Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Centre 1 - Aras Attracta
Centre ID:	OSV-0003321
Centre county:	Mayo
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Suzanne Keenan
Lead inspector:	Ivan Cormican
Support inspector(s):	Lorraine Egan
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 October 2016 10:15	12 October 2016 19:30
13 October 2016 09:30	13 October 2016 18:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 03: Family and personal relationships and links with the community
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 15: Absence of the person in charge
Outcome 16: Use of Resources
Outcome 17: Workforce
Outcome 18: Records and documentation

Summary of findings from this inspection

There are three centres on the Aras Attracta campus, Centre 1, Centre 2 and Centre 3. Following a number of inspections in 2014 and 2015, inspectors found that the provider was failing to ensure that residents had a safe and good quality services. The provider submitted a plan to the Health Information and Quality Authority (HIQA) about how it proposed to improve the services, and HIQA undertook a programme of inspection days to verify whether the actions were resulting in a positive impact in the safety and quality of service to residents. The inspection days for Centre 1 were:

- 25 February 2014
- 26 May 2014
- 24 September 2014

• 12 July 2015
• 30 March 2016

Following the initial inspection days, inspectors found that the provider was implementing their action plan but that the actions were not resulting in sufficient improvements in the quality of life for residents. Subsequently, in October 2015 HIQA required the provider to undertake its own audit of their services under regulation 23, and to submit an action plan to HIQA based on that audit. The provider was then required to repeat that audit three months later and to assess themselves on the impact of their action plan from the initial audit.

Inspectors then continued with their programme of inspection days and found that while there were still significant non compliances, the provider was making progress in relation to improving safety and quality of life of residents.

This report records the progress of the provider as found on the most recent of those inspection days in October 2016.
In general, while there continues to be areas where the provider is not yet meeting the requirements of the regulations, inspectors found that the safety and quality of life for residents had improved over the course of the inspection programme. In general, inspectors found that there had been improvements in the following areas:
• The centre had measures in place to protect residents from being harmed or suffering abuse.
• The healthcare needs of residents were being met
• Residents had been assessed to manage their own medications.

However, the provider continues to have non-compliances in the following areas:
• The social care needs of residents were not being met.
• Fire precautions within the designated centre required significant improvement.
• The centre was under-resourced to meet the assessed needs of residents.
• Improvement was required to the provision of staffing numbers, skill-mix and staff training.

These findings are set out in this report and the areas of non-compliance are included in the action plan at the end of the report.

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

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

Theme:
Individualised Supports and Care

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

Findings:
During the inspection, inspectors found that staff treated residents in a kind and caring manner, however, inspectors also found that improvements were required in relation to residents' dignity and consultation.

Inspectors spoke with staff members who indicated that advocacy was available to residents in the designated centre. Inspectors also noted that information was readily available throughout the designated centre in relation to access to advocacy. Inspectors found that information on residents' rights was also on display and available in the centre. Throughout the inspection, inspectors observed that staff spoke with residents in a very kind and caring manner. Staff were observed knocking on residents' bedrooms prior to entering and staff that were interviewed had a good knowledge of residents' personalities, likes and dislikes.

From a review of the premises inspectors found that the provider had implemented some measures to enhance residents' privacy. Inspectors found many of the residents in the designated centre shared bedrooms, with up to four residents sharing some bedrooms. This was brought to the attention of the provider on the previous inspection. Inspectors reviewed the actions from this inspection and found that the provider had put up privacy screens for some residents; however, in the main these failed to maintain all aspects of the residents' privacy and dignity. Inspectors found that these privacy screens were very clinical in nature and did not lend themselves to a homely environment. Static screens had been installed to offer some residents a more robust divide between adjacent beds. However, inspectors found that these measures had a limited impact in

respecting the dignity and privacy of residents.

Inspectors found that residents were not consulted in all aspects of the running of the centre. Inspectors observed that menus were on display in relation to the meal choice for that day, but there was no evidence to suggest that residents were consulted in the formulation of these menus. Inspectors spoke with staff members who stated that residents were not facilitated to have residents' meetings. Inspectors also spoke with staff who indicated that residents were consulted on a daily basis in regards to the daily activities. However inspectors found that personal plans lacked documented evidence of this.

