### 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>Rathmore House</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0002037</td>
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<tr>
<td>Centre county:</td>
<td>Wicklow</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>Enable Ireland Disability Services Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Fidelma Murphy</td>
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<tr>
<td>Lead inspector:</td>
<td>Karina O'Sullivan</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</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>3</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 21 April 2017 09:00
To: 21 April 2017 20:30

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

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<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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Summary of findings from this inspection

Background to the inspection:
This was the third inspection of this designated centre. This inspection was completed as a result of the provider submitting an application to renew the registration this designated centre in accordance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

How we gathered our evidence:
As part of the inspection, the inspector visited the designated centre, met with three residents and spoke with the person in charge and three staff members. The inspector viewed documentation such as, support plans, recording logs and policies and procedures. Over the course of this inspection residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the centre. This included meal times and activities. The inspector spoke with three residents, one resident stated "I would not come here if I didn't like it, I love it here".

Description of the service:
This designated centre was operated by Enable Ireland Limited, a company registered as a charity. The company is governed by a non executive board of directors to whom the CEO (chief executive officer) reports. This designated centre is based in Co Wicklow and provided respite breaks from home for adults attending a number of day services or adult outreach programmes in Dublin operated by Enable Ireland. The centre provided planned respite breaks for up to five residents at any given time on a weekly basis. The designated centre offered over 62 residents the opportunity to avail of two night stay from 1 to 4 times in a given year. Typically a stay commenced on a Wednesday and ended on a Friday, with one stay per month commencing on a Thursday and ending on a Saturday. Three residents resided in the centre at the time of this inspection. The provider had produced a document called the statement of purpose, as required by regulation, this described the service provided. The inspector found the service provided was in line with the statement of purpose. The centre aimed to provide residential accommodation in the form of a holiday break for adults both male and female over the age of 18 with a primary physical disability as outlined in the statement of purpose.

Overall judgments of our findings:
Ten outcomes were inspected against. Seven outcomes were found to be moderately non-compliant. Two outcomes were found to be substantially compliant and one outcome was found to be compliant. Areas of improvement included, information contained within residents' files, risk and medication management.

The person in charge facilitated the inspection, with the service manager facilitating aspects of the inspection in the afternoon.

All proposals outlined and plans agreed will be verified at the next inspection.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.
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):
No actions were required from the previous inspection.

Findings:
The inspector found improvements were required in relation to the management of complaints and the complaints procedure.

The inspector found the complaints policy required improvement to nominated a person other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

The inspector also viewed complaints within the designated centre and identified the management of complaints was not corresponding with the organisation policy. The inspector also viewed an incident where a resident had made a complaint and this was not documented as a complaint nor was there any evidence of follow up with the resident. The inspector also found some staff members were not familiar with the reporting structure in relation to the complaints policy.

Residents spoken with outlined how they were consulted while staying in the designated centre, the inspector also viewed evidence of this within minutes of meetings viewed.

No other aspect of this outcome was inspected against during this inspection.

Judgment:
Non Compliant - Moderate
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 inspector found the social care needs of each resident was supported and facilitated in the designated centre.

The inspector acknowledged a person-centred approach was applied to the area of social care needs within the designated centre. The inspector viewed a sample of residents' social care needs documents and spoke with three residents and found that residents' had the opportunities to participate in meaningful activities appropriate to their interests and preferences. Each resident had documented social care needs and in some files this was completed by the residents themselves. This document was updated yearly and the inspector found from viewing documents in place the wishes of residents were respected. For example, residents were asked who they would like to spend their time in the centre with. Residents were also asked to identify their likes and dislikes and what activities they would like to partake in during their stay in the centre.

Residents were also given the opportunity to identity if they wished to achieve any social care goals during their stay, and others had chosen not to, this was respected. Since the last inspection a tracker system had commenced, however, this was at implementation stage where residents' goals were tracked. The person in charge identified this would then assist staff members to assess the effectiveness of the goals set. Goals set included areas some residents wished to partake in while in the designated centre, for example, horse ridding and attending nearby amenities such as, heritage centres and gardens.

