

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Joseph's House for Deaf and Deafblind Adults
Centre ID:	OSV-0002090
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Catholic Institute for Deaf People
Provider Nominee:	John Lamont
Lead inspector:	Helen Thompson
Support inspector(s):	Conan O'Hara
Type of inspection	Unannounced
Number of residents on the date of inspection:	26
Number of vacancies on the date of inspection:	12

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 December 2016 09:30	12 December 2016 20:30
19 December 2016 11:00	19 December 2016 13:00

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

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection

This was an unannounced inspection that was conducted in line with HIQA's remit to monitor ongoing compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. This was HIQA's fifth inspection in this centre and was carried out by two inspectors over two days. The required actions from the centre's previous inspection in November 2014 were also reviewed as part of this monitoring event.

How we gathered our evidence

The inspectors met with a number of the staff which included nursing staff, care staff, household staff, a chef, the person in charge and members of the management team for this centre. Additionally, in assessing the quality of care and support provided to residents, the inspectors spent time observing staff engagement with residents. The inspectors noted that residents appeared happy and contented in their home with staff interactions observed to be person centred and respectful.

As part of the inspection process, inspectors completed a walk through the centre, spoke with staff and reviewed various sources of documentation which included the statement of purpose, residents' files and a number of the centre's policy documents. An interpreter joined the inspectors for the afternoon of the first day and supported the inspectors in communicating with residents and some members of staff. Inspectors interviewed five residents to garner their opinions on the quality of care and support they received. Overall, those interviewed reported that they were happy living there.

One inspector returned for a second day to review a number of documents which included staff files.

Description of the service

The centre was established specifically to meet the needs of people who are deaf or deaf-blind. Some residents also had secondary needs, for example, intellectual disability, mental health needs, clinical needs and behaviours that challenge. The service provider had produced a statement of purpose which outlined the service provided within this centre. The stated aim of the service is to meet the physical, social, emotional, psychological and spiritual needs of those people who choose to become part of the service.

The centre was made up of the main building and two adjoining units all within a cul-de-sac in a residential area. It was close to amenities such as shops, restaurants, banks and bus stops. There was capacity for 38 residents but it was now home to 26 male and female residents over 18 years of age.

Overall judgment of our findings

Eleven outcomes were inspected against. Two outcomes were found to be of major non-compliance and five were found to be of moderate non-compliance. Significant areas for improvement were identified in the core outcomes of governance and management and residents' social care needs, especially the residents' care planning system. Improvement was also required under safeguarding, with regard to the assessment and provision of residents' behavioural supports, in the centre's risk management system, staff training, notifications to HIQA and the provision of all policies as required.

Residents' healthcare and medication needs were found compliant with the regulations. As the actions from the previous inspection were found to be implemented, the centre's premises was observed to be in compliance with the regulations. However, the centre's statement of purpose still required some amendments to move from substantial to full compliance.

These findings along with others are further detailed in the body of the report and the action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

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

Theme:

Effective Services

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

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

Findings:

In general, the inspectors found that residents' care plans were not comprehensively informing staff of the care and delivery of support requirements of residents. Additionally, improvements were required for some residents regarding the identification, implementation, review and evaluation of their social goals. Some residents' opportunities to engage in meaningful activities needed to be further developed. The inspector observed that residents and their representative were involved in the personal planning process. However, documentation was not made accessible for residents.

Inspectors found that residents' files and care plans were organised between an on-line and a paper file system. The on-line system coordinated residents nursing and clinical assessments with correlating plans of care. These included diabetes, medication management plans and eating and drinking plans. However, not all staff had access to this system to inform and guide the delivery of their practice and support to residents. The paper files observed were not found to be updated and reflective of some of the residents' current supports.

The inspectors did note that there was some communication of changes in residents' needs through a handover system and the usage of a critical information sheet in residents' files to direct staff. However, this sheet was found to be out of date with the current presentation of some residents.

Additionally, significant gaps were observed in some residents' social goal identification,

assessment, planning, review and evaluation. One resident's social goals were last reviewed in September 2015 with no evidence of follow up since then. In general, limited structured and socially integrated activities were planned for residents with a lot of downtime observed during the inspection.

The inspectors were informed that some residents attended activities in the deaf village in Cabra and some others attended external day service provision.

Inspectors observed that accessible versions of plans were not available to residents or their representative.

Inspectors observed that families were involved in the planning and the review process with some multidisciplinary support also noted to be available to residents.