The provider had systems in place for the management of complaints and found that this was effective. The designated centre also had a policy and procedures in place for managing complaints. Inspectors observed that complaints were recorded and responded to in a timely fashion, with feedback being given to the resident in relation to the outcome of their complaint.

Inspectors reviewed the management of residents' finances within the centre. Monies and recording systems which were available were found to be thorough and regularly audited. Inspectors also noted that two staff members were required to sign the removal of any residents' money from the designated centre.

Judgment:
Non Compliant - Moderate

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
There was a policy on communicating with residents. Staff were observed communicating respectfully with residents. Improvement was required to ensure residents received all required support to communicate to the best of their abilities.

An inspector read some residents' communication plans. All residents had a communication profile which briefly outlined the way the resident communicated. Two residents had communication books which contained a more comprehensive outline of the way the resident communicated. An inspector was told that communication books were identified as required to support residents to communicate in line with their individual assessed needs and that a communication book would be developed for all residents who required support to communicate.

It was not evident that residents had received all required support to communicate to the best of their abilities. Residents' communication needs had not been assessed to determine if assistive technology and aids and appliances could promote their full capabilities.

Each resident had access to radio and television. However, residents did not have access to the internet.

Information in the centre was available in an accessible format.

Judgment:
Non Compliant - Moderate

Outcome 03: Family and personal relationships and links with the community
Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:
Individualised Supports and Care

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

Findings:
Inspectors found that residents were supported to maintain relationships with family and friends. Families spoken with outlined their satisfaction with the service provided and the ways the provider and staff communicated with them. Improvement was required to the support provided for residents to develop personal relationships and links with the wider community.

Family members were invited to attend multidisciplinary meetings with the resident to discuss all aspects of the resident's care and support. There was evidence that families were kept informed and updated of relevant issues where the resident wished for their family to be involved.

An inspector spoke with family members who outlined their satisfaction with the care and support provided in the centre. Family members also spoke positively of the communication and consultation with them in regard to planning for housing options with their family member when the centre would close in a number of years. This included individual meetings with each family to discuss the resident’s and family’s preference regarding the location of the house the resident would move to in the future. Furthermore, a family forum had been established in 2015 to communicate with all families, and this included the input of an external rights-based advocacy service.

Residents could meet with visitors in a private visitors’ room, in their bedrooms or in the communal areas.

Some residents spent time with family and friends external to the centre. These visits and outings were facilitated by residents' family members and friends where residents required support. The centre also provided some staff support and transport.

There was no assessment of residents' wishes to develop links with the community. Although some residents were supported to access the community, this depended on staff availability. Inspectors were told this area would be developed when transition plans were formulated for residents. However, only two residents living in the centre had a transition plan in place at the time of inspection, as the remainder of residents would not be moving from the centre for a number of years.

Judgment:
Non Compliant - Moderate

Outcome 04: Admissions and Contract for the Provision of Services
Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

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

Findings:
There were policies and procedures in place for admitting residents, including transfers, discharges and the temporary absence of residents.

Inspectors were told the centre had ceased admitting new residents to the centre. However, the provider nominee stated that residents could be transferred between the three centres on the Aras Attracta campus. Improvement was required to the procedures for admitting residents to the centre. This is documented in outcome 5.

Residents had service agreements. Inspectors viewed a sample of these and found that the service provided was as stated in the agreements. The agreements stated that the fee charged was detailed in the attached appendix, however of the sample of four agreements viewed, only one had an appendix attached to the service agreement. The fee charged to each resident was therefore not stated in these service agreements.

Inspectors found aspects of the service agreements were not factually accurate. For example, they stated hairdressing was provided but inspectors found residents paid for this service. In addition, the arrangements for the collection and deduction of residents' social welfare detailed in the service agreements were not consistent with the practice which was outlined to inspectors by the provider nominee and evident in bank statements.

Judgment:

Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
During the inspection, inspectors found that improvement was required in relation to the assessment and provision of social care for residents. Although some plans had been developed, the plans were not adequately comprehensive and were not implemented for all residents.

