and personal care assessment of need required improvements as it did not outline residents’ current needs and focussed on goals that they may wish to achieve in the future.

An annual review had been completed that included consultation with residents and their representatives where appropriate. From this goals were agreed for the following year. There were some meaningful goals agreed for residents, which included going on holidays, attending a concert, learning new skills. However, some of them were not meaningful. For example, one resident’s future goal was to ensure that they had a warm room.

In addition, to this there were no records to demonstrate how decisions had been made at the annual review and whether the plan was being effectively reviewed so as to
improve outcomes for residents. For example, when inspectors asked about the progression of goals for one resident. They were informed that an "X" mark beside the goal indicated that an agreement was not reached at the annual review and therefore this goal was not progressing for the resident. There were no other goals set as an alternative for this resident.

From a review of social activities for residents, inspectors found that some residents had very little meaningful activities during the day. For example, inspectors were shown a weekly activity calendar for the centre. However, some residents were not recorded on this calendar and there were no records in their personal plans to demonstrate what activities were available to them on a daily basis. Inspectors did observe some activities being carried out with residents in the centre over the course of the inspection including relaxation therapies and artwork.

In addition, some external therapists attended the centre during the week to provide therapies to some residents. This included dog therapy and aromatherapy.

Aspects of personal plans were made into an accessible format for residents.

One resident spoke to inspectors about some of their goals for the year and found that the goals identified were meaningful to them. They also spoke about their healthcare needs and how they were supported by staff to ensure that their needs were met.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and suitable premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

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

Findings:
The inspectors found that some of the actions from the last inspection had not been implemented, significant improvements were still required so as to ensure that the premises was suitable in order to provide private accommodation for residents and to ensure that the dining room, communal space and storage facilities were appropriate in the centre.
At the last inspection inspectors found that the layout and design of the centre did not meet the needs of the residents. This actions had not been implemented and significant improvements were still required to address the following areas:
- Inadequate storage facilities in the centre
- Multi occupancy rooms in the centre. One of which accommodated four residents.
- One dining area in the centre required significant improvements as it did not afford residents privacy.
- There were no cooking facilities in the centre.
- Some of the communal areas in the centre were small and could only accommodate a limited number of residents who required the use of a wheelchair at any one time.

Inspectors met with the provider and a person participating in the management of the centre to discuss the progression of the premises on the first day of the inspection. Plans had been drawn up and the inspectors were informed that the funding required to address the premises issues were considerable and this was currently been discussed with the HSE for additional funding in order to progress this.

Inspectors found that centre was clean and well maintained. There were systems in place for the disposal of general and clinical waste.

Records made available to inspectors demonstrated that equipment in use in the centre was adequately maintained.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Effective Services

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

**Findings:**
Overall, inspectors found that there were health and safety systems in place. However, improvements were required with fire management systems in the centre.

The centre had a policy in place on the management of risk in the centre which contained the risks specified in Regulation 26. The centre maintained a risk register in line with the policy which outlined a number of risks in the centre and the controls in place to control the risk.

The risks outlined in the risk register included fire, behaviours, absconding, storage of
oxygen and medication. Individual risk assessments were also in place for risks including smoking, choking, falls, malnutrition and behaviour.

Inspectors reviewed a sample of incidents and found that there was a clear system of recording and follow up. There was a system in place to review incidents in the centre. The person in charge held weekly meetings to discuss incidents with staff. In addition, the person in charge reviewed incidents with the risk officer monthly to identify trends and guide future practice.

There were arrangements in place for fire safety management. The fire evacuation map was on display in a prominent location. There was certification and documentation to show that the fire alarms, emergency lighting and fire equipment were serviced on a regular basis.

The centre completed fire drills and inspectors reviewed the record of these drills. The fire drills did not record the numbers of staff attending drills and this information was submitted post inspection. From this information, inspectors found that fire drills did not accurately reflect how an evacuation would occur with the assigned staff numbers on duty.