Collaboration among staff members in the designated centre with staff members in the day services where residents attended was evident in the sample of resident's files viewed. The person in charge sent out documentation to the day service or family home to identify any changes to the resident since the last visit to the centre. Residents were also asked if they had any suggestions to make their next visit more enjoyable.

Residents spoken with identified that their stay within the centre was a "get away and a break" and "an opportunity to relax with friends". On the day of inspection residents
went out for lunch and shopping and on the previous night had gone to a local pub. The inspector viewed these activities within the residents' files as activities they would like to participate in when in the designated centre. It was also clear that residents', wishes were respected during their stay within the designated centre as a short break or holiday.

The inspector acknowledged that this was a respite house and therefore, the volume of information required was significantly reduced compared to fully time residential centres.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The centre was suitable for the number and needs of residents. Improvements were required in relation to the risk management and emergency planning systems.

The centre had an organisational risk management policy in place, which included the specific risks identified in regulation 26. The centre had a risk register, which recorded a number of risks within the house and the controls in place to address these. The inspector found this document required updating to ensure all location risk were identified.

The inspector also viewed individual resident's risk assessments in place in areas, such as, epilepsy and choking. Improvements were required within these documents as the actual risk rating was inaccurate, this was discussed with the person in charge and service manager who confirmed this. Risk assessments for residents using bed rails were in place, however, some of these were undated and others were uncompleted in relation to the rationale for the use of such devises.

The centre had an emergency evacuation plan dated 24 February 2017 in the event of a fire, however, no other emergencies were identified such as, adverse weather conditions, flooding and power failure. Nor was this information contained within the health and safety statement.

The inspector viewed a fire drill dated 05 April 2017, three residents evacuated the designated centre with the assistance of five staff members. Residents had PEEP's
(personal emergency evacuation plans) in place to assist staff to safely evacuate all residents. However, some of these were not reflective of practice within the designated centre in relation to the use of emergency exits for residents categorised with high support needs.

There was a system in place for recording accidents and incidents occurring in the designated centre. The person in charge outlined the process for dealing with these and ensuring learning from any adverse incidents or accidents occurred. The inspector viewed a number of incidents which occurred in the centre and the follow up of these incidents to mitigate future reoccurrence. The inspector found the follow up of one incident was not as described, for example, the incident was to be discussed at a team meeting; however, this was not evident within the minutes viewed.

The inspector viewed six staff members training records and all staff members had received training in the area of people moving and handling.

There was certification and documentation to show the fire alarm, emergency lighting and fire equipment were serviced by an external company this was dated June 2016.

**Judgment:**
Non Compliant - Moderate

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### Outcome 08: Safeguarding and Safety

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe Services

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

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

**Findings:**

The inspector found improvements were required to protect residents from being harmed and to keep people safe due to staff members' knowledge on the reporting structure and the different forms of abuse. Improvements were also required in relation to the implementation of environmental restrictions.

The inspector spoke with members of staff and some staff members were very unclear in relation to what constitutes abuse and what was the procedure should an allegation of abuse arise within the designated centre. However, residents spoken with were very clear on what to do should they observe or experience poor aspects of service delivery.
The inspector was informed no restrictive practice was used within the centre however, on viewing documentation the inspector found an incidence where environmental restrictions had been implemented. This was not completed in accordance with the organisation's restrictive policy. The inspector discussed this on the day of inspection with the person in charge and service manager.

The inspector viewed safeguarding plans and acknowledged the improvements within these documents since the previous inspection.

The inspector viewed training records for six staff members of staff and found one staff member required training in the area of adult protection and safeguarding training.

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

Findings:
Each resident was supported to achieve best possible health. However, improvements were required within the information contained in resident's healthcare plans to effectively guide staff members while residents were in the designated centre.

The inspector viewed an epilepsy plan, however, aspects of this was blank and did not provide any guidance for staff members. Another document identified a resident had "serious epilepsy". The inspector found this did not effectively guide staff members in care provision. Within another file the inspector viewed a resident had a diagnosis of epilepsy, however, the residents' healthcare needs document was blank, there was no information in relation to the resident's diagnosis other than identifying epilepsy. The inspector found this was not providing guidance for staff members to effectively provide care for residents.

