<table>
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<tr>
<th>Centre name:</th>
<th>Cork City North 13</th>
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<td>Centre ID:</td>
<td>OSV-0003310</td>
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<td>Registered provider:</td>
<td>COPE Foundation</td>
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<tr>
<td>Provider Nominee:</td>
<td>Liza Fitzgerald</td>
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<tr>
<td>Lead inspector:</td>
<td>Geraldine Ryan</td>
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<tr>
<td>Support inspector(s):</td>
<td>Noelle Neville</td>
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About monitoring of compliance

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

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

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

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

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

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>31 August 2016 08:30</td>
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</tr>
<tr>
<td>01 September 2016 09:00</td>
<td>01 September 2016 17:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tbody>
<tr>
<td>Outcome 05: Social Care Needs</td>
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<tr>
<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 17: Workforce</td>
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**Summary of findings from this inspection**

Background to the inspection:
The first inspection in this centre was triggered as a result of information received by HIQA. During the inspection, non-compliance with the regulations was found in 10 of the 11 outcomes inspected against, 8 of the outcomes were judged to be in major non-compliance.

An immediate action plan was issued in relation to governance and management. The provider submitted a satisfactory response to this required action within the timeframe set by HIQA.

This inspection was unannounced and was carried out 2 days. An immediate action plan was issued on the first day of inspection in relation to the staffing and skill mix. The provider submitted a satisfactory response to this action and within the timeframe set by HIQA.

Description of service:
The centre consists of four community residential bungalows which are based in the
outskirts of a city. As stated in the centre’s statement of purpose, the centre provides residential accommodation and services for the following:

- care of the older person physical with mental health difficulties, behaviours that challenge and with varying degrees of intellectual disabilities
- maximum support to a resident with behaviours that challenge, mental health difficulties and a moderate intellectual disability
- maximum support to residents with behaviours that challenge, mental health difficulties, and a mild to moderate intellectual disability
- high support to residents with behaviours that challenge, mental health difficulties with varying degrees of intellectual disabilities

The centre provides accommodation and support for nine residents.

How we gathered our evidence:
Inspectors met and spent some time with six residents, sought permission to be in their home and to access documentation. Inspectors reviewed a sample of files pertaining to residents with co-existing healthcare needs and supports, personal care plans, medication management, risk assessments, accident/incident logs, the complaints log, fire safety records, the centre’s policies/procedures and viewed the premises.

Practices and interactions between residents and staff were observed. Staff engaged with residents in a respectful manner. Residents invited inspectors into their home and some residents spoke about their lives in the centre. Residents spoke warmly about the person in charge and staff. However, some residents voiced how they would like to have a home of their own.

Overall judgment of our findings:
On this inspection six outcomes were judged as major non-compliant and four outcomes were judged as moderate non-compliant. One major non-compliance was identified in Outcome 17: Workforce: that resulted in an immediate action being issued to the provider. The response from the provider satisfactorily addressed the immediate risk

Non-compliances were noted in the following outcomes:

- residents’ rights, dignity and consultation; residents not being supported to live where they choose (outcome 1)
- multidisciplinary (MDT) review of residents' personal care plans (outcome 5)
- suitable premises (outcome 6)
- effective fire safety management systems (outcome 7)
- residents' access to psychology and dietetic services (outcome 11)
- medication management (outcome 12)
- governance and management (outcome 14)
- staffing skill mix and staff training (outcome 17)

The reasons for these findings are explained under each outcome in the report and the regulations which are not being met are included in the action plan at the end.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors followed up on the status of the seven actions generated from the inspection of 9 July 2015. Of the seven actions generated, it was found that five actions were completed. These actions were in relation to the provision of advocacy; two signatures on each financial transaction; the identification of the complaints officer; the complaints log and the complaints procedure.

Two actions in relation to the inappropriate placement of residents issued were not addressed in a satisfactory manner or by the timeframe submitted by the provider (11 September 2015). These actions are reissued in the action plan at the end of this report.

The inspector looked at complaints management within the centre and found that a general complaints folder indicated that 10 complaints were recorded in 2016. While action was taken in all complaints, there was evidence that one complainant was not satisfied with the action/or not taken. This was in relation to the provision of an external smoking area. There was evidence that the complainant received a copy of the complaint.