A comprehensive assessment of residents' personal and social care needs had not been carried out. Residents' plans were health and activity focused, and it was therefore not evident how the identified goals contributed to the holistic care and support of residents. For example, residents with a diagnosis of dementia did not have care plans outlining the support required and some residents who required support with sensory integration did not have a corresponding plan in place.

Staff held specific roles and responsibilities in supporting residents, for example nursing staff were responsible for providing clinical care and 'activity' staff were responsible for providing opportunities for residents to participate in activities. Staff were knowledgeable of residents' needs under their remit. However, all aspects of residents' health, personal and social care needs were not known by all staff. It was therefore not evident that all opportunities to provide holistic care were identified and implemented. For example, some residents benefitted from water-based therapy to fulfil their sensory needs. However, bathing residents was not used as an opportunity to meet these needs.

Residents had documented goals for 2016. However, the majority of goals comprised of once-off activities or events, for example an outing or birthday party, and some residents' goals differed in different folders in the centre. The achievement of these goals was not documented. It was not evident if the goals were contributing to an improved quality of life for residents as the effectiveness was not assessed and the achievement of goals was not maintained for all residents.

In the weeks prior to the inspection a resident had been admitted to the centre from one of the other centres on the campus. It was stated by staff and the provider nominee that this centre was a more suitable setting for the resident in regard to the layout of the premises and staffing skill-mix. The inspectors found that a transition plan had been developed. An inspector viewed the transition plan and found it did not contain all required information and failed to identify a significant area of importance for the resident. As a result this had a negative impact on the resident and other residents living in the centre.

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):
No actions were required from the previous inspection.

Findings:
During the inspection, inspectors found that the premises was clean, warm and had spacious living areas. However, inspectors also found that the premises lacked sufficient fire doors to promote the safe evacuation of residents in the event of a fire occurring. This will be discussed under Outcome 7. Inspectors also found that the premises did not support the dignity of all residents in the centre, as discussed in Outcome 1.

The designated centre comprised of two units within a large premises of a congregated setting. Both units were in close proximity to each other and shared a common entrance. The units were home to 38 residents, with one respite bed also available. One unit was home to 17 residents and contained one respite bed. This unit had communal areas, a separate newly installed kitchen, and number of single and shared bedrooms. The second unit was home to 21 residents and was divided into three wings with a central kitchen area. Each wing had a large communal area and separate visitors' room. Again, in this unit there were a number of single and shared bedrooms.

Inspectors found that communal areas within the designated centre required attention with paint flaking in some areas. Inspectors also found that the communal areas lacked suitable soft furnishings. Inspectors also found that some residents' bedrooms lacked personal touches such as photographs and achievements.

Inspectors noted that the centre was well equipped with suitable aids and appliances

such as hoists and high-low beds, including pressure relieving mattresses, all of which were regularly serviced.

Judgment:
Substantially Compliant

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

Theme:
Effective Services

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

Findings:
During the inspection, inspectors reviewed a sample of documentation in relation to fire precautions within the designated centre, such as personal emergency egress plans (PEEP), fire drills, fire evacuation plans, fire risk assessments, fire risk registers and maintenance records of fire equipment. Inspectors also discussed fire precautions with the provider nominee, nurse managers and staff on duty.

Inspectors found that significant improvements were required in relation to fire precautions within the designated centre. These improvements had been highlighted with the provider on previous inspections and recommendations to address these issues had also been detailed in a report generated by a fire consultant. Inspectors found that not all recommendations of this report had been implemented by the provider, such as the installation of fire doors to allow for the compartmentalisation of various areas of the designated centre in the event of a fire.

Inspectors reviewed fire drills which were occurring regularly within the designated centre and found residents were not being fully evacuated from the designated centre. Inspectors found that each resident had a PEEP in place which listed the staffing resources needed to evacuate that resident safely. While the PEEPs indicated the level of staffing required to support residents to evacuate by using a red amber green system, they did not include information about the individual factors, behaviours that challenge or the residents' differing support needs due to a day or night-time evacuation.