Judgment:

Non Compliant - Major

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):

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

Findings:

Overall, the inspectors found that the centre had addressed the issues identified in the previous inspection. Not all areas of this outcome were reviewed as part of this inspection.

Inspectors reviewed the audit of the design and layout of the centre. On the walk through of the centre, inspectors were shown the two additional toilets installed, the modified shower room, two additional storage areas for cleaning materials and a storage area for hoists.

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):

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that the systems in place to promote the health and safety of residents, visitors and staff required improvement in the areas of risk management and infection control.

The centre had a health and safety statement which outlined the responsibilities of the various post holders within the organisation. There was a policy in relation to the unexpected absence of a resident.

The centre had a draft policy in place for risk management which did not include two of the four risks specified in Regulation 26. The centre maintained a risk register 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 slips, trips and falls, access to professional services, medication and fire. However, some improvement was required regarding the management of individual risks. For example, care plans for smoking were in place for residents who smoked. The care plans stated that smoking risk assessments were to be completed every three months and on the day of inspection the smoking risk assessments were not in place. Also, inspectors observed that a resident's risk assessment was not reviewed to reflect risk related discussions and recommendations from their case conference.

Inspectors reviewed a sample of incidents and found that there was a clear system of recording and follow up.

There were arrangements in place for fire safety management. The fire evacuation map was on display in a prominent location. Daily checks were in place which covered fire exits, equipment and alarm panel. There was certification and documentation to show that the fire alarms, emergency lighting and fire equipment were serviced on a regular basis. The centre had sensory equipment in place to alert residents of a fire such as vibrating pillows, pagers and light. The centre completed regular fire drills and inspectors reviewed the record of these drills. Personal Emergency Evacuation Plans (PEEPs) were in place for each resident which reflected the resident's mobility and cognitive understanding. Staff spoken with were able to tell inspectors of what to do in the event of a fire.

The centre had procedures in place for the prevention and control of infection. However, inspectors found that some improvement was required. Inspectors observed personal protective equipment and hand wash facilities located throughout the centre. In addition, the centre employed household staff. Inspectors found that while some measures were in place to manage healthcare associated infections, residents were not comprehensively protected against healthcare associated infections in line with the

national standards. The centre had systems in place to manage Hepatitis B, however, it did not have a clear system in place to ensure that all residents were vaccinated.

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):

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

Findings:

Overall, the inspectors found that there were measures in place in the centre to protect residents from being harmed or suffering abuse. There was a positive behaviour support approach evident for residents that engaged in behaviour that was challenging, however, significant improvement was required in the provision of specialist behaviour support and staff training. The centre promoted a restrictive free environment for residents but improvement was required to fully meet the regulatory requirements.

The inspectors found that there were systems in operation for responding to incidents, allegations and suspicions of abuse and that these were being appropriately utilised to ensure that residents were protected. There was evidence of communication with and referral to other agencies, for example, the HSE.

Staff members outlined how they would respond to potentially abusive situations for residents and were clear with regard to their reporting responsibilities.

Residents' personal and intimate care needs were outlined in plans to inform staff practices and support to residents.

The inspectors found that residents' positive behaviour support needs were not being comprehensively supported with no behaviour specialist intervention available to assess and support residents' needs. This deficit was identified in the centre's risk management system and was noted to the inspectors by the person in charge during the introductory meeting. Residents' behaviour support plans were not observed to be current, reflective of their current status or reviewed post incidents of behavioural expression. In summary, inspectors observed a lack of clear guidance for staff to positively support

residents on a day to day basis.

There was evidence that some residents' needs had been reviewed by psychiatry and psychology.

The centre did promote a restrictive free environment. However, inspectors noted that no individualised protocol documents were present to guide staff practice in the administration of psychotropic PRN (as required medication) to residents. Also, the inspectors noted gaps with regard to multidisciplinary team members involvement in reviews of mechanical restraints and the consent process for their usage. Inspectors did observe that an audit of restraints implemented with residents had been completed by the nurse manager with some of these issues identified.

Staff had not been provided with all the necessary training and education to facilitate them in fully supporting the needs of some residents that engaged in behaviours of concern. This includes specialist behavioural training and education regarding mental health conditions. This issue had been identified during the previous inspection.

During the inspection staff were observed to treat residents in a warm and respectful manner with the inspectors observing that residents appeared contented. The centre had the policies in place as required by regulation.