Each house had a complaints folder. While there was evidence that actions were taken to address some complaints, some complaints were not addressed; for example;
- one complaint dated 13 January 2016; concerned residents living with other residents in the house; the reasons why were clearly set out. It was noted that similar complaints about living arrangements were made in 2015
- another complaint was in relation to not being able to attend activities; this was noted
to be as a result of peer behaviour in the house, and a lack of staff.

The complaints policy, dated July 2015, was not centre-specific and referred to the organisation. The complaints policy and the easy-to-read version required updating to reflect new personnel.

A sample of residents’ financial transactions was reviewed. There was evidence that all transactions were appropriately receipted, co-signed, dated and recorded transactions balanced on the associated ledgers.

There was documented evidence that client forum meetings were convened and a variety of topics were discussed; for example; meals, fire safety, personal belongings, policy to prevent falls, how to give consent. However, a documented comment stating that ‘all service users were happy with current environment’ did not concur with the complaints record or information in residents' PCPs.

While there were adequate facilities for residents accommodated in some houses, the inappropriate accommodation of some residents, with co-complex mental health and intellectual disability needs, did not meet their individual needs. Routines and practices did not promote residents’ independence and voiced preferences. One resident informed the inspector that they had been asking ‘for years’ for their own place.

There was evidence on the day of inspection of how these living arrangements impacted in a very negative manner of the quality of life of the residents. Furthermore, a resident’s relative met with the inspector and while complimentary of the care and kindness of the staff, reiterated what the resident had communicated concerning the preference to ‘have their own place’.

**Judgment:**
Non Compliant - Major

**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:**

Inspectors reviewed four residents' personal care plans (PCPs). There was evidence that residents were actively involved in the development of their PCPs and in particular residents' involvement and consultation, identifying choices around short and long-term goals.

Plans were presented in an organised manner. There was evidence the PCPs were reviewed and updated as required. Appropriate plans were in place around residents’ needs; for example; communication, personal care, activities and education and learning. A nominated staff member was responsible for implementing actions to achieve these goals. These were seen to be reviewed at regular intervals and revised with a clear rationale for any amendments as well as evidence of consultation with both the resident and family members.

There was evidence that some short and long term goals were tracked, reviewed and updated. Goals included; for example; attending a concert, going to the zoo, attending a course, visiting family, attending art classes, cooking breakfast and there was evidence that these goals were achieved.

However, a number of goals for residents had not been followed up as a result of mental health issues and there was no further detail of an alternative plan in place. Some goals were generic; for example; one resident's goal was to have a happy and healthy life.

Another resident’s goal was to live elsewhere; the resident had expressed this on a number of occasions. There was no evidence that this was progressed; staff also confirmed this. It was referenced in the resident’s multi-behavioural support plan dated 2 July 2015, that a possible long term residence and staff supports for this resident would promote the privacy and dignity of this resident and other residents accommodated in the house. A funding proposal had been submitted to the Health Service Executive (HSE). There was no evidence that this was progressed. The person in charge and the provider representative had no further information on this matter.

Another resident expressed to the inspector that it was their wish to have a place of their own; somewhere to relax and have visitors. Staff confirmed that the resident had voiced this on many occasions however, this was not documented in the resident's PCP or as a goal they would like to achieve.

There was evidence that residents were consulted with and participated in the development of a comprehensive personal plan in consultation with their family and the residential service. However, while residents had access to allied services such as speech and language therapist (SALT), occupational therapy, physiotherapy, a GP, a consultant psychiatrist and social work, a multidisciplinary annual review to assess the effectiveness of the PCP and take into account changes in circumstances, was not carried out.

The centre had access to on-site vehicles and inspectors saw residents being transported to and from a variety of activities and outings.
Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
The centre comprised four terrace bungalows accommodating nine residents. While each house had its own private entrance, all bungalows shared a rear communal garden.

House one accommodated three residents. The house was clean and warm.

House two accommodated one resident and, overall, the design and layout of the premises was in keeping with the statement of purpose and provided accommodation appropriate to the assessed needs of the resident. The house was homely, warm and clean.