For example, the records submitted indicated that 16 staff had attended the day time fire drill. This was not an accurate reflection of the actual staff on duty during the day as the number of staff on duty during the day could range from 9 to 11 staff, depending on the time of day.

In addition, a night time drill completed indicated that six staff had attended this evacuation. However, only four staff were on duty at night.

Personal Emergency Evacuation Plans (PEEPs) were in place for each resident but required additional detail to guide practice. All staff with the exception of one staff member and five relief staff had completed fire training. While staff spoken with were able to tell inspectors of what to do in the event of a fire, the inspectors also found that a significant number of staff had not received training in the use of one evacuation aid in the centre.

The centre had an infection control policy in place. There were household staff in place and inspectors found the centre to be clean. There was personal protective equipment, hand wash gels and facilities located throughout the centre.

There was a policy in relation to the unexpected absence of a resident.

The centre had access to the campus vehicles. Inspectors reviewed a sample of vehicles and found that the vehicles used by staff was appropriately taxed, insured and had a national car testing certificate.

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:**
Overall, inspectors found that there were measures in place in the centre to protect residents from being harmed or suffering abuse. However, improvements were required in staff training, behaviour support plans and the management of restrictive practices in the centre.

There was a policy on the prevention, detection and response to abuse. Staff members outlined how they would respond to potentially abusive situations for residents and were clear with regard to their reporting responsibilities. Staff had received training in safe guarding, with the exception of some relief staff who were employed in the centre.

During the inspection staff were observed to treat residents in a warm and respectful manner with inspectors observing that residents appeared contented.

There was a policy on the provision of intimate care. Personal and intimate care needs were outlined in plans to inform staff practices and included the preferences of residents.

There was a policy on the provision of behavioural support. The inspectors reviewed a sample of behaviour support plans. The plans in place were developed with a clinical nurse specialist in behaviour. Overall, the behaviour support plans outlined the behaviour, proactive and reactive strategies to support residents.

However, one behaviour support plan reviewed did not reflect the current practice in the centre and the information contained in this plan did not reflect best practice. This was discussed with the person in charge.

There was a policy in place on the use of restrictive practices including physical, chemical and environmental restraint. Some restrictive practices were in place and the rationale and circumstances for use of these practices were set out in residents' plans.

Corresponding risk assessments were in place and practices were subject to regular review by a multi disciplinary team. There were examples of how some environmental
restrictions had been removed since the last inspection. For example, a lock on a resident’s wardrobe was removed.

However, the inspectors found one other restrictive practice in use in the centre had not been identified, recorded and reviewed as such. For example, inspectors found a resident’s wardrobe was being locked and while the rationale was documented in the risk assessment it was not identified as an environmental restraint.

Inspectors were informed at the feedback meeting that the provider was in the process of introducing a positive approaches committee to review restrictive practices in the service.

Judgment:  
Non Compliant - Moderate

Outcome 09: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:  
Safe Services

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

Findings:
The inspectors found that a record of all incidents occurring in the centre was maintained and where required were notified to HIQA. However, one restrictive practice in the centre had not been notified.

Judgment:  
Substantially Compliant

Outcome 10. General Welfare and Development
Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:  
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.
**Findings:**  
The inspectors found that some opportunities for new experiences and social participation were available for residents. Residents also engaged in some activities during the day and were being supported to achieve goals set.

During the course of this inspection it was found that residents were supported to engage in some learning and social activities of their choosing.

For example, some residents attended day activation programme on a session basis. One resident had an individualised day service and attended activities in line with their own personal preferences. Other residents like to engage in sensory stimulating therapies and programmes, for example relaxation therapies.

From a sample of plans reviewed inspectors found that residents were engaged with walks on campus, music therapy, drives, dog therapy, aromatherapy and art therapy. However, as discussed in Outcome 5 some residents social care needs were not being met in the centre.