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 centre maintained a record of all incidents occurring in the designated centre. However, inspectors found that the centre did not notify the Chief Inspector of all notifiable incidents as required by the regulations, specifically incidents of alleged abuse of residents.

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):

No actions were required from the previous inspection.

Findings:

Overall, the inspectors found that residents in this centre were supported to achieve and enjoy the best possible health.

A review of residents' plans showed that their healthcare needs were being responded to in a timely manner, assessed and supported. The inspectors found that residents were supported by some multidisciplinary personnel which included psychiatry and physiotherapy, though the nurse manager noted that accessing some supports for residents can be difficult. Residents also attended allied health care services.

The inspectors observed that most residents were supported by their general practitioner (GP) who visited the centre, or by a community based GP. There was evidence of case conferences to review, evaluate and plan for residents' evolving needs.

Residents' nutritional needs were assessed and documented in their care plans and the inspectors noted that a dietician was available to residents as required. Meals were prepared in the centre's main kitchen by a chef. Specialised diets were facilitated and residents' weights were monitored. Inspectors were informed that the dietician had recently liaised with the chef and new menu plans were drawn up post a review of residents' nutritional needs. The inspector found that residents' choice and preferences were acknowledged and supported. The mealtime was observed to be a positive experience. Residents interviewed were very happy with the food provided.

Judgment:

Compliant

Outcome 12. Medication Management

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

Theme:

Health and Development

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

No actions were required from the previous inspection.

Findings:

Overall, the inspectors found that residents were protected by the centre's policies and procedures for medication management. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Policies were reviewed and updated with changes. Medicines in the centre were stored as required and residents' medication records were kept in a safe and accessible place.

A pharmacist was available to the residents and there was evidence of ongoing review of the residents' medical status and their medication by their general practitioner (GP) and psychiatrist. An electronic medication management system was being trialled and assessed in the centre by the pharmacist and nursing team. The clinical nurse manager (CNM) 2 and a staff nurse noted that they had recently completed additional INMO medication training.

Medication in the centre was only administered by registered nurses. However, a small number of care staff were also trained in the safe administration of medication. This training was completed to facilitate residents' medication needs when on outings, overnight trips and holidays with care staff. The centre operated a particular procedure to ensure good practice for this situation.

There was a system in place for reviewing and monitoring safe medication management practices. Medication errors were monitored and reviewed by the pharmacist and CNM2 and subsequently at the centre's governance meeting. Inspectors noted evidence of errors being followed up and discussed at the nurses' team meeting.

The inspector observed that some residents in this centre were responsible for the administration of their own medication. There was evidence of assessment and discussion of this life skill with the resident and the GP.

Judgment:

Compliant

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):

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

Findings:

Inspectors reviewed the statement of purpose dated January 2015 and found that it did

not contain some of the information required by Schedule 1 of the Regulations. This was also identified in the previous inspection. The person in charge informed inspectors that the centre was in the process of updating the statement of purpose.

Judgment:

Substantially Compliant

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

Overall, the inspectors found that improvement was required in the centre's management systems to ensure the delivery of safe and quality services. Improvements were also required to ensure that the service provided is effectively monitored and that residents and their representatives are consulted.

The inspectors found that there was weak oversight and accountability of the centre. This was evident from review of the centre's safety and risk management system, gaps with the residents' personal planning system, the poor provision of behavioural support for residents, the lack of follow through on finalisation of the centre's policies and procedures to inform staff practices and observed deficits in workforce training requirements.

Additionally, from a self-assessment perspective, no annual review of the quality and safety of care provided to residents in the centre was available for the inspectors to view. Also, the inspectors observed that the required six monthly unannounced visits by the registered provider had not been completed. There was no evidence of structured consultation with residents or their representatives regarding service provision. No clear or current auditing process was observed.

Inspectors found that there was a management structure in place. The person in charge (PIC) has been in the role for a number of years and was supported by the provider nominee (PN). The PIC met regularly with the centre's nurse and care manager through the forum of a clinical governance meeting where clinical and care related issues were communicated and discussed. However, there was no systematic centre governance

meeting structure observed between the PIC and PN.
The PIC was clearly familiar with, and identifiable to the residents.

The inspector observed that there were arrangements in place for staff to exercise their responsibilities and express any concerns regarding the quality and safety of the services provided.

Judgment:
Non Compliant - Major

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):

No actions were required from the previous inspection.

Findings:

Overall, inspectors found that the staffing levels were appropriate to meet the needs of residents in the centre. However, some improvements were required with regard to the provision of staff training.

