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:	Willowglade
Centre ID:	OSV-0002400
Centre county:	Dublin 14
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St Michael's House
Provider Nominee:	Declan Ryan
Lead inspector:	Karina O'Sullivan
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	6
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
24 October 2016 10:30	24 October 2016 20:30

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

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
Outcome 18: Records and documentation

Summary of findings from this inspection

Background to the inspection:
This was the second inspection of this designated centre. The purpose of this inspection was to follow up on actions from an announced registration inspection carried out in the designated centre in June 2015, to monitor on-going compliance with the with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and to inform a registration decision.

How we gathered our evidence:
As part of the inspection, the inspector visited the designated centre, met with six residents and spoke with the person in charge and three staff members. The inspector viewed documentation such as, care plans, person-centred support plans, recording logs and policies and procedures. Over the course of this inspection residents communicated in their own preferred manner with the inspector. Residents allowed the inspector to observe their daily life in the designated centre. This included meal times and activities.

Description of the Service:
This designated centre is operated by St. Michaels House (SMH) and is situated in South Dublin. Six residents resided in the designated centre. The provider had

produced a document called the statement of purpose, as required by regulation, this described the service provided. The inspector found the service provided was in line with the statement of purpose. The designated centre aimed to provide residential accommodation for both male and female adults over the age of 18 with intellectual disabilities. The designated centre consisted of a seven bedroom bungalow six used by residents one for staff when on sleepovers.

Overall Judgments of findings:
Eight outcomes were inspected one outcome was compliant and one outcome was found to be substantially compliant with six outcomes found in moderate non-compliance. Areas of improvement identified included, medication management, information contained within residents' files and risk management.

All inspection findings regarding compliance and non-compliance are discussed in further detail within the inspection report and accompanying action plan.

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

Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Resident's social care needs were identified and residents had the opportunity to participate in activities appropriate to their interests and preference. These included areas such as, holidays, shopping, music events and attending various events within the community.

The system of personal social plans within the designated centre involved personal outcome measures encompassing 23 quality of life indicators as an assessment. The information gained during the process contributed to the development of a personal plan. This plan was to be completed annually. The inspector viewed five residents' plans and the following was noted:

- some plans were not reviewed annually for example, some personal plans were dated 2015

- goals were set, however, some did not have a date and this information was not available in the designated centre. From discussions with the person in charge and through reviewing a number of documents. It became evident these goals were set in early 2015. No evidence of review or the level of progress of these goals were evident

- within another plan viewed goals were set in Jan 2015 and reviewed in November 2015, no goals were present for 2016. One goal identified swimming, a review of this goal sound that swimming had not taken place as they needed to purchase appropriate swim wear. However, this review took place 11 months previously, and the swim wear had still not been purchased. Staff referred to other health issues which had prevented

the resident from achieving this goal. No health issues were documented within the review of the goal.

- other goals set, such as redecorating a resident's bedroom was completed. Clear collaboration and evidence of this was contained within the resident's plan, including choosing the colour. Another goal within the plan was for the resident to go on holidays. Staff confirmed the resident did not go on holidays, this goal was not reviewed nor was there evidence of progression since the 19 September 2015.

Clear collaboration with the day services were evident for example, one resident wanted to have a day off from their day service when they felt like one. This was agreed with the resident and staff from both the designated centre and the day service.

Person-centred information was contained in some aspects of residents' plans where the wishes and preferences of residents were documented. For example, having breakfast before having a shower or if a resident was asleep in the morning the resident preferred not to be woken by night staff. Instead day staff members were to attend to the resident's needs when they wake up.

Residents' family members were consulted in relation to the personal plans in line with residents and family members' preferences. There was evidence for this maintained within the resident's files.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The inspector found the designated centre was suitable and safe for the number and needs of residents. Improvements were required in the area of risk, sharp and fire management.

There was certification and documentation to show the fire alarms, emergency lighting and fire equipment were serviced.

The designated centre had an organizational risk management policy in place dated April 2016 this included, the specific risks identified in regulation 26. The designated centre had a risk register and this recorded a number of risks within the house and the controls

in place to address these.