**Judgment:**  
Compliant

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

**Findings:**  
The inspectors found that for the most part residents were supported to achieve best possible health. However, one of the actions from the last inspection required improvements.

From a sample of residents personal plans viewed, they were found to contain a healthcare assessment of need along with support plans in place outlining how their needs were met. Residents had timely access to allied health professionals and on the days of the inspection both a general practitioner and a physiotherapist visited the centre.

Residents had end of life plans in place where appropriate. Improvements had been made since the last inspection around residents who had "do not resuscitate orders" in
place. They had been discussed with relevant representatives of the residents and the multi-disciplinary team. However, there were no records to demonstrate how the capacity of the resident had been assessed so as to be included in these decisions in line with best practice or the centres own policy.

In addition, other clinical decisions that were documented for residents in terms of end of life care were not clearly recorded and did not guide practice for staff. For example, when inspectors asked staff about some decisions there were not clear what constituted active management for some residents.

However staff, were clear that in any event, when a resident became unwell they would seek medical attention immediately. There was also an absence of records demonstrating when and with whom some of these decisions had been decided.

For example, records of discussions with residents’ representatives and other relevant allied health professionals. This was discussed with the residents' general practitioner on the second day of the inspection and at the feedback meeting. The person in charge had agreed to submit records to demonstrate this. However, from the records submitted some of the requested information was not available to submit and some of it had conflicting information recorded.

Residents were afforded opportunities to choose meals available to them given their communication needs. Meals were provided from a central kitchen on the campus. Staff were observed to offer assistance to residents during meal times and residents were observed to have access to snacks and drinks outside of meal times which were provided by staff.

The advice of dieticians and other specialists was implemented in accordance with each resident’s personal plan.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management

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

Theme:
Health and Development

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

Findings:
The inspectors found that there were procedures in place to ensure that residents were protected in the centre. However, some improvements were required in the policies and
procedures and medication management plans for residents.

The medication management procedure in place did not fully outline the procedures in the centre regarding the ordering and disposal of medication in the centre. However, inspectors met with staff who were clear on this process.

Medications were dispensed from a local pharmacy. Medications received into the centre were recorded by staff; a copy of which was maintained on residents’ medication folders. This record did not include a balance of the current stock in the centre. However, the person in charge intended to include this on the records going forward.

Medications were stored in a locked trolley and controlled medications were stored in a separate medication cupboard in the centre. There was also a locked medication cupboard in one of the offices in the centre to store surplus medication stocks. A locked fridge was in the centre for the storage of medication where required. Records were in place to demonstrate that fridge temperatures were monitored daily.

A sample of prescription sheets and administration record sheets were viewed and were found to contain the relevant information.

There was a system in place for the handling and disposal of unused and out of date medications in the centre. Records were maintained demonstrating that medications returned to the pharmacy were recorded and signed by the staff and the pharmacy from which the medication was been returned to.

An audit on medication management practices in the centre had been completed last year in the centre. The inspectors found that a considerable number of events had occurred in the centre as highlighted in this audit, that had not been recorded on the services own medication error forms.

However, inspectors found that the findings from the audit had been discussed with staff. A further audit had been completed and while this was not available on the day of the inspection it was subsequently submitted to HIQA. The inspectors found that the audit found that practices had improved in the centre since the last audit had been completed.

On review of one resident’s personal plan inspectors found that information contained in this referred to the use of covert medication practices, in response to a resident refusing medications.

Inspectors were informed by the person in charge that this practice was not implemented in the centre and that if the resident refused medication it was recorded in a section of their prescription sheet. This would then be discussed with the resident’s general practitioner. Inspectors asked for records confirming this, however this was not received by the end of the inspection. The person in charge agreed at the feedback meeting to submit these records to HIQA. However, the information submitted did not confirm this.

In addition, inspectors found that the service procedures were not fully implemented.
For example, it stated that if a resident refused medication the possible causes should be documented clearly in their personal plan. This was not in place.

