Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Greenville House
Centre ID:	OSV-0002113
Centre county:	Cork
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Cork Association For Autism
Provider Nominee:	Cormac Coyle
Lead inspector:	Julie Hennessy
Support inspector(s):	Kieran Murphy
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
07 June 2017 09:30	07 June 2017 16:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection:
This was the sixth inspection of this centre by the Health Information and Quality Authority (HIQA). The first inspection took place on 21 and 22 October 2015, the second on the 4 and 9 May 2016, the third on 16 November 2016, the fourth on 4 January 2017 and the fifth on 4 April 2017.

On 24 February 2017 the provider was issued with notices to refuse and cancel registration of this centre on foot of on-going concerns regarding the quality and safety of the service identified over successive inspections. The provider submitted a representation to HIQA on 24 March 2017 that proposed how to address the grounds cited in the notices of proposal. The purpose of this inspection was to inspect against that representation submitted by the provider. While the previous inspection was also carried out against the provider's representation, a decision was made following that inspection to afford the provider more time to implement their action plan.

Since February 2017, the Board of Cork Association of Autism had received substantial support from their main funder, the Health Service Executive (HSE), to address the failings cited as grounds in the notices of proposal. This support took the form of secondments of senior management and clinical and quality personnel to provide the necessary leadership and competency required to drive improvement

across the service.

How we gathered our evidence:
As part of the inspection, inspectors met with five residents, a senior manager on secondment from the HSE who fulfilled the dual role of chief executive officer and representative of the provider, the social care leader, a number of staff on-duty, the interim director of services and a quality manager (both of whom were also on secondment). Inspectors also reviewed relevant documentation, including recently completed assessments for residents, behaviour support plans, the risk register and a sample of care plans.

Description of the service:
The centre provides residential care specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque environment and there is also a day service and other facilities, such as horticulture and outdoor gym equipment in the grounds. The centre comprises a main house and six cottages and can accommodate 13 residents. The main house can accommodate five residents and the cottages can accommodate either one or two residents.

Overall judgement:
The previous inspection identified initial improvements to the service being provided and this inspection evidenced further and significant progress. A complete review of all aspects of quality and safety of care and support to residents had taken place. These changes were clearly demonstrated as being driven by a person-centred approach. Priority assessments of need and behaviour support plans had been developed and new care plans were being developed. The risk register had been revised. Supervision, training and up-skilling of staff was being provided. While further progress was required in a number of areas, changes to date had resulted in demonstrable improvements for residents in terms of reduced incidents and behaviours of concern. Also, concerted efforts had been made to improve communication with families, advocates and the HSE safeguarding team.

While work in relation to the following had commenced, two failings remained at the level of major non-compliance pending their implementation:
- the systems in place at the time of inspection did not provide adequate reassurance that medicines would be administered as prescribed and that satisfactory measures were in place to mitigate against the risk of medication errors. While a new system had been developed, the implementation of that system had not commenced at the time of this inspection (outcome 12);
- a plan was required in relation to the governance and management arrangements for this centre in the medium- to long-term. A governance review had been commissioned by the HSE and was due to commenced shortly to inform such a plan (outcome 14).

The inspection findings are detailed in the body of this report and required actions outlined in an action plan at the end of this report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
Overall, progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome.

As cited in the notices of proposal, the provider had failed to satisfactorily address matters of significant concern that related to the quality and safety of care provided to residents raised by concerned persons.

In response, the organisation had revised the complaints policy and a full review of how complaints were being managed in the service had taken place. The complaints officer was now identified as a member of the senior management team. The representative of the provider had met with families individually, and with the HSE confidential recipient in relation to their experience of how complaints had been managed and to seek to close complaints to the satisfaction of any complainant. At the time of inspection, there were no open complaints.

Families were encouraged to be involved in the lives of residents, with positive relationships between residents and family members being supported. The chief executive officer of the service outlined that a family forum was being introduced where family and staff from the service could meet on a regular basis to discuss issues relating to the service being provided to residents.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

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

Findings:
Overall, satisfactory progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome. A comprehensive assessment of needs was yet to be completed for all residents, although progress was being made in this area.