There were individual risk assessments for residents in place these included fire, self harm and unexplained absences. However, some of these did not identify ongoing review of risk since 2015 and others contained different information to the support plans in place. The inspector discussed this with the person in charge and some of these documents were not supporting safe delivery of care due to inconsistencies between documents.

The inspector viewed a falls assessment with a score of 86 recorded on the 10 June 2015. The document highlighted a score of 50 or more was a high risk no follow up was present.

Fire drills had taken place and documents recorded the time taken to evacuate however, the names of residents whom participated in fire drills was not available. The inspector requested evidence that all residents using the service in the designated were able to evacuated. Staff could not provide this information on the day of inspection. The person in charge identified they would ensure all residents using the designated centre were able to evacuate. This information was subsequently provided to the inspector following inspection.

The inspector viewed a sample five personal evacuation plans for residents and these included any particular arrangements a resident may require such as, the use of mobility aids. However, when the inspector viewed the emergency folder available for staff to use, an outdated version of these documents was contained in this folder.

Sharps were used within the designated centre and the inspector requested to see documentation in relation to the management and disposable of sharps. This was not available. There was no label or tagging system used for the sharps bin.

The designated centre had a health and safety statement dated June 2014 this outlined the responsibilities of the staff members within the organization. The statement referenced a wide range of policies and procedures that supported the statement and guided staff in their work practices. The designated centre had an emergency evacuation plan in place for a number of various events such as fire, adverse weather conditions, flooding and power failure. The plan identified specific alternative accommodation to be provided in the event residents could not return to the designated centre.

There was a system in place for recording accidents and incidents occurring in the designated centre. The person in charge outlined the process for dealing with these and ensuring learning from any adverse incidents or accidents occurred. The inspector viewed clear evidence of this where an incident had occurred and this was discussed at a team meeting resulting in an alternative safer product sourced to carry out the procedure in future.

The vehicle used to transport residents had certification from the National Authority and an in date insurance certificate.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

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

Findings:
The inspector found appropriate measures to protect residents from being harmed were in place within the designated centre. Improvements were required in relation to behavioural support plans and the review of restrictive practices.

The inspector viewed two behavioural support plans, these documents identified proactive and reactive strategies. However, in one instance there was no guidance contained for when staff were to administer prescribed medication as part of a behaviour management strategy.

There was a policy in place on the prevention, detection and response to abuse.

Restrictive practices were in place however, some of these were awaiting review since July 2016.

Staff members had received training in the area of prevention, detection and response to abuse. Some staff members spoken with by the inspector were unclear in relation to the management of an allegation of abuse and were unclear of the reporting structure.

The inspector found residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs

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

Theme:
Health and Development

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

Findings:
Each resident was supported to achieve the best possible health. However, improvements were required in the information contained in resident's healthcare plans.

The healthcare needs of residents were completed via a plan called 'personal assessment and support plan'. The assessment contained twelve activities of daily living.

Residents had access to allied healthcare professionals, the inspector viewed evidence of this including optician, dentist and dietician. The inspector found some of the recommendations were not implemented for example, a review dated the 27 April 2016 identified specific recommendations. The inspector requested to view evidence of this intervention however, this was not available. Staff confirmed this was not implemented despite follow up appointments with the specific members of the multi disciplinary team. This aspect of care provision was also identified in the previous inspection therefore, this remained outstanding.

The inspector found multiple versions of documents present for example, within one resident's file five speech and language guidelines were present. The inspector found this could potentially lead to inconsistent care delivery for the resident.

Some support plans were not reviewed, instead a review date was present when the inspector discussed this with staff it became evident the date was inserted when the plan was developed and the review dates was the proposed date for review. No evidence of review of some support plans was evident. These were highlighted to staff members on the day of inspection.

Other support plans contained clear collaborations with residents and the provision of person-centre care. For example, pictures were available within a residents plan when they required a specific procedure to be conducted. This was outlined in a step by step process to ensure the resident remained comfortable in the procedure.