There no residents self medicating in the centre.

**Judgment:**
Substantially Compliant

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**Outcome 13: Statement of Purpose**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a written statement of purpose in place that set out the aims and objectives of the centre and stated the facilities and services to be provided for residents. Some minor improvements were required, however they had been addressed prior to this report been finalised.

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

**Findings:**
The inspectors found that there were effective management systems in place in the centre. However, some minor improvements were required in supervision for the person in charge.

The person in charge was fulltime in their role. They were interviewed at the last inspection and were found to be suitably qualified and knowledgeable of their requirements under the regulations. They had protected time of 24 hours a week to ensure effective governance of the centre. They were supported in their role by a clinic nurse manager 1.

The person in charge reported to an assistant director of nursing and a person participating in the management of the centre. Weekly meetings occurred with all persons in charge and the person participating in the management of the centre. In addition, clinic nurse manager meetings were held every month with the assistant director of nursing to discuss practice issues across the campus. However, inspectors were informed that although they spoke regularly on the phone and met informally, no formal meetings were taking place with the person in charge and the senior managers they were reporting to.

Regular staff meetings were being held in the centre.

An unannounced quality and safety review had been completed in December 2016 and actions developed from this were still in progress. Some of the findings included insufficient staffing levels in the centre in order to meet residents social care needs.

An annual review had been completed for the centre. However, it did not include the views of residents or their representatives on the quality of care being provided in the centre.

| Judgment: | Substantially Compliant |

**Outcome 15: Absence of the person in charge**

_The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence._

| Theme: | Leadership, Governance and Management |

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

No actions were required from the previous inspection.

**Findings:**

The inspectors were satisfied that the provider was aware of their obligation to notify HIQA in the event of the person in charge been absent from the centre for more than 28
days and to ensure that appropriate arrangements were in place for the management of the centre during this absence.

Judgment:
Compliant

### Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

**Theme:**
Use of Resources

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

**Findings:**
The inspectors found that the resources for the centre in terms of staffing levels had been reviewed. The provider was also in talks with the HSE regarding renovation works that were required in the centre. Both of these issues are discussed an actioned in Outcome 6 and 17 of this report.

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:**
Findings:
The inspectors found that there were insufficient staffing levels in the centre in order to meet all of the residents social care needs. Improvements were still required in staff training and personnel records in the centre.
Since the last inspection a staffing review was completed in the centre by an external agency that had been commissioned by the provider. This review found that there were staffing deficits in the centre to meet residents assessed needs. This was currently under review with the provider and the HSE. There was a team of registered nurses working in the centre and a team of health care assistants.

One additional staff member had been added to the staff compliment of the centre since the last inspection and two nurse vacancies had been filled. Inspectors found that the staff compliment had been increased during the day. There were now eight staff on duty up to 5.30pm in the centre. However, the staff spoken with, along with the findings from the unannounced quality and safety review for the centre and a review of residents personal plans found that not all residents' social care needs were being met in the centre.

In addition, there were periods during the day/night where staff were redeployed from the centre to assist with other areas of Peamount. The inspectors found that this had not been appropriately assessed in order to ensure that resident's needs could be met in the centre when staffing was reduced. The person in charge had raised these concerns to senior managers and while the inspectors were informed by the provider that this was under review, there were no records to demonstrate that the person in charge was involved in this process.

There was a planned and actual rota in place and improvements were required so as to ensure that staffs' grades were recorded on them.

Staff training records were reviewed after the inspection. There were some gaps in the records and not all staff employed in the centre were included on the training records. These included:
- There were no records available for one full time member of staff and five relief staff who were employed in the centre.
- Of the records viewed one staff had not completed training in fire safety, basic life support, challenging behaviour and infection control.
- 21 staff had not received training in the use of one fire evacuation aid in the centre.
- 20 staff had not completed training in dementia training despite it been an assessed need for some residents.

Falls awareness training was in the process of being completed for all staff and some staff had completed training in risk assessment training.