In light of the above findings, inspectors issued the provider with an immediate action on the first day of inspection. Inspectors asked the provider to ensure that all residents could be evacuated from the designated centre in the event of a fire occurring. As such, the provider carried out a complete evacuation of the centre. Following the inspection, the provider also carried out a night-time fire drill. After the inspection, the provider submitted an action plan in response to the concerns raised by inspectors. The provider also employed a suitable qualified person to carry out an audit of fire precautions and

evacuation procedures within Centre 1 – Aras Attracta.

The centre had implemented risk management procedures. Inspectors noted that risk assessments were implemented for issues such as restrictive practices, health and safety, and environmental risks. Risk assessments were regularly reviewed and adjusted. However, inspectors noted that some improvements were required in relation to fire risk assessments.

Inspectors reviewed a sample of accident and incident forms which showed that management and staff were actively responding to incidents within the centre. Inspectors noted that managers of the centre met on a regular basis to monitor and review all incidents in the centre.

Judgment:
Non Compliant - Major

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:
On the day of inspection, inspectors found that the designated centre had measures in place to protect residents being harmed or suffering abuse. The actions from the previous monitoring inspection had been partially addressed with some improvements noted to the use of restrictive practices within the centre. However, inspectors found that more improvements were required in relation to the use of chemical restraint for some residents.

Inspectors spoke with a number of residents who indicated that they felt safe in the designated centre. Inspectors observed warm interactions between residents and staff, and on occasions observed residents and staff laughing and sharing a joke. Inspectors reviewed a sample of residents' personal plans. Inspectors found that, where needed, residents had safeguarding plans, risk assessments and positive behavioural support plans. Staff spoken with by inspectors had a good understanding of these documents. Staff could also clearly account for situations which may be considered abusive in nature

and the procedures to be followed to ensure the safeguarding of residents. Information on the reporting of abuse was also on display for residents, visitors and staff at various points throughout the designated centre. Inspectors noted that the provider had a designated officer in place for the safeguarding of residents and a clinical nurse specialist for the implementation of behavioural support plans.

Inspectors found that where restrictive practices were in place residents had the necessary risk assessments and behavioural support plans, which had been formulated through a multidisciplinary process. Inspectors noted that both risk assessments and behavioural support plans had been recently reviewed in relation to restrictive practices.

However, inspectors also found that some improvements were required to the use of chemical restraint. Inspectors reviewed documentation that stated that a resident had at one stage been administered a chemical restraint. Inspectors noted that the resident did not have a behavioural support plan in place or an underlying mental health diagnosis which required the use of the administered medication. However, a referral had been made to the behavioural support team, for this resident, in relation to the use of chemical restraint prior to the monitoring inspection.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
During the inspection, inspectors found that the best possible health of residents was promoted within the designated centre. However, inspectors noted that some minor improvements were required in relation to residents' care plans.

Overall, inspectors found that there was a consistent level of care delivered to residents within the designated centre which was nurse led. Inspectors reviewed a sample of residents' personal plans which contained detailed medical histories and, where necessary, an associated health care plan. Inspectors noted that these healthcare plans were regularly reviewed to meet the changing needs of residents. Residents with skin integrity needs had appropriate risk assessments in place. Inspectors also noted that residents with mobility issues had been assessed by the occupational therapist in relation to the use of hoists and mobility aids. However, inspectors found that one care plan stated that a resident's blood pressure should be monitored daily. Inspectors found

that this was not the case and in some instances the resident's blood pressure had not been taken for nine consecutive days.

Inspectors noted that residents were regularly reviewed by the general practitioner. Residents also had access to allied health professionals such as speech and language therapists, occupational therapists, physiotherapists and dieticians. Care plans were readily available to support residents who had difficulty when swallowing and who also required specialised diets in response to their medical needs.

Inspectors found that residents, who required the care of mental health professionals, regularly attended mental health clinics. Residents were also supported to receive care from specialists such as gastroenterology, ear, nose and throat and urology.

Inspectors observed that the meals which were available to residents appeared nutritious and appetising. Modified diets were available to those residents who required these diets.

Judgment:
Substantially Compliant

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

Theme:
Health and Development

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

Findings:
During the inspection, inspectors found that the designated centre had policies and procedures in place for the management of residents' medications. Inspectors noted that there were improvements required in relation to prescription sheets used with the centre.