The inspector did acknowledged the improvements which had occurred since the previous inspection in relation to resident's diagnosis. This information had been collated for each resident and present in each residents file within the designated centre.

The inspector found other information in relation to resident's mobility was inaccurate as
documents referenced the use of over head hoists, however, these were not available within the centre. The inspector asked to view feeding, eating, drinking and swallowing (F.E.D.S) assessment for one resident who was identified as a high risk of choking. However, the person in charge identified this was not available within the centre.

Residents had access to a G.P.(general practitioner) service and an out of hours system was available while staying in the centre.

Regarding food and nutrition, the inspector found residents participating in mealtimes within the centre in accordance with residents' preferences in relation to food choices. Residents participated in cooking in accordance with their own preferences. Refreshments and snacks were available for residents outside within the designated centre.

Judgment:
Non Compliant - Moderate

### Outcome 12. Medication Management

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

#### Theme:
Health and Development

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

#### Findings:
The inspector found the medication management system within the centre required some improvement in relation to the management and administration of medication.

No guidance was available in relation to the administration of some PRN medicine (a medicine only taken as the need arises). The inspector found staff members were not always guided effectively and consistently in the administration of medication. For example, residents were prescribed two medications for pain without guidance for staff on which to administer.

Administration recording documents were in place for each resident and a number of these were viewed by the inspector. These were found to be up-to-date and showed staff administered and signed for medication. However, the maximum dose to be administered in a 24 hour period was not specified on some administration records.

Some residents were supported to self-medicate. Elements of the related assessments required review, for example, it was not always clear which staff member completed the assessment and calchiew was identified for headaches in one assessment.
The centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. However, some of the practices within the centre were not reflective of the policy, for example, disposal of medication, staff members sent medications back to family members in an envelope, some staff members were unclear of the procedure to follow should residents refuse to take their medication. The inspector also found staff members were not familiar with the revised policy within the centre, despite this document dated 16 January 2017. The inspector also found the document did not provide effective guidance to staff members for example, the following was stated "some over the counter medication may need to be prescribed" this did not provide effective guidance to staff members.

There was a system in place for recording, reporting errors and reviewing medication. The inspector viewed incidents which occurred within the centre and found preventative measure were put in place to mitigate the risk of future reoccurrences.

The inspector found the signature bank within the designated centre was completed.

**Judgment:**
Non Compliant - Moderate

**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:**
The inspector found the statement of purpose did not fully meet the requirement of the regulations as some of the information contained in Schedule 1 was not evident including:

- the staffing numbers were not representing accurate whole time equivalents levels
- the registration information was not reflected within the document
- the room size was not specified nor were floor plans included within the document
- the specific care that the designated centre intends to meet
- details of any specific therapeutic techniques used within the designated centre and
what arrangements are in place for their supervision

- the arrangements made for consultation with and participation of residents in the operation of the designated centre

- the arrangements for respecting the privacy of residents.

Judgment:
Non Compliant - Moderate

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 the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

There was an annual review of the quality and care completed in this designated centre this was dated 2016 with an action plan attached.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six-monthly basis. This reviewed the safety and quality of care and support provided in the centre. The inspector viewed one completed on the 01 and 02 March 2016 and another one dated 23 June 2017, the inspector found some of the actions were not followed up on.

The inspector found the auditing system was limited within the designated centre to ensure the service provided was safe, appropriate to residents' needs, consistent and effectively monitored, for example, trending accidents and incidents, medication errors and resident's social care plans.

The person in charge remained unchanged since the previous inspection. The inspector viewed staff meeting minutes with topics, such as, health and safety, training and maintenance as standard agenda items. The person in charge also attended coordinator meeting, these meetings included managers from residents' day services which were
attended by residents. This meeting facilitated collaboration between various day services and the respite house to assist in the effective delivery of service provision.

The inspector viewed supervision completed by the service manager with the person in charge and the person in charge to staff members.