A review of personnel files had taken place at an earlier date to this inspection by HIQA. This review found that the relevant information was contained on files. Improvements were required so as to ensure that gaps in employment were recorded for all staff. All nursing staff had up to date registration with their relevant professional body.

Supervision was in place for staff and staff spoken to felt supported in their role. However, supervision was not in place for night staff.

Inspectors were shown records to demonstrate that garda vetting was in place for
personal assistants and students that were employed in the centre.

There were no volunteers employed in the centre.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Use of Information

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

**Findings:**
The inspectors found that systems were in place to maintain complete and accurate records in the centre. However improvements were required in some areas.

Inspectors found that the centre had operational policies in place as set out in Schedule 5 of the regulations. However, inspectors found some of the policies did not reflect practice in the centre. For example, the visitors policy, the medication management policy and the admissions policy.

A resident’s guide was available in an easy read and illustrative format that provided detail in relation to the service, a summary of the statement of purpose and function, the contracts to be agreed and the complaints process.

The inspectors found that records relating to residents were maintained and stored securely in the centre. However, improvements were required so as to ensure that records were completed in full and that supports relating to residents care were included in the residents plan in order to guide practice. For example, on a number of occasions during the inspection it was difficult to access information as it was contained in the resident’s medical file and not on their personal plan.

A directory of residents was available which also met the requirements of the regulations.
A copy of insurance cover was available in the centre.

**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:**

Anna Doyle  
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 Peamount Healthcare</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001921</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>22 and 23 February 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19 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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The rationale of using residents’ funds to pay for personal assistants was not clear; and the practice was not applied equally for all residents.

1. Action Required:
Under Regulation 09 (1) you are required to: Ensure that the designated centre is
operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.

Please state the actions you have taken or are planning to take:
1. Social Worker to liaise with residents around the use of personal assistants
2. Multidisciplinary meetings to be held to ratify personal assistants where required
3. A Personal Assistant Policy in now in place to guide practice.

**Proposed Timescale:** 01/05/2017

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some practices in place did not ensure that each resident's privacy and dignity is respected and required review as outlined in the report

2. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

Please state the actions you have taken or are planning to take:
1. Individual equipment will have an identifier personal to the individual.
2. Engage with multidisciplinary team around a more friendly identification for residents that are a falls risk i.e. falling star, falling leaf.

**Proposed Timescale:** 01/05/2017

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no formal consultation with residents about how the centre is planned and run on a centre level

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

Please state the actions you have taken or are planning to take:
A Resident and Family Meeting to be held on a regular basis to involve all in the running and development of the centre and around any future changes in the centre.
Proposed Timescale: 01/05/2017
Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the management and recording of residents’ monies as outlined in the report.

4. Action Required:
Under Regulation 12 (1) you are required to: Ensure that, insofar as is reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.

Please state the actions you have taken or are planning to take:
1. The resident that paid for a healthcare treatment in 2016 was refunded
2. Three monthly statements will be cross referenced against resident’s personal account by the Person in Charge.
3. A weekly money check will take place as per policy

Proposed Timescale: 01/05/2017
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaint records reviewed did not include whether the complainant was satisfied with the outcome of the complaint.

5. Action Required:
Under Regulation 34 (2) (d) you are required to: Ensure that complainants are informed promptly of the outcome of their complaints and details of the appeals process.

Please state the actions you have taken or are planning to take:
The outcome of all complaints will be recorded through the Health Care Charter system and feedback will be requested from the compliant.

Proposed Timescale: 16/04/2017

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:
The social and personal care assessment of need required improvements as it did not outline residents’ current needs.
6. **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. The social and personal assessment of needs will outline residents current needs
2. Formal minutes will detail all discussions with family or representatives at annual reviews or any other meetings

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

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no records to demonstrate how decisions had been made at the annual review and whether the plan was being effectively reviewed so as to improve outcomes for residents.