House three accommodated two residents with dual diagnosis, both of whom had had recorded incidents of significant behaviour that might challenge, such that the use of both physical restraint and single segregation was warranted. A review of personal care plans, including behavioural support strategies, indicated that the complex needs of these residents were not met by the design and layout of the premises and their current placement did not meet the requirements of the Regulations. In this context, the individual placements in an appropriate setting required review.

House four accommodated three residents. Residents' rooms were comfortable, homely with adequate storage for belongings, individualised with personal items and photographs.

However, there was inadequate provision of private space for residents as required by Schedule 6 of the Regulations in three of the four houses.

In addition, on this inspection the following was noted:
• cigarette ends discarded on the footpath outside the front door of one house. This was addressed on the day of inspection.
• discarded cartons noted outside one house. This was addressed on the day of
inspection.
- flaking paint on external window sills
- the ceiling in one bathroom in house one was in a state of disrepair
- flaking paintwork was noted in the sitting room of house four
- the dining room wall, in one house, was in a state of disrepair.

**Judgment:**
Non Compliant - Major

**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

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

**Findings:**
Inspectors followed up on the eight actions generated from the 8 July 2015. Following the reconfiguration of the initial centre, four actions were not applicable to this centre.

Two of the three actions concerning this centre were addressed;
- staff belongings were stored in a secure manner
- a suction machine was available.

One action concerning evacuation arrangements of residents required review. Of the fire drills reviewed the following was noted:
- the number of staff and residents who participated in the drill was not recorded
- the times the fire drill was carried out was not recorded (31 January 2016, 12 June 2016 and 25 June 2016).

Five residents' personal emergency evacuation plans (PEEPs) were reviewed and while one resident had an up-to-date PEEP in place the following was noted:
- one resident did not have a PEEP
- two plans were not dated
- one plan was last reviewed 7 March 2014.

Staff training in fire safety was reviewed and it was found that one staff member had not received training in fire safety and prevention; 13 staff were due to attend the organisations' annual fire safety training.

**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:**
Two actions were generated from the inspection undertaken on the 8 July 2015 and these concerned procedures and policies in relation to restrictive practices. Neither action was addressed in a satisfactory manner.

As noted in the previous inspection, the policy on restrictive practices, dated 2014, did not reference the use of a safe room. This had not been addressed.

There was evidence that residents' PCPs contained detailed guidance on the use of separation segregation and the use of a safe room. Staff spoken to, were knowledgeable on the use of this restrictive practice. There was evidence that the practice was regularly reviewed and records were maintained for the periods of when separation segregation was in place. However, there was evidence that some incidents of peer to peer interactions resulted in the use of single separation and it was evident that the incompatibility of residents resulted in incidents and consequential use of the safe room.

As noted in the previous inspection the centre accommodated residents with dual diagnoses and had numerous recorded incidents of significant behaviours that challenge with some incidents directed at each other. Inspectors evidenced one such incident on this inspection and it was evident that incompatibility of the residents caused and escalated the incident. Staff stated that this type of incident was a regular occurrence and a review of the incident log concurred with this. There was evidence that escalated behaviours exhibited by a resident did not occur when the resident was not in the centre and this was confirmed by a relative.

**Judgment:**
Non Compliant - Major
### 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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The quarterly notifications as required by the Authority did not include the use of single segregation in the centre.

**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:**
Two actions were generated from the inspection undertaken on the 8 July 2015. As this centre was generated from a reconfiguration of a larger entity, one action was not applicable to this centre.

The second action was in relation to delay in referral to dietetic services. This had not been addressed; for example; one resident had been referred to a dietician in January 2016 with a repeat request sent on a monthly basis. To date, this resident had not been reviewed by the dietetic services.

In addition, the following was noted on this inspection; a resident's fluid and food intake was being recorded. However, detail of this was not included in the resident's care plan. While the resident's fluid intake was recorded, there was no evidence that the fluid intake was totalled on a daily basis on the 25 August 2016, 26 August 2016, 27 August 2016 and 30 August 2016. No output was recorded.
Sleep records were maintained for some residents. However, gaps were noted in the records; for example; in one resident's record, gaps of three consecutive nights and two consecutive nights were noted. Another resident's sleep record indicated that the sleep record was not maintained for 15 consecutive nights (16 August 2016 to the 30 August 2016).