As cited in the notices of proposal, the provider had failed to ensure that a comprehensive assessment of needs had been completed for all residents. As a result, the provider had also failed to ensure that arrangements were in place to meet individual residents' on-going needs and to ensure that there were adequate arrangements in place for review of residents' personal plans and behaviour support plans.

Since the notice of proposal had been issued, the provider had made progress in relation to securing the services of appropriate healthcare and allied healthcare professionals required to complete comprehensive assessments of need. The services of a clinical psychologist had been secured with priority assessments completed for residents who required psychology input. Where residents required more immediate inputs, for example, by dietetics or speech and language therapy, these had also been sourced and completed assessments were informing the care to be provided to individual residents. For the longer term, the provider had taken steps to secure multidisciplinary supports that would ensure that a comprehensive assessment of needs would be completed for all residents. The services of some other required multidisciplinary supports had been successfully sourced with a commencement date provided for these professionals. Other required supports were still being sourced by the provider. This will be further discussed under outcomes 8 and 11.

Personal planning meetings were scheduled or had taken place with involvement of residents and their representatives. The provider outlined that this process would be strengthened once a full multidisciplinary team is in the place.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
Overall, satisfactory progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome.

As cited in the notices of proposal, the provider had failed to demonstrate that the systems in place for the assessment, management and on-going review of risk were adequate, including learning from serious incidents or adverse events involving residents.

At this inspection, progress had been made with respect to development of the risk management policy and risk register. The risk management policy included the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. There had been a new incident management system introduced and an inspector reviewed a sample of incident forms from May 2017. There was a robust system in place to ensure that all incidents were followed up by senior staff on duty and were reported to senior management of the service. There was a proactive quality and safety committee which reviewed all incidents and accidents on a monthly basis, including any medication errors.

The designated centre had a risk register in place. Key risks had been identified. A risk assessment had been completed for each hazard with control measures outlined. Each resident also had a summary individual risk register that identified specific risks relevant to each resident. This risk register allowed for escalation of risks to the corporate risk register. Based on discussion and review of the risk registers, key risks had been identified and were being managed by the provider.

Incidents were being tracked and analysed on a monthly basis. The social care leader outlined how the incident log was managed and reviewed through weekly health and safety meetings. A review of the incident log demonstrated that incidents were being effectively analysed with action plans developed to address any emerging trends or areas of concern.

Judgment:
Compliant

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):

Findings:
Overall, satisfactory progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome. Further improvement was required to the restrictive practice committee to ensure effective oversight of any restrictive practices in use.

As cited in the notices of proposal, the provider had failed to implement positive behaviour supports to ensure that appropriate interventions are put in place to identify and alleviate the cause of any behaviour that is challenging. the provider had also failed to ensure that adequate arrangements were in place to review the effectiveness of behaviour support plans. Gaps in training relevant to safeguarding and behaviour support were also cited.

Residents had access to a psychiatrist. An external service provider also provided behaviour support services to a small number of residents. A psychologist had recently commenced in the service and had completed or commenced assessments for residents on a priority needs basis. A behaviour analyst was working in the service and was providing support to other residents, along with advice and training to staff.

However, while a number of positive behaviour support plans had been developed with input from appropriate professionals in this field, not all had. Inspectors reviewed an example of a positive behaviour support plan that had been developed in relation to self-injurious behaviour by the staff team. Recent incidents demonstrated that the behaviour support plan was not proving effective. This was being addressed as the behaviour analyst had been assigned to provide this support. While intimate care support plans were in place for all residents, inspectors viewed an intimate care support plan that required updating to reflect a resident's current needs.

The provider had also arranged for engagement with the national safeguarding team and two meetings had been held. The representative of the provider and social care

leader outlined how this had better supported managers to understand about safeguarding issues, the reporting of concerns and what is expected from a safeguarding plan. Inspectors reviewed the records of safeguarding concerns and found that a safeguarding plan was in place for any such concern, that had been agreed with the national safeguarding team and which was being implemented.

A log of restrictive practices was maintained and notified to HIQA each quarter. Any chemical restraint was overseen by a consultant psychiatrist. A restrictive practice committee had been recently re-convened for the service. An inspector reviewed the minutes of these meetings, which demonstrated that evidence to support the use of any restrictive practices was sought by the committee before sanctioning any practice. However, an understanding of consent was not reflected in the minutes and the membership of the committee going forward was unclear. The representative of the provider agreed that the committee required further review and development to ensure its effectiveness.