A sample of residents' prescription sheets and administration records were reviewed by inspectors. Prescription sheets contained relevant information such as residents' names, known allergies and date of birth. However, inspectors found that some prescription sheets contained unclear information in relation to the medications prescribed. Medications for one resident were charted as twice daily, yet the morning medication administration time had been crossed out. Some medications were charted as one or two tablets to be administered at 22:00, but inspectors found that one tablet had been administered at 22:00 and another at 01:30. Inspectors also noted that 'as required' medication for the treatment of epilepsy had no indications for its use detailed on the prescription chart.

Both pharmacy staff and nursing staff were carrying out regular audits of medications within the designated centre. Two non-nursing staff had also been trained in the safe administration of medications. Although these staff had not administered medications prior to the monitoring inspection, it was planned for the near future. Residents had also been assessed to self-administer medications. On the day of inspection no residents were self administering medication, however, one resident had been recently identified as wishing to manage their own medications.

Judgment:
Substantially Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
During inspection the designated centre had a statement of purpose in place. Inspectors found that some improvements were required in relation to this document.

Inspectors found that for the most part, the statement of purpose described the service being delivered in the designated centre. However, inspectors noted that the statement of purpose needed revision to clarify:
- the extent of complex needs that the centre can cater for
- age criteria of residents
- the review of residents' personal plans in light of any changes to the residents' support needs
- the arrangements for residents to attend education, training and development
- the use of personal emergency egress plans and the availability of emergency lighting

Judgment:
Substantially Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure

that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:
During the inspection, inspectors found that overall the designated centre had effective governance management structures in place. However, inspectors noted that the provider had failed to respond to a fire risk management report which highlighted issues as discussed in Outcome 7.

During the inspection, the person in charge was not present. Inspectors found that the provider nominee had detailed knowledge of both residents and staff in the designated centre. They had carried out three-monthly reviews of the quality and care provided within the designated centre. The last three-monthly review, which had been recently carried out, focused on areas such as staffing levels, residents' families, quality improvement, notifications, safeguarding and complaints. The review also generated an action plan and had been monitored for improvement since the previous review. However, inspectors noted that the annual review of the quality and safety of care and support in the centre had not been carried out.

Inspectors found that regular team meetings were taking place and that support and supervision was taking place for management within the centre. Planned support and supervision was due to commence with all staff by the end of the year. Inspectors noted that night staff were also supported by a night-time supervisor who was available in the event of an emergency.

Judgment:
Non Compliant - Moderate

Outcome 15: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The person in charge had not been absent from the centre for a period which would require HIQA to be notified. The person in charge was absent from the centre on the days of inspection due to planned leave.

Persons participating in the management of the centre were identified as the persons who would manage the centre in the absence of the person in charge. These managers were present on the days of inspection and were responsible for the running of the centre.

Inspectors found these persons worked in the centre on a day-to-day basis and were knowledgeable of the care and support needs of residents. They also provided support and guidance to staff working in the centre.

Judgment:
Compliant

Outcome 16: Use of Resources
The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:
Use of Resources

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

Findings:
During the inspection, inspectors found that the designated centre was under-resourced to meet social needs of residents.

As discussed in Outcome 17, inspectors found that although the centre was adequately resourced to meet the healthcare needs of residents, it was under-resourced to meet the social needs of residents. Inspectors were informed that a recently deployed activation team had been tasked with providing personal care and assistance with meal times. Inspectors noted that these tasks were carried out by this team, instead of providing social supports for residents. This left each resident with approximately 12 minutes each day of social supports. Inspectors interviewed staff who indicated that it was difficult to facilitate the social needs of residents due to the current staffing arrangements. Staff also suggested that they were unable to attend mandatory training due to on-going staff shortages.

Judgment:
Non Compliant - Major

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

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

Findings:
Staff working in the centre on both days of inspection were observed providing care and support for residents in line with their assessed needs. However, due to staff shortages, there was a focus on the provision of task based care. Improvement was required to the provision of staffing numbers and skill mix in the centre and the provision of training for staff. In addition, the provider was required to take immediate action in relation to Garda vetting on the day of inspection.