Residents were facilitated with regular and timely access to their GP and a consultant psychiatrist who visited weekly and as required. However, residents’ access, particular residents with significant behavioural issues, to psychology services was limited. This was confirmed by the person in charge.

There was evidence of resident specific risk assessments; for example; self harm, absconding and choking.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Health and Development

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

**Findings:**
Two actions generated by the inspection undertaken on the 8 July 2015 were completed; these concerned the safe storage of medications no longer in use, and their return to the dispensing pharmacy.

However, on this inspection it was evidenced that residents did not receive their medication in a timely manner. This concerned residents who exhibited escalating behaviours that challenged and where strategies to diminish the behaviours failed and it was assessed that the resident required administration of a medication as required (PRN). In order to be effective the PRN medication needs to be administered within a particular timeframe. As staff on night duty were not trained to administer medication, it was necessary to call the clinical nurse manager (CNM) to administer medication.

The inspector found that the time it took the on-call person to reach the centre to administer a medication was lengthy due to the fact that the CNM on night duty covered a wide geographical area. For example; in July 2016, one resident, exhibiting escalating behaviours that challenged, required a medication as required (PRN) on two occasions. It was at least one hour before the on-call person was able to visit the centre and
administer the medication. Staff spoken with confirmed this.

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

Findings:
Improvements were required to the arrangements in place to ensure the effective governance, operational management and administration of this designated centre. While the person in charge currently oversaw this centre he was also the person in charge for another centre. The following examples indicate that the governance and management of the centre did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored:
• there was no local deputising arrangement in place to support the person in charge when he was not in the centre either due to annual leave or working in the other centre. The person in charge and the provider representative confirmed that there was no formal deputising arrangement in place
• staff were not able to identify the relevant individual responsible in the event the person in charge was on leave or working in the other centre and stated that they sorted it out between themselves. Staff were unaware of reporting mechanisms. In the event of 'after hours', staff reported that they would ring the on-call person
• the quality of life of residents was impacted in a negative manner as a result of the inappropriate placement of residents in the centre and the increased incidents of peer to peer incidents. This has not been addressed by the provider despite the matter being raised on numerous occasions as evidenced in the complaints log, residents' PCPs, resident forum meetings and by relatives
• there was evidence of inadequate oversight and supervision of checks of residents' healthcare needs; for example; residents' fluid and food intake records and sleep records.

This lack of oversight and governance arrangements resulted in negative outcomes for
residents as outlined in the body of this report.

**Judgment:**
Non Compliant - Major

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### Outcome 17: Workforce

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

#### Theme:
Responsive Workforce

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

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

#### Findings:

Two actions were generated by the inspection undertaken on the 8 July 2015 in relation to staff training and staffing levels and skill mix, neither action was addressed in a satisfactory manner.

The following deficits were particularly noted in relation to staff training as a number of residents with dual diagnosis exhibited behaviours that challenged:

- two staff had not attended training on management of actual or potential aggression (MAPA) with 18 staff were overdue training. This did not enable staff to manage and safely support residents, in the centre, who exhibited significant behaviours.
- 30 staff required up to date training on the protection of the vulnerable adult
- seven staff were not trained in safe manual handling and 17 staff were overdue training
- 20 staff were due to attend training on hand washing techniques

Staff informed inspectors that they cook residents’ meals and a number of staff confirmed that they had not attended training in Hazard Analysis & Critical Control Point (HACCP) and safe food handling.

The person in charge stated that while training for staff had been organised, that only a certain number of staff could be accommodated to attend the training as there was no additional staff available to cover staff to attend training.