Training in relation to safeguarding of residents was being rolled out. Further sessions were required and had been scheduled by the end of this month (June 2017). This will be addressed under outcome 17. Training in relation to positive behaviour support had also been provided.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
Overall, progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome. Work had been completed in relation to residents' care plans. Further improvement was required to ensure that residents had access to the full range of multidisciplinary supports that they required and that there was follow through on recommended actions by healthcare professionals.

As cited in the notices of proposal, the provider had failed to provide residents with access to services provided by allied health professionals, where required. The provider had also failed to ensure adequate oversight of the implementation of recommendations made by medical or allied health professionals.

Residents had access to a general practitioner (GP) of their choice, to out-of-hours GP services and to consultants.

As previously mentioned under outcome 5, the provider was actively sourcing the services of allied health professionals, as appropriate to residents' needs. The services of a clinical psychologist had been secured, with an occupational therapist and speech and language therapist to commence shortly. The provider also stated that some services were yet to be sourced, including physiotherapy, dietetics and social work. This was relevant to ensure that recommendations for support could be progressed.

In addition, inspectors found a case whereby an urgent referral to a dietician had been recommended by a resident's GP and this needed to be progressed. The representative of the provider confirmed the day following the inspection that he had requested a full audit of all resident's files to ensure that there were no other outstanding urgent referrals.

The social care leader and a clinical nurse manager on secondment had been working with the staff team to develop new care plans for residents. The completion of care plans had been appropriately prioritised based on need. Inspectors reviewed a sample of an active care plan that had been developed for a resident with multiple and complex needs and found that it clearly directed the care and support to be provided. The social care leader stated that the remaining care plans would be implemented by the end of this month (June 2017), in accordance with a previous action and timeline provided to HIQA.

However, as residents were often accompanied by family members during healthcare appointments, information required to inform the care to be provided to residents in this centre was not always available or sufficiently clear. For example, inspectors were told that one resident had been seen by a consultant specialist in relation to an on-going issue. However, there was no record of this visit or care plan available to ensure that the resident was being appropriately supported for this healthcare issue. Inspectors also found that some residents were accompanied by staff to the doctor or specialist appointments. However, staff were making notes of these appointments but were not always updating the care plan accordingly, as required to ensure follow through of any recommendations.

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):

Findings:
Aspects of this outcome were inspected as they related to the grounds cited in the notices of proposal to refuse and cancel the registration of this centre. At the time of inspection, adequate reassurances were not provided in relation to the safe management of medication.

As cited in the grounds of the notices of proposal, the centre was not being operated in compliance with regulations and standards and this was relevant to all aspects of clinical care. Major non-compliances were identified in relation to medication management at previous inspections. At the previous inspection, the social care leader outlined a new system that would be implemented to support safe medication management. A policy had been developed and approved by the Board that outlined the new system. This would be rolled out to staff in the short-term, with training delivered by a community pharmacist. The auditing system going forward would involve monthly internal audits and quarterly audits by a community pharmacist.

However, at this inspection, this new system had yet to be implemented. As a result, a level of risk remained. For example:
- the documentation and recording of medicines that were transcribed did not ensure accuracy as it was not demonstrated that two persons were involved in the transcribing process, as required;
- arrangements in place for the storage of refrigerated medicines were not satisfactory;
- while a medication audit had been schedule for the day of the inspection, an audit that considered all aspects of the medication management cycle was not available for review;
- it was not demonstrated whether instructions for the use of "as required" or PRN medicines and chemical restraint viewed in a behaviour support plan were in line with the instructions of the prescriber;
- a copy of the original prescription was not available for the purposes of checking or auditing that medicines were administered as prescribed;
- information viewed in a resident's file indicated that supplements that had not been prescribed and were not approved by relevant licencing bodies (medical or pharmaceutical) were being administered by staff.

This outcome will remain at the level of major non-compliance pending the full implementation of the new system.