**Judgment:**
Substantially Compliant

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### 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

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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 was unable to determine if there was a sufficient number of staff members available to meet the needs of residents. The rota was not accurately maintained and the assessed needs of residents were not linked to specified staffing supports.

The inspector found there was no actual or planned rota reflecting the hours exact staff member worked within the designated centre.

The inspector viewed a sample of staff member’s files and found some files did not contain all the information as identified in Schedule 2. This was also identified during the previous inspection.

Three staff members required refresher training in the area of epilepsy and the administration of rescue medication, from the sample of six staff members training records viewed.

The inspector observed residents received assistance in a respectful manner.

These were no volunteers within the centre.

**Judgment:**
Non Compliant - Moderate

**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 inspector found there was no directory of residents established or maintained within the centre.

No other aspect of this outcome was inspected during this inspection.

**Judgment:**
Substantially Compliant

**Closing the Visit**

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

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

**Report Compiled by:**

Karina O'Sullivan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Enable Ireland Disability Services Limited</th>
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<td>Centre ID:</td>
<td>OSV-0002037</td>
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<tr>
<td>Date of Inspection:</td>
<td>21 April 2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>22 June 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 designated centre did not nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
appropriately responded to and a record of all complaints are maintained.

1. **Action Required:**
Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

**Please state the actions you have taken or are planning to take:**
1. Local policy has been amended to include Adult Services Manager name and contact details
2. The Adult Services Manager will ensure that records of all complaints are maintained and that the outcomes are communicated. This has been communicated to all

**Proposed Timescale:** 21/06/2017

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No evidence or record was maintained within the designated centre to identify that complainants were informed promptly of the outcome of their complaints and details of the appeals process.

2. **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:**
1. Staff have been directed to adhere to the Enable Ireland policy and record appropriately and to ensure they complete Appendix 2 of complaints policy in the event of a complaint
2. The person managing the complaint will communicate the outcome to the complainant within the agreed timeframes in the policy. This has been communicated to all managers
3. The complaint record will include details of how the outcome was communicated

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

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector viewed documentation where a resident made a complaint, however, this was not investigated as a complaint.

3. **Action Required:**
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

**Please state the actions you have taken or are planning to take:**
1. The Complaints policy has been gone through with all staff individually
2. All staff have been instructed in how to fill in Appendix 2 of complaints policy following all complaints received
3. Further training and awareness around the complaints policy is scheduled for the next staff meeting 30.06.17

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

**Theme:** Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff members were unclear of the complaints procedure therefore, they maybe unable to provide an effective complaints process for residents.

**4. Action Required:**
Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
1) The Complaints policy has been gone through with all staff individually
2) Further training and awareness around the complaints policy is scheduled for the next staff meeting 30.06.17
3) Service users will be given an opportunity to go through the complaints procedure to ensure that they have a clear understanding of how to make and follow up on a complaint 29.09.17

**Proposed Timescale:** 29/09/2017

**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 systems in place in the centre for the assessment, management and ongoing review of location and individual risks required improvement.

The system for responding to emergencies required improvement to provide guidance for responding to emergencies other than fire.
5. **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:**
1) A slot has been allocated at the next staff meeting to update all on the revised risk management services division policy & procedure and to go through process of risk assessment and risk rating
2) All potential emergencies other than fire are now being identified and the policy is being updated to include these. This will then be communicated to all staff and service users
3) Risk register will be a standing item on the agenda at team meetings

**Proposed Timescale:** 28/07/2017

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate arrangements for evacuating all residents in the designated centre and bringing them to a safe location were not evident as some PEEP's were not reflective of practice.

6. **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:**
All PEEP plans have now been amended to include evacuation through exit door in room 3

**Proposed Timescale:** 16/06/2017

**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector found an incidence where environmental restrictions had been implemented. This was not completed in accordance with the organisations restrictive policy.

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
Please state the actions you have taken or are planning to take:
1. All staff have been briefed again on the policy and procedures
2. All staff have been advised to seek consent from service users and to ensure that consent is sought, received and noted on relevant forms

Proposed Timescale: 21/06/2017
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff members were very unclear in relation to the different forms of abuse and what was the procedure should an allegation of abuse arise within the designated centre.