The second action was not addressed and necessitated the issuance of an immediate action plan in relation to the fact that the provider did not ensure that staffing levels were always adequate to ensure that the delivery of service was safe and appropriate to the assessed needs of residents, and particularly in houses where residents presented with complex needs. The provider's response was satisfactory to address the risk
identified in that a staff nurse was rostered on night duty.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Geraldine Ryan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

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<th>A designated centre for people with disabilities operated by COPE Foundation</th>
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<tr>
<td>Date of Inspection:</td>
<td>31 August 2016 and 01 September 2016</td>
</tr>
<tr>
<td>Date of response:</td>
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Requirements

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

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider did not ensure that each resident's privacy and dignity was appropriately respected in relation to their personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

**Please state the actions you have taken or are planning to take:**
A review of living arrangements will be undertaken. This will involve review of compatibility, residents' wishes and assessment of need. The review will be undertaken by the divisional manager and positive behaviour support department. A detailed action plan and a transition plan where appropriate will be developed to address findings.

**Proposed Timescale:** 28/02/2017  
**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider did not ensure that the nominated person recorded details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

2. **Action Required:**
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
The Complaints Policy will be reviewed and adapted to ensure that it includes a local protocol. The local Complaints Policy will reflect the current personnel that are working in the centre. An easy to read version will be available in each of the houses within the designated centre. The Complaints Policy will be reviewed with residents in the Residents Forum meeting. All complaints will be monitored and reviewed by the Person in Charge in compliance with the organisational complaints policy.

**Proposed Timescale:** 01/12/2017

**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of goals for residents had not been followed up as a result of mental health issues and there was no further detail of an alternative plan in place.
Some goals were generic; for example; one resident’s goal was to have a happy and healthy life.

Another resident’s goal was to live elsewhere; the resident had expressed this on a number of occasions. There was no evidence that this was progressed; staff also confirmed this. It was referenced in the resident’s multi-behavioural support plan (MEBs) dated 2 July 2015, that a possible long term residence and staff supports for this resident would promote the privacy and dignity of this resident and other residents accommodated in the house. A funding proposal had been submitted to the Health Service Executive (HSE). There was no evidence that this was progressed. The person in charge and the provider representative had no further information on this matter.

Another resident expressed to the inspector that it was their wish to have a place of their own; somewhere to relax and have visitors. Staff confirmed that the resident had voiced this on many occasions, however this was not documented in the resident’s PCP and as a goal they would like to achieve.

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:
All goals will be entered into the person’s PCP. Each person’s goals will be actioned appropriately. Training on PCPs goal identification will be provided to keyworkers to enable them to support individual residents identify meaningful and personal goals and objectives.

Discussions at a senior management level have taken place to plan for a reduction in the number of residents living in the centre. Re-engagement of discussions with HSE regarding funding proposals is to take place. A plan to source housing outside of the centre to meet the needs of residents who wish to live elsewhere will be developed by the divisional manager and relevant stakeholders.

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:
A multidisciplinary annual review attended by the relevant specialisms, to assess the effectiveness of the PCP and take into account changes in circumstances was not carried out.

4. Action Required:
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:
A multi–disciplinary annual review of each residents person centred plan has taken
place.

**Proposed Timescale:** 16/12/2016

<table>
<thead>
<tr>
<th>Outcome 06: Safe and suitable premises</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Effective Services</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The centre was not kept in a good state of repair externally and internally.</td>
</tr>
<tr>
<td><strong>5. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>The rear exterior of the premises has been painted. Internal painting is scheduled. A smoking shelter has been commissioned.</td>
</tr>
</tbody>
</table>

**Proposed Timescale:** 16/12/2016

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
</tr>
<tr>
<td>The design and layout of the premises did not meet the aims and objectives of the service and the number and needs of residents.</td>
</tr>
<tr>
<td><strong>6. Action Required:</strong></td>
</tr>
<tr>
<td>Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
</tr>
<tr>
<td>An external review of the centre is complete. This review will inform the development of individualised plans based on assessment of need, which will be progressed within the organisation and with the funding body to identify appropriate supported living arrangements for all residents. Re-engagement with funding body will take place to allow for the progression of recommendations from review. Divisional manager will liaise with Finance Department and relevant stakeholders to ensure recommendations are met.</td>
</tr>
</tbody>
</table>

**Proposed Timescale:** 28/02/2017

<table>
<thead>
<tr>
<th>Theme: Effective Services</th>
</tr>
</thead>
</table>
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inadequate provision of private space for residents as required by Schedule 6 of the Regulations.

7. Action Required:
Under Regulation 17 (7) you are required to: Ensure the requirements of Schedule 6 (Matters to be Provided for in Premises of Designated Centre) are met.