The centre maintained planned and actual rosters and inspectors reviewed a three week sample. The roster showed that during the day, two nurses (excluding the nurse manager) were on the day shift with seven care staff. In the afternoon the number of care staff reduced to five. At night, there was a waking night nurse, two waking care staff and one sleep over care staff available. An activities coordinator and deafblind support staff were also rostered. The person in charge informed inspectors that the centre was currently in the process of completing a staffing review. This was being undertaken by an external consultant.

An inspector reviewed four staff files on the second day of inspection. These files were found to contain all the information required under Schedule 2 of the regulations.

Inspectors reviewed a sample of staff training and found that not all staff had up-to-date mandatory training in safeguarding vulnerable persons, manual handling and fire safety. Some staff had received training in dementia, bereavement, diabetes, dysphagia and sign language classes. It was noted that some nursing staff had recently attended a urology master class and phlebotomy training.

Inspectors observed evidence of regular staff meetings. Staff were supervised through monthly team meetings, handovers and managers working on the floor. A formal staff supervision system had been rolled out in early 2016 but the care manager informed inspectors that it had been put on hold due to the planned development of a new organisation wide uniform supervision system. Managers informed inspectors at the feedback meeting that they were scheduled to attend supervision training on 14 December 2016.

Staff members' interactions with residents were observed to be person centred and positive.

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):

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

Findings:

In the previous inspection, inspectors identified that staff did not have access to centre specific policies to guide their practice. While the centre manager noted that a new committee is in place to progress policies, inspectors found several policies to be in a draft format.

Inspectors also observed some issues with residents' records. This included a lack of dates, full names and authors on some documentation.

Not all areas of this outcome were reviewed as part of this inspection.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Helen Thompson
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Catholic Institute for Deaf People
Centre ID:	OSV-0002090
Date of Inspection:	12 and 19 December 2016
Date of response:	17 February 2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

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

Residents' care plans did not reflect all their assessed needs or clearly inform staff practices and care delivery.

1. Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

resident no later than 28 days after admission to the designated centre which reflects the resident's assessed needs.

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

- All Residents have a Care Plans within 28 days. Audit on Care Plans commenced on 19th December 2016.
- All relevant information from EPICARE re Resident Clinical Care Plans that guides delivery of care has been pulled from EPICARE and are updated as required, in a new section of the paper care plan, Section 8 - My Healthcare Needs. All care staff have been informed at Care Team Meeting on 12th January 2017 of accessibility of Healthcare Plans in Section 8 and this has been documented in the meeting minutes.
- Small group discussions with all care staff commenced on 16th January 2017. The purpose of these meetings are go through the updated Care Plan with each staff and make sure all care staff know how to access and know the relevance of Section 8 – My Healthcare Needs to guide their practice of care delivery. Also discussed were; New Goals, Reporting and Documentation. These meetings are to be completed by 28th February 2017.

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

Residents' plans were not available in an accessible format.

2. Action Required:

Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

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

- Residents have been informed that all Care Plan information is available to all residents on 11th January 2017 at the Resident's Committee Meeting.
- Communication assistance will be given to all residents to help access any Clinical Information that is stored on EPICARE that is not available in paper format. Full explanation to Residents at Resident's Committee Meeting 1st February 2017.

Proposed Timescale: Completed

Proposed Timescale: 17/02/2017

Theme: Effective Services

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

Some residents' social care goals and plans had not been reviewed in a timely manner.

3. Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

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

- .New Goal Sheet format out of draft and implemented. Staff coaching on new goal sheets ongoing and due to be completed by 28th February 2017.
- Care staff developing new goals with residents following completion of coaching, this will be commenced by 28th February 2017 and to be reviewed 31st March 2017 to ensure every resident who wishes to achieve a goal or goals has a SMART goal.
- Skills Teaching Using Systematic Instruction Training has been sourced and will commence on confirmation of training dates for care staff. This will help with creating meaningful goals for residents.
- A monitoring system will be in place to ensure progress on goals is being achieved through bi-weekly Social Care Meetings. A tracking template will be created to ensure each resident is engaged in meaningful activity.
- On the day of inspection inspectors noted a lot of downtime this was due to a creative workshop that staff were attending to learn creative skills to engage residents in craft and sensory activities.

Proposed Timescale: 31/03/2017

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 management of risk required improvement as outlined in the body of the report.

4. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

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

- Risk Policy out of draft and accessible to all staff, residents and visitors from 1st February 2017
- The four risks specified have been included in the updated policy.
- Risk Register to be reviewed and updated as necessary on a bi-monthly basis or as needed, the next review scheduled for Thursday 2nd February 2017.
- Emergency Response Plan available
- A new call system has been installed in the Smoking Room

Proposed Timescale: Completed

Proposed Timescale: 17/02/2017

Theme: Effective Services

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

Residents were not appropriately protected against healthcare associated infections in line with the national standards as outlined in the body of the report.

5. Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

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

- GP informed of need for Hep B vaccination for residents
- Residents to be informed of the Vaccination Programme and informed of the risks involved. Consent to be sought and the residents Right to Refuse to be respected. This will be done in consultation with St. Joseph's House advocate from 24th February 2017.

Proposed Timescale: 31/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Staff did not have the necessary training to support and respond to residents' behavioural support needs.

6. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Appropriate training sourced and staff will be facilitated to attend.

Proposed Timescale: 31/07/2017

Theme: Safe Services

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

Multidisciplinary input into the consent process for the use of a restraint was not

evident for some residents.

7. Action Required:

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

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

Multidisciplinary Team Meeting re Restraints to be held on 9th March 2017.

Proposed Timescale: 09/03/2017

Theme: Safe Services

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

No individualised protocol documents were available to inform staff practice in the administration of psychotropic PRN to residents.

8. 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:

Individualised psychotropic PRN care plan documents being developed for all residents and to be completed by 3rd March 2017.

Proposed Timescale: 03/03/2017

Theme: Safe Services

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

No comprehensive behaviour assessment was completed to understand and alleviate some resident's behaviour that challenged.

9. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

- Behaviour assessments will be carried out by an external specialist for residents who present with behaviours that challenge.
- Referral for Psychologist sent to Deaf Hear Ireland for special behaviour assessment

Proposed Timescale: 31/05/2017

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:

Inspectors found that the centre did not notify the Chief Inspector of all notifiable incidents as required by the regulations.

10. Action Required:

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

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

All notifications including alleged incidents have been sent as evident from 12th December 2016

Proposed Timescale: Complete

Proposed Timescale: 17/02/2017

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:

The Statement of Purpose did not contain some of the information required by Schedule 1 of the Regulations.

11. 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:

Statement of Purpose updated and signed off (copy attached)

Proposed Timescale: Completed

Proposed Timescale: 17/02/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The centre's management systems did not comprehensively ensure the delivery of a safe and quality service for residents.

12. 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:

- PIC and Registered Provider nominee to have formal monthly meetings, schedule in place for 2017
- Registered Provider receives weekly Clinical Governance Meeting Minutes
- Weekly Monitoring report sent to Registered Provider each Friday

Proposed Timescale: Completed

Proposed Timescale: 17/02/2017

Theme: Leadership, Governance and Management

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

An annual review had not been completed to assess the quality and safety of care and support in the centre.

13. Action Required:

Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

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

Annual Review Report to be complete by 30th April 2017

Proposed Timescale: 30/04/2017

Theme: Leadership, Governance and Management

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

The required six monthly unannounced visits by the registered provider were not

completed.

14. Action Required:

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

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

Six monthly walk around inspection planned by Register Provider and CEO and to be completed by the end of February 2017

Proposed Timescale: 28/02/2017

Outcome 17: Workforce

Theme: Responsive Workforce

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

Not all mandatory training was up to date for some staff of the centre.

15. 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:

- Safeguarding Training programme planned for 2017 for all staff with the HSE, all outstanding safeguarding training completed 1st February 2017.
- Challenging Behaviour training to be planned post assessment with residents to ensure person centred training is delivered to staff by 31st July 2017
- Fire Training & Manual & People Handling to be completed by 15th March 2017

Proposed Timescale: 31/07/2017

Outcome 18: Records and documentation

Theme: Use of Information

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

Several policies as required by Schedule 5 of the Regulations were in a draft format.

16. Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement

all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

Policies to be signed off – numbers of outstanding polices completed by 10th February

Proposed Timescale: 10/02/2017

Theme: Use of Information

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

Some of the residents' records were not adequately maintained.

17. Action Required:

Under Regulation 21 (3) you are required to: Retain records set out in Schedule 3 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

- New signature bank in place
- Staff updated re-signing documents at the care plan meetings with Care Manager.

Proposed Timescale: 28/02/2017