Some residents were not involved in meaningful activities during the day.

7. **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:**
1. All discussions with resident and family / representatives will be minuted to include any decisions that have been made in relation to a resident’s care and support.
2. The effectiveness of the plan will be reviewed 4 monthly to ensure improved outcomes for the resident.
3. A review of how meaningful activities are planned and delivered in a person centred way will take place to ensure all residents are involved in meaningful activities on an ongoing basis

**Proposed Timescale:** 01/05/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some social and personal goals agreed for residents were not meaningful.
8. **Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
A review of each residents meaningful activities will take place with the multidisciplinary team to ensure they are person centred and meet the needs of the individual.

**Proposed Timescale:** 30/07/2017

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**Outcome 06: Safe and suitable premises**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Significant improvements were still required to the premises to address the following areas:
- Inadequate storage facilities in the centre
- Multi occupancy rooms in the centre. One of which accommodated four residents.
- One dining area in the centre required significant improvements as it did not afford residents privacy.
- There were no cooking facilities in the centre.
- Some of the communal areas in the centre were small and could only accommodate a limited number of residents who required the use of a wheel chair at any one time.

**9. Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

**Please state the actions you have taken or are planning to take:**
The corporate refurbishment plan for this centre is on hold pending further discussions with HSE. There is no approval from HSE to progress these works.

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

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**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:**
One permanent staff member and five relief staff had not completed fire safety training in the centre.
A significant number of staff had not completed training in the use of one evacuation aid used in the centre.

10. **Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**
Training in the use of the fire evacuation aid is to take place for all staff. Ongoing review of Mandatory training tracker to ensure compliance.

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<th>Proposed Timescale: 30/06/2017</th>
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<td>Theme: Effective Services</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal Emergency Evacuation Plans (PEEPs) were in place for each resident required additional detail to guide practice.

The fire drill records did not provide assurances that all residents could be evacuated from the centre when the least amount of staff were on duty in the centre.

11. **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. Personal Emergency Evacuation Plans will be reviewed for all residents to ensure there is the required detail to guide practice
2. Night time / early morning fire drill took place on the 17th February at 0650 with the rostered night staff on duty and 2 staff members from other locations to support the evacuation. Residents were safely evacuated.

Proposed Timescale: Complete

| Proposed Timescale: 19/04/2017 |

| Outcome 08: Safeguarding and Safety |

| Theme: Safe Services |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One behaviour support plan had not been updated to reflect the current practice in the
The details included in the above mentioned behaviour support plan was not in line with best practice.

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

**Please state the actions you have taken or are planning to take:**
The positive behaviour support plan will be reviewed in line with best practice.

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<tr>
<td>Theme:</td>
<td>Safe Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
One environmental restriction in the centre had not been identified as such and was not subject to a regular review so as to ensure that the least restrictive practice was been used.

**13. 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:**
This environmental restrictive practice has ceased

Proposed Timescale: Complete.

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<th>Proposed Timescale:</th>
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<tr>
<td>Theme:</td>
<td>Safe Services</td>
</tr>
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</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some relief staff employed in the centre had not completed safeguarding training.

**14. 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:**
All staff working in the centre will have safeguarding training

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

### Outcome 09: Notification of Incidents

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
One restrictive practice in the centre had not been notified to HIQA.

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

**Please state the actions you have taken or are planning to take:**
All restrictive practices will be notified to the chief inspector.

Proposed Timescale: Complete

**Proposed Timescale:** 19/04/2017

### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no records to demonstrate how the capacity of the resident had been assessed so as to be included/excluded in decisions around end of life interventions in line with best practice or the centre’s own policy.

16. **Action Required:**
Under Regulation 06 (3) you are required to: Support residents at times of illness and at the end of their lives in a manner which meets their physical, emotional, social and spiritual needs and respects their dignity, autonomy, rights and wishes.