Regarding food and nutrition the inspector found residents participating in mealtimes within the designated centre in accordance to the residents' preferences in relation to food choices. Residents participated in cooking in accordance with their own preferences. However, during the inspection poor practice was identified in relation to support provided to one resident's meal experience. The practice observed was not in line individual's feeding guidelines. To protect the resident involved the detail of this poor practice is omitted from the report as it was discussed in detail with the person in

charge and the service manager.

The inspector viewed user-friendly menu selection refreshments and snacks were available for residents outside mealtimes within the designated centre.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

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

Findings:
The inspector found policies and procedures were in place for the safe management of medications. Improvements were required in relation to the management of medication within the designated centre.

The designated centre had written policies and procedures related to the administration, transcribing, storage, disposal and transfer of medicines. Medication was supplied to the designated centre by a local pharmacist and medication was recorded when received.

The inspector viewed prescription sheets one of these required the insertion of a photograph of the resident.

Administration recording sheets were in place for each resident, a number of these were viewed by the inspector. These were found to be up-to-date and showed staff administered and signed for medication. The inspector also viewed records for p.r.n medicine (a medicine only taken as the need arises). The inspector found incidences of this medication being administered not as prescribed such as, gastrointestinal medication.

The inspector found various tropical medication unlabelled and without an opening date in the designated centre in bathrooms. Some medications did not have an expiry date specified on the label.

The inspector found medications were not stored securely within the designated centre. On the day of inspection the inspector found the drug keys hanging from the lock of the press door.

The inspector crossed checked the balances of some medication and found these to be

accurate.

The inspector also viewed guidelines in relation to the administration of psychotropic p.r.n. medication. The guidance available to staff was unclear for when this medication was to be administered for example, what indicators were available to staff to identify when this intervention was required.

There was a system in place for recording, reporting errors and reviewing medication, the person in charge presented some of these to the inspector.

Staff signatures were present within the signature bank.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
The inspector found improvements were required in the monitoring of the quality of care and experience for residents, the completion staff supervision and audits within the designated centre.

There was an annual review of the quality and care completed in this designated centre for 28 October 2015.

There was a person nominated on behalf of the provider to carry out an unannounced visit on a six monthly basis. This reviewed the safety and quality of care and support provided in the designated centre. The inspector viewed one completed in 2015 dated 28 October 2015. No other unannounced visits were available for 2015 in the designated centre. The inspector also viewed another one completed on the 16 July 2016. Actions plans were developed however, the inspector was unable to see evidence of the required actions being achieved as both action plans were blank and remained unsigned by management.

The inspector observed auditing of areas within the designated centre however, this system required improvement for example, no auditing was present within the designated centre in relation to medication administration.

The management structure was clearly defined with identified lines of authority and accountability. The person in charge reported to a regional manager. The regional manager met with the provider nominee regularly and outstanding issues pertaining to the designated centre were discussed at these meetings.

The person in charge met with the regional service manager along with other persons in charge within the region (cluster meetings). The inspector viewed minutes dated 18 May 2016 and the 07 September 2016. Issues relating to staffing, assessments and documentation were discussed during this meeting.

The inspector viewed minutes of staff meetings within the designated centre. Minutes viewed were dated 23 February 2016, 19 May 2016 and 18 July 2016. Various areas were discussed including health and safety, staffing and residents needs.

There was no formal supervision in place for staff in the designated centre.

The person in charge had changed since the previous inspection and from discussions, interview and information provided, the inspector found the person in charge demonstrated sufficient knowledge of the legislation and their statutory requirements. Staff spoken to stated they felt supported by the person in charge. The person in charge was employed on a full time basis.

Judgment:
Non Compliant - Moderate

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:
The inspector found there were sufficient staff numbers with experience deployed to meet the assessed needs of the residents. .

From a sample of 10 staff members training records reviewed, one staff member required training in people moving and handling from the records presented to the inspector on the day of inspection. Updated records were subsequently submitted to HIQA, this identified manual handling training was completed in 2015.

There was no formal supervision in place for staff in the centre.