Staffing numbers and skill mix:
It was not evident the staff numbers and skill mix were adequate to meet the needs of all residents. Although basic care and support needs were met, and there were some residents receiving individualised support on a daily basis, there were inadequate staff numbers to ensure all residents' needs were met.

Inspectors observed that staff employed to engage in activities with residents were required to provide care and support for parts of the day. In addition, staff shortages and staff sick leave resulted in these 'activity' staff being redeployed as health care assistants to ensure residents' care and support needs were met and to ensure residents' medical appointments were facilitated.

An analysis of the required staffing levels and skill mix had been carried out for individual residents with a view to ascertaining the staffing needs of residents when residents would move out of the centre in the coming years. However, inspectors were told an analysis of the required staffing levels and skill mix had not been carried out in the centre. Inspectors found that, due to staffing levels, the majority of care provided to residents living in the centre was task based throughout the days of inspection.

Staff supervision:
The supervision of staff working in the centre remained informal. However, inspectors noted there was a clinical nurse manager present in the centre to provide support to staff on a daily basis. Staff spoken with stated the managers were accessible and that all concerns were brought to their attention. The formal supervision and support system as outlined in the previous action plan had not yet commenced in the centre. Inspectors

were told the training for managers was taking place and that the system would be implemented following this.

Staff files:
An inspector reviewed a sample of staff files and found they did not contain all information required by the regulations. For example, the work the person performed in the centre and date on which the employee commenced employment.

In addition, one staff file did not contain a copy of Garda vetting. A letter contained in the file referenced a Garda vetting which, it stated, had been obtained and was stored in the provider's head office. This was brought to the immediate attention of the provider nominee who stated they would get a copy of the Garda vetting and carry out a review of all staff files to ensure all staff had evidence of Garda vetting on file. The provider was required to submit a written response outlining the measures taken to ensure all staff working in the centre had Garda vetting. The provider nominee confirmed that no staff members would commence work in the centre until Garda vetting was received.

Some staff working in the centre were employed by external organisations. The provider had implemented a system to ensure that the information specified in Schedule 2, for example evidence of Garda vetting and appropriate training, was in place for these persons. This information was emailed to the provider nominee prior to these persons working in the centre. An inspector viewed the file of a staff member employed by an external organisation and found that all information required was in place.

Staff training:
Inspectors viewed training records and found that some staff had not received all required training. This included training in manual handling (7% of staff) and training in responding to behaviour that is challenging including de-escalation and intervention techniques (48% of staff).

The reason outlined to inspectors for staff not having received training was staffing shortages, which prevented staff from attending scheduled training events.

Staff rota:
An actual and planned staff rota was maintained in the centre. The rota contained details of the staff who were working in the centre. This included staff names, roles, start and finish times and reasons for absence, where applicable.

Judgment:
Non Compliant - Major

Outcome 18: Records and documentation
The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational

policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:
Use of Information

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

Findings:
During the inspection, inspectors found that some improvement was required in relation to documents required as per Schedule 2 of the regulations as mentioned in Outcome 17.

Overall, inspectors found that documentation was present in the designated centre to support staff in the delivery of care to residents. Inspectors also noted that due to the extent and retention of documentation, care plans were difficult to find and on occasion there were multiple copies of care plans and more than one file for each resident. At one point, two staff members were asked for a specific care plan for a resident. Both staff indicated that the care plan may be located in different files and as such appeared confused as to where the care plan should be located.

Judgment:
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:

Ivan Cormican
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Health Service Executive
Centre ID:	OSV-0003321
Date of Inspection:	12/13 October 2016
Date of response:	27 March 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 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 failed to ensure that residents were actively consulted in the running of the designated centre.

1. Action Required:
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted

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

and participates in the organisation of the designated centre.

Please state the actions you have taken or are planning to take:
· Individuals who use the service will be actively involved in the monthly house/unit resident meetings to commence in January, 2017. This will ensure residents exercise choice and control in their daily lives and documented evidence will be recorded by way of minutes. Residents will be supported by the SALT to optimise communication and best outcomes.