Judgment:
Non Compliant - Major

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):

Findings:
Relevant grounds cited in the notices of proposal to refuse and cancel registration of the centre were included in this inspection. Overall, the Board of Cork Association of Autism had received substantial support from their main funder, the Health Service Executive (HSE) to address the failings cited as grounds in the notices of proposal. This support took the form of secondments of senior management, clinical and quality personnel to provide leadership and guidance and to implement improvements to the service being provided on the ground. However, a plan was not in place that detailed the governance and management arrangements for this centre in the medium- to long-term and the requirement for such a plan is the sole reason that this outcome remains at the level of major non-compliance. A governance review had been commissioned by the HSE and was due to commenced shortly to inform such a plan.

The provider in their representation had stated that a review of governance and management structures would be completed by their main funder (the HSE) with a timeframe of 30 June 2017. At this inspection, the terms of reference had been agreed with the governance review due to start, but behind the original timeline. As a result, a plan for this centre was not in place that detailed the governance and management arrangements in the medium- to long-term.

The provider in their representation had stated that current board of directors of CAA will remain in place pending completion of the review of governance and management of the service and inspectors found this to be the case on inspection. An unannounced visit to the centre was required and had been scheduled by the representative of the provider.

As cited in the notices of proposal, the provider had not demonstrated that they were competent or capable of carrying on the business of the designated centres in compliance with the requirements of the Act, Regulations and Standards. The provider had also failed to ensure that the centre was being operated in compliance with regulations and standards as evidenced on successive inspections. Finally, the provider had failed to ensure that those responsible for the governance and management of the centre have the necessary competence and capability to implement the required changes to ensure residents are safe and have a good quality of life.

Since the notices were issued, the HSE had seconded a senior manager to this service for a period of six months, who had also been nominated as representative of the provider in their interactions with HIQA. In addition, another senior manager was

supporting the human resources (HR) function within the service. Clinical support was being provided for a half day a week to this service. However and as identified on the previous inspection, it was not demonstrated that this arrangement was sufficient to ensure clinical oversight to residents. This is evidenced under outcomes 11 and 12 (healthcare and medication management). The representative of the provider had identified the requirement for additional clinical oversight and had seconded a person on a full-time basis to provide this support for an agreed period of time.

In addition, a social care leader was providing support to the clinical nurse manager and senior managers. The social care leader demonstrated that she was following through on required actions and understood the nature of the challenges in the service. The post of the person in charge was vacant but was shortly to be filled on a three-month basis on secondment by a suitably qualified and experienced manager, pending the successful recruitment of a permanent person in charge.

Inspectors found that the secondment of suitably qualified and experienced managers to the service had resulted in significant progress in addressing deficits relevant to the quality and safety of the service being provided to residents. These changes were clearly demonstrated as being driven by a person-centred approach. Improvement was evident in the areas of communication, the completion of priority assessments of need and behaviour support plans, the development of new care plans, revision of the corporate and local risk registers and policies to underpin the care and support to be provided. In addition, a system of staff supervision had been introduced, lines of responsibility had been clarified and a new team leader structure was being rolled out to strengthen the support being provided to frontline staff. While further progress was required, changes to date had resulted in demonstrable improvements for residents in terms of reduced incidents and behaviours of concern. Also, concerted efforts had been made to improve communication with families, advocates and the HSE safeguarding team.

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):

Findings:

Overall, satisfactory progress was demonstrated against the grounds cited in the notices of proposal to refuse and cancel the registration of this centre as relevant to this outcome.

As cited in the notices of proposal, the provider had failed to ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents or to ensure that staff received appropriate training to support residents' needs.

At this inspection, inspectors found that a training needs analysis had been completed across the service and staff training needs were being continuously reviewed. A training matrix had been developed. Inspectors spoke with staff who said that they had received recent training in relation to safeguarding, positive behaviour support, infection control, medicines management and an introduction to autism. Training had also been organised in relation to other specific areas to support residents, for example, relationships and sexuality. Some training still had to be organised, although this was being sourced by management, for example, in relation to communication and sensory training.