The inspector found there were adequate staffing supports to meet the assessed needs of residents.

Staff files were not reviewed as part of this inspection as these are held within the organizations head office off site. These were reviewed as part of the previous inspection.

These were no volunteers within the designated centre.

Judgment:
Compliant

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

Findings:
The inspector viewed this outcome in respect of the action identified from the previous inspection and found the action was achieved. During the course of the inspection other areas pertaining to this outcome was identified.

Over the course of the inspection the inspector found the retrieval of schedule 3 documents difficult. Some documents were present in duplicate versions for example, speech and language guidelines, multiple versions of risk assessments and other aspects of residents documentation was blank such as, pain management and daily programme of activities.

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 St Michael's House
Centre ID:	OSV-0002400
Date of Inspection:	24 October 2016
Date of response:	12 January 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:
Some residents' personal plans were not reviewed annually.

1. 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.

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

Please state the actions you have taken or are planning to take:
The PIC has prepared a timetable to ensure that each resident has an annual personal plan that is reviewed on a 6 monthly and yearly basis. She has assigned a staff member as keyworker for each resident.
The PIC will sign off on the yearly plan.
The designated centre has adopted a new format for the yearly personal plans which is being currently rolled out,. All personal plans will be completed using the new format.
Documentation is available for the HIQA Inspector to review

Proposed Timescale: 30/03/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some personal plan reviews did not assess the effectiveness of each plan and take into account changes in circumstances and new developments.

2. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The PIC will ensure that keyworkers record and document all the relevant evidence of progression of goals and why some goals will not proceed as in the case in 2015 due to physical illness.
The PIC has started this process and will review with keyworkers at regular bi-monthly intervals. The Process started on 23/11/16. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Began 23/11/16 and is ongoing

Proposed Timescale: 23/11/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some resident's plans did not contain the names of those responsible for pursuing objectives in the plan within agreed timescales.

3. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out

of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
The PIC has assigned a named keyworker to each resident who holds responsibility for carrying out goals and ensuring that the goals are worked upon in a timely fashion. The PIC will review with the keyworker bi-monthly. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Began 23/11/16

Proposed Timescale: 23/11/2016

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:
Individual risk assessments in place required review. Follow up to some identified risks such as, falls were not evident.

Sharp boxes were present in the designated centre, these were untagged.

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:
A. The PIC has linked with the Physiotherapist and new guidelines have been put in place regarding identified risks such as falls dating from 26/10/16. Documentation is available for the HIQA Inspector to review

B. In keeping with HSE and HIQA standards all sharp boxes are tagged before collection. These tags have a unique number and can be traced back to the unit that generates the waste. This has been completed since 26/10/16. . Documentation is available for the HIQA Inspector to review

Proposed Timescale: completed 26/10/16

Proposed Timescale: 26/10/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire safety management and fire drills within the designated centre did not identify all residents could safely evacuate from the designated centre.

5. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The PIC has ensured that the fire drills are rotated so that all residents within the designated centre can evacuate safely. In order to ensure that all the residents take an active part in the fire drill a record of residents involved in individual fire drills is recorded within the fire fact folder. This began from 24/10/16. Documentation is available for the HIQA Inspector to review.

Proposed Timescale: Completed 24/10/16

Proposed Timescale: 24/10/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restrictive practices were not reviewed as recommended.

6. 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 PIC has reviewed all the restrictive practices within the designated centre and will review all such practices annually or as necessary. All restrictive practices will be reviewed again in July 2017 or when deemed necessary. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Completed

Proposed Timescale: 12/01/2017

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Behaviour support plans did not provide up-to-date information to ensure staff had the knowledge and skills, appropriate to their role, to respond to displays of behaviour and to support residents to manage their behaviour.

7. 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:
The PIC has ensured that the Psychologist reviewed the Behaviour Support Plans and amended as necessary. The PIC has ensured that the plan clearly directs staff as to when to administer prescribed medication as part of the behaviour support policy. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Completed 15/11/16

Proposed Timescale: 15/11/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had received training however, some staff were unclear of the reporting structure within the designated centre.