**Please state the actions you have taken or are planning to take:**
Where there are capacity issues around informing and including residents in end of life care these will be addressed by the medical support, multidisciplinary team in consultation with the resident’s circle of support and documented in the individuals care plan and end of life plan.
Proposed Timescale: 30/06/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not clear about some end of life interventions outlined in residents personal plans and the interventions were not specific enough to guide practice.

17. Action Required:
Under Regulation 06 (2) (b) you are required to: Facilitate the medical treatment that is recommended for each resident and agreed by him/her.

Please state the actions you have taken or are planning to take:
All residents will have end of life care plans in their personal plans which will outline all interventions to guide practice.

Proposed Timescale: Complete

Proposed Timescale: 19/04/2017

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:
The policy and procedure around a resident's refusal of medication was not implemented into practice.

The medication management procedure in place did not fully outline the procedures in the centre regarding the ordering and disposal of medication in the centre.

18. 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:
1. The policy and procedure around the refusal of medication will be implemented
2. The medication management procedure will be reviewed around the ordering and disposal of medication, and inventory has been put in place to record stock on unit.
3. Staff training will continue for medication management

Proposed Timescale: Complete
### 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:
The annual review for the centre did not include the views of residents or their representatives.

19. **Action Required:**
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
1. A family/representative questionnaire has been designed and will be sent to families to encourage input into service. Letters sent out 30th March ’17
2. The newly constituted Resident and family meetings will also support resident/family views.
Both of these structures will feed into future annual reviews of the service

**Proposed Timescale:** 30/05/2017

### Outcome 17: Workforce

**Theme:** Responsive Workforce

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

20. **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:
Formal meetings will take place between the Person in Charge and their line manager

**Proposed Timescale:** 07/04/2017
There were insufficient staffing levels in the centre in order to meet all of the residents’ social care needs.

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

**Please state the actions you have taken or are planning to take:**
A planned reorganisation of day services will support an increase in staffing levels to facilitate increased social activities within the centre.

Activities staff will be allocated to the centre

The staffing levels in the centre will not fall below what is required to meet the assessed needs of the residents

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

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels had not been reviewed so as to ensure that resident’s needs could be met in the centre when staffing was reduced.

22. **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:**
1. The PIC will ensure that when rostering staff the continuity of the care and support of residents will be a priority.
2. The dependency levels of the residents will be reviewed on a monthly basis,

**Proposed Timescale:** 30/05/2017

**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was a planned and actual rota in place and improvements were required so as to ensure that staffs' grades were recorded on them.

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

Please state the actions you have taken or are planning to take:
All rosters are now actual rosters on the shared folder and record staff grades

Proposed Timescale: 19/04/2017
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no supervision in place for night staff employed in the centre.

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

Please state the actions you have taken or are planning to take:
Supervision has commenced for all night staff

Proposed Timescale: 30/05/2017
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were some gaps in the records and not all staff employed in the centre were included on the training records. This included - there were no records available for one full time member of staff and five relief staff who were employed in the centre. Of the records viewed one staff had not completed training in fire safety, basic life support, challenging behaviour and infection control. 21 staff had not received training in the use of one fire evacuation aid in the centre, over 20 staff had not completed training in dementia training despite it been an assessed need for some residents.

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

Please state the actions you have taken or are planning to take:
1. A new dementia training specific to intellectual disability will be rolled out.
2. Where gaps appear in training log, staff identified will receive notification in writing to attend courses.

Proposed Timescale: 30/06/2017
### 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 of the policies under Schedule 5 of the regulations required improvements in order to guide practice. These included the:

- Admission Policy
- Medication Management Policy
- Visitors Policy

#### 26. 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:**
All above polices are being reviewed at present to ensure they guide best practice.

**Proposed Timescale:** 07/04/2017

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**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some records pertaining to residents care was not included in their personal plans.

Some records maintained were not completed in full.

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

**Please state the actions you have taken or are planning to take:**
1. All records pertaining to residents care will now be included in their personal plans
2. All records will be completed

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