A supervision policy and programme had been devised and had commenced. A senior manager had been identified to provide training in relation to the supervisory process for all engaging in the supervision process. Inspectors viewed a document clarifying roles and responsibilities within the service, so that all management and staff grades would be clear in relation to their own role, responsibilities and reporting relationships. A new team leader structure was being rolled out, where team leaders would support staff on the ground, for example in relation to implementing care plans and behaviour support plans. The representative of the provider confirmed that team leaders were being up skilled and would supported by management to carry out their role through a competency assessment framework. Team meetings also took place with a pre-agreed agenda.

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:

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Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Cork Association For Autism
Centre ID:	OSV-0002113
Date of Inspection:	07 June 2017
Date of response:	28 June 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:
A comprehensive assessment of needs was yet to be completed for all residents.

1. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
Additional work has commenced with other MDT members, MDT meetings will take place on a regular basis.

All outstanding comprehensive assessment of needs will be completed with revised support and care plans in place for every service user by 14 August 2017

Proposed Timescale: 14/08/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The restrictive practices committee required further review and development to ensure its effectiveness.

2. 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:
The Restrictive Practice Committee will now include members of the MDT team. Clear terms of reference are currently being drafted and will be in place by 21 July 2017.

Person In Charge has significant experience and knowledge of Restrictive Practice and Human Rights and will cascade Restrictive Practice training to all staff by 31 August 2017

Proposed Timescale:
Clear terms of reference are currently being drafted for the revised Restrictive Practice Committee and will be in place by 21 July 2017.

Restrictive Practice training to all staff by 31 August 2017

Proposed Timescale: 31/08/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors viewed an intimate care support plan that required updating to reflect a

resident's current needs.

3. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
As part of the comprehensive assessment of need, revised care plans will inform how staff will provide personal intimate care to those who require support in this area in accordance to the wishes and dignity of each resident.

Proposed Timescale: 14/08/2017

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:
Further improvement was required to ensure that residents had access to the full range of multidisciplinary supports that they required.

4. Action Required:
Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

Please state the actions you have taken or are planning to take:
Residents will have access to MDT support via the organisations or by arrangement with the HSE.

Terms of reference for the organisations MDT procedure will be implemented by 21 July 2017

Proposed Timescale: 21/07/2017

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As detailed in the findings, necessary information required to ensure that residents' healthcare needs were appropriately supported and reflected in their care plans was not always available.

5. 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. Letters have gone out to GPs to request any outcomes of allied health professional appointments
2. Where a resident is supported to attend an appointment, and with the residents consent, a devised template will now go with the resident. This will allow for the allied health professional to record any outcome of the appointment.

Proposed Timescale: Immediate and all future appointments

Proposed Timescale: 28/06/2017

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Adequate reassurances were not provided with respect to practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines.

6. 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:
Revised Medication Policy in place, Quality and Governance Manager has commenced rolling out the Medication Management Training based on the new revised policy across the organisation. This will be completed by 14 July 2017.

Proposed Timescale: 14/07/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Appropriate and suitable practices were not in place relating to the storing of medicines that required refrigeration.

7. Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated

centre is stored securely.

Please state the actions you have taken or are planning to take:
Revised Medication Policy in place, this will ensure appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines and will ensure that any medicine that is kept in the designated centre is stored securely are in place. The Quality and Governance Manager has commenced rolling out the Medication Management Training based on new policy across the organisation. This will be completed by 14 July 2017.

Weekly medication audits have also commenced across the organisation

Proposed Timescale: 14/06/2017

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:
A plan had not been agreed that detailed the governance and management arrangements for this centre in the medium- to long-term.

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

Please state the actions you have taken or are planning to take:
Interim defined management structure is now in place within the designated centre, it identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. Interim Person In Charge has commenced in post as of 12 June 2017.

Recruitment of a permanent Person In Charge has commenced and will be completed by 31 Sept 2017

The Provider Nominee/Interim CEO and Organisation Board Chairperson will be part of the HSE Review of Governance and Management Structures Committee, this committee will recommend the the future governance and management arrangement for the centre

Proposed Timescale: 30/09/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While a training programme was in place, gaps were identified and some training had yet to be sourced.

9. 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:
Training needs analysis has been completed, all outstanding and any refresher training will be completed by 15 Sept 2017, also as part of each staff members supervision staff training will be reviewed.

Proposed Timescale: 15 Sept 2017 and ongoing

Proposed Timescale: 15/09/2017