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

Please state the actions you have taken or are planning to take:
The PIC discussed the importance of the Safeguarding Policy with all staff ensuring that staff are clear on the steps that need to be taken to ensure the prevention of abuse at staff meeting dated 23RD November 2016.
The PIC has prioritised staff for Safeguarding training and training date scheduled is 27th January 2017.

Proposed Timescale: 27/01/2017

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some healthcare plans were undated and did not contain a review of the effectiveness of the plan, therefore the inspector was unable to establish if some residents were in receipt of appropriate healthcare.

9. 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:
The PIC has clearly delegated the responsibility of reviewing all healthcare plans to keyworkers which are to be evaluated in a timely manner to ensure that each resident is receiving the appropriate care. This is to be done bi-monthly. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Began 23/11/16

Proposed Timescale: 23/11/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some recommendations made by members of the multi disciplinary team were not implemented.

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

Please state the actions you have taken or are planning to take:
The PIC has ensured that the recommendations made by the multidisciplinary team member have been completed. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Completed 07/11/16

Proposed Timescale: 07/11/2016

Theme: Health and Development

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

Assistance was not offered in an appropriate manner during meal times for one resident.

11. Action Required:
Under Regulation 18 (3) you are required to: Where residents require assistance with eating or drinking, ensure that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.

Please state the actions you have taken or are planning to take:
The PIC addressed this issue with all staff on 25/10/16 . She ensured that the appropriate assistance is offered to all residents during meal times and reiterated this at the next staff meeting which was held on 23/11/16. Records are available for the HIQA Inspector to review

Proposed Timescale: Commenced on 25/10/16

Proposed Timescale: 25/10/2016

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:
Medication within the designated centre was not stored securely.

12. 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:
The PIC has taken steps to ensure that all staff will adhere to the medication management policy in order to ensure all medication is stored safely. The PIC has prioritised the Safe Administration Medication training for the staff of the designated centre. Refresher training is scheduled for 9th February 2017

Proposed Timescale: 09/02/2017

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Prescription sheet required the insertion of a photograph of the resident.

Some p.r.n. medication was not administered as prescribed.

Some tropical medication was unlabelled and did not contain a date of opening.

Some medications did not have an expiry date specified on the label.

13. 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:
A. The PIC has taken steps to ensure that all staff adhere to the medication management policy. The PIC has prioritised the Safe Administration Medication training for the staff of the designated centre.

B. The PIC has ensured that the local pharmacy label all topical medications both on the box and the tube.

C. The PIC has ensured that the local pharmacy includes all expiry dates on the medical information label.

Proposed Timescale: (A) 9th February 2017.
B).C) Completed on 25/10/16

Proposed Timescale: 09/02/2017

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:
Unannounced visits to the designated centre at least once every six months were not evident. One was available within the designated centre.

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:
An unannounced visit to the designated centre by the service manager took place on 14/11/16. Documentation will be made available to the HIQA Inspector to review

Proposed Timescale: Completed 14/11/16

Proposed Timescale: 04/11/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Regular audits were not taking place within the designated centre such as, medication management.

15. 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:
The Service Manager has conducted an audit review of Medication Management. Medication audit reviews will be conducted 6 monthly. Documentation will be made available to the HIQA Inspector to review

Proposed Timescale: Completed 12/01/17

Proposed Timescale: 12/01/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No formal supervision system was in place for staff members.

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

Please state the actions you have taken or are planning to take:
The PIC has allocated protected time within the roster to have 1:1 supervision with all staff members on a regular basis.

Proposed Timescale: 06/03/2017

Outcome 18: Records and documentation

Theme: Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some schedule 3 documents were present in duplicated versions and other aspects of plans were blank.

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:
The PIC has reviewed all files and has implemented a system to prevent duplication of documentation. The PIC introduced a monitoring system whereby the PIC and designated key worker review the file on a bi-monthly basis by key workers. Documentation is available for the HIQA Inspector to review

Proposed Timescale: Commenced on 23/11/16

Proposed Timescale: 23/11/2016