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

Please state the actions you have taken or are planning to take:
1) All staff are scheduled to attend the HSE Safeguarding Awareness Programme
2) Learning from this HSE training will be reviewed at staff meeting in July
3) Safeguarding will be a standing item on agenda at team meetings (commencing July)

Proposed Timescale: 28/07/2017

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:
Some epilepsy plan did not guide staff members in effective delivery of care.

9. 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:
1. All epilepsy plans will be reviewed and updated accordingly prior to each service users attendance at respite (by Dec 2017)
2. All Emergency medication forms will be reviewed to ensure they are in date and completed according to policy prior to each service user attending respite (by Dec 2017)
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some resident’s healthcare plans did not contain accurate information in relation to the healthcare needs of residents.

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

Please state the actions you have taken or are planning to take:
1) Staff will receive training in FEDS 18.07.17
2) Health care plans will be reviewed prior to each service users attendance at respite (by Dec 2017)
3) The multi-disciplinary team and day services staff will ensure that accurate information in relation to health care needs is shared with staff at Rathmore (Dec 2017)

Proposed Timescale: 22/12/2017

Outcome 12. Medication Management

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Risk assessments and assessment of capacity to assist residents to take responsibility were not completed accurately.

11. Action Required:
Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:
All service users who self-medicate will have an updated assessment in line with Enable Ireland policy when scheduled to attend respite (Dec 2017)

Proposed Timescale: 22/12/2017

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No guidance was available in relation to the administration of some PRN medicine.

The maximum dose to be administered in a 24 hour period was not specified on some administration records.

The practices within the designated centre were not reflective of the policy for example, disposal of medication.

Staff members were not familiar with the revised policy within the designated centre.

The system of managing over the counter medication was unclear.

12. **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. Medication policy has been communicated to all staff and will be reviewed in further detail at staff meeting with particular emphasis on PRN meds and disposal of medicines
2. Staff have been made aware that policy must be adhered to at all times PRN medication forms will be reviewed for individual service users prior to their attendance at respite to ensure there is clear guidance on administration
3. All forms are being reviewed to ensure the maximum dosage is specified and where this is not the case they are being updated
4. Over the counter medication will be documented in the service users medication pack

**Proposed Timescale:** 28/07/2017

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**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the information set out in Schedule 1 was not identified within the document.

13. **Action Required:**
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 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. Statement of Purpose is currently being updated to include
   - Room sizes / Floor plans
   - Registration documentation
• Staff Ratios / WTE’s
• Consultation with residents
• Arrangements for respecting privacy of residents

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

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**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 management systems in place in the centre required improvement to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

14. **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. All actions related to previous internal inspections are being progressed and have timeframes agreed for completion
2. Staff meeting agendas will be structured to include standing items in relation to review and audit to ensure transfer of learning. This will include safeguarding issues, accidents, incidents and medication errors

**Proposed Timescale:** 31/08/2017

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A planned and actual staff rota, showing staff on duty at any time during the day and night within the designated centre was not maintained.

15. **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:
A revised planned and actual staff rota will be put in place to accurately reflect staff on duty.
**Proposed Timescale:** 28/07/2017  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Some of the information and documents as specified in Schedule 2 were not available for all staff members.

**16. Action Required:**  
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.  

**Please state the actions you have taken or are planning to take:**  
An audit will be completed on the staff files to identify any gaps and any missing documents will be made available to the file.

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**Proposed Timescale:** 28/07/2017  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Three staff members required refresher training in the area of epilepsy and the administration of rescue medication.

**17. 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. Three staff members are scheduled to attend emergency epilepsy medication training on 20.06.17  
2. All Staff members had first aid training at time of inspection (see factual inaccuracy form)

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**Proposed Timescale:** 20/06/2017

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**Outcome 18: Records and documentation**  
**Theme:** Use of Information

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no directory of residents established or maintained within the designated
18. **Action Required:**
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
A Directory of Residents is being compiled currently and will be maintained.

**Proposed Timescale:** 22/06/2017