Please state the actions you have taken or are planning to take:
A review of the premises is currently being undertaken to assess the provision of private space. The review will be conducted by the Provider Nominee, PIC/PPIM. They will involve also Health and Safety officer and Facilities Department when conducting review.

Proposed Timescale: 28/02/2017

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:
One staff member had not received training in fire safety and prevention; 13 staff were due to attend the organisations’ annual fire safety training.

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

Please state the actions you have taken or are planning to take:
The training records of staff have been reviewed and the training needs of staff have been identified. Staff have been booked on to fire training to take place on dates in November and December 2016

Proposed Timescale: 16/12/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of staff and residents who participated in the drill was not recorded.

The times the fire drill was carried out was not recorded (31 January 2016, 12 June

Five residents' personal emergency evacuation plans (PEEPs) were reviewed and the following was noted:
• one resident did not have a PEEP
• two plans were not dated
• one plan was last reviewed 7 March 2014.

9. **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:**
All residents now have a PEEP.
All plans are now reviewed and dated.
A protocol is in place to ensure that all times, residents present and staff present are recorded for future fire drills.

**Proposed Timescale:** 04/11/2016

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**Outcome 08: Safeguarding and Safety**

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre's policy on the use of a restrictive practice did not reflect national policy.

10. **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 centre’s policy on restrictive practices has been updated to reflect national policy
All instances of restrictive practice are reviewed and will be included in the quarterly returns to the Chief Inspector.
The PIC and PPIM will undertake an audit of restrictive practices in the designated centre.

**Proposed Timescale:** 31/01/2017

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The incompatibility of the residents resulted in peer to peer incidents and consequential use of the safe room and single separation.

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

**Please state the actions you have taken or are planning to take:**
A review of the compatibility of residents will be undertaken. Where incompatibility has been identified appropriate plans will be put in place. These plans will be progressed to ensure the protection of residents from abuse. Safeguarding plans will be in place for all residents.
The compatibility review will be undertaken by a senior member of the Positive Behaviour Support team. The Provider Nominee, PIC and PPIM will action the review.

**Proposed Timescale:** 28/02/2017

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**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:
The quarterly notifications as required by the Authority did not include the use of single segregation in the centre.

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

**Please state the actions you have taken or are planning to take:**
All quarterly notifications required by the Authority will now include the use of a safe room (single segregation) within the centre.

**Proposed Timescale:** 04/11/2016

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**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:
Residents did not have access to dietetic or psychology services.

13. **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:**
Following the inspection a Multi-Disciplinary Team review was undertaken which included a Dietician and Psychologist.

Referrals to MDT are made by the Person in Charge and a system is in place locally for monitoring, tracking and following up on referrals. Individual Therapy Departments operate a referral system based on prioritisation.

All referrals are acknowledged and triaged by the Therapy Department. Residents are seen within the criteria framework developed by that Therapy Department.

**Proposed Timescale:** 04/11/2016

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**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:**
Residents did not receive their medications in a timely manner.

14. **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 registered staff nurse has been rostered on duty 24/7 to ensure prompt and appropriate administration of medication

**Proposed Timescale:** 25/11/2016

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**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements in place to ensure the effective governance, operational management and administration of this designated centre were not sufficient to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

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:
Details of governance arrangements will be clearly displayed in the centre
A CNM1 has been appointed to the centre and will commence on the 12th December 2016. The Cnm1 will assume the role of PPIM

Proposed Timescale: 12/12/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not ensuring that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme:
- two staff had not attended training on management of actual or potential aggression (MAPA) with 18 staff were overdue training
- seven staff were not trained in safe manual handling and 17 staff were overdue training
- 30 staff required up to date training on the protection of the vulnerable adult
- 20 staff were due to attend training on hand washing techniques
- a number of staff spoken to by inspectors had not attended Hazard Analysis & Critical Control Point (HACCP) and safe food handling.

16. 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:
A training plan and schedule has been devised to ensure that all staff will be offered mandatory training and local training needs
A training matrix will be maintained locally and the PIC and PPIM will have oversight of ensuring training needs are met.

Proposed Timescale: 16/12/2016