· Management will liaise with catering to work to ensure planned consultation with residents in the formulation of menus going forward.

· The activities co-ordinator will work with residents and staff to ensure there is documented evidence on each resident's file reflecting consultation with regard to daily activities.

Proposed Timescale: 31/01/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the dignity of residents was promoted in the designated centre.

2. 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:
· As the Service is now in a transitory phase it is the planned goal of Centre 1 to reduce resident numbers by moving residents into the transitional social care houses on site as they become available, there will also be two residents transferring out into the community this year which will reduce the number of 4 bedded areas from 3 to 1. This will enhance the privacy and dignity for other residents living in centre 1. Transitional plans are in place for the two individuals moving to their own localities and families are involved.

· Static screens are in place to enhance dignity and privacy of residents and the natural transition process will further promote personal privacy and space as 2 residents are planned for transition to community. Within this transitional plan, residents will have the privacy of their own room or be given the decision to choose if they wish to share.

· Individualisation of personal space with personal effects is ongoing and will be completed by 31st March, 2017.

Proposed Timescale: 31/03/2017

Outcome 02: Communication

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have access to the internet in the centre.

3. Action Required:
Under Regulation 10 (3) (a) you are required to: Ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.

Please state the actions you have taken or are planning to take:
· Each resident has access to radio and television.
· Although there is no WIFI access onsite, all residents will have a personal tablet computer by 28 February, 2017 to ensure access to media and optimise communication.
· A number of residents like to use mobile phones and they can access the internet by this medium also.

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:
Residents were not facilitated to access assistive technology and aids and appliances to promote their full capabilities.

4. Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
· A full internal audit of all communication plans is currently under way and will consider all required support for residents to communicate to the best of their abilities.
· A full comprehensive communication action plan will emanate from this to incorporate what assistive technology and aids and appliances could be used to promote their full capabilities.

Proposed Timescale: 30/04/2017

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident that all residents were assisted and supported at all times to communicate in accordance with residents' needs and wishes.

5. Action Required:
Under Regulation 10 (1) you are required to: Assist and support each resident at all times to communicate in accordance with the residents' needs and wishes.

Please state the actions you have taken or are planning to take:
· Two residents have communication passports. A body of work will commence in the centre in January, 2017 led out by the SALT to roll out Communications Passports for all residents in the centre to ensure that everyone who engages or works with a person knows how the person prefers to communicate.

· Pictorial choice boards have been developed and will roll out to all residents where the SALT assessment deems that this will support communication. These aids support individual resident's social choice which will be displayed on a daily basis. Pictorial communication aids will also support communication at resident's meetings going forward.

· The centre is developing LAMH initiatives for example "Sign of the Week", communication passports, talking mats, pictorial choices in areas like the restaurant with input from the Speech and Language Therapist who hosts a weekly learning event for staff and residents to achieve competency in optimal communication. This is being included in the unit induction process for all staff.

· Residents will be supported by the SALT to optimise communication and best outcomes.

Proposed Timescale: 30/04/2017

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Supports to develop personal relationships and links with the wider community not been provided for all residents.

6. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.

Please state the actions you have taken or are planning to take:
· A wheelchair accessible vehicle available for use at all times in the centre and we also have 19.5 hrs per week wheelchair accessible transport available to us from a volunteer with a driver. We also have access to independent community transport to promote social inclusion. In addition we have acquired a new vehicle exclusively for the use of centre 1.

· The services transport insurance policy now supports the driving of HSE transport by contracted non HSE staff following an induction process. These actions have supported the residents to engage more with their localities.

· An SSDL trained social care staff member and the transition team is engaged in the development of meaningful days with individuals currently residing in the centre. Documented evidence of these interventions and action plans will be in place commencing 09/01/2017. Staffs who are currently undergoing SRV and SSDL training are currently working with individuals to put resident's wishes into action.

· Promotion of the Volunteer Service in Centre 1 has allowed us to match some of our residents with appropriate volunteers in the community with skills, interests and qualities to suit resident's needs and to enhance social engagement.

· A number of residents will go on holiday this year from February, 2017. Holidays of choice will roll out throughout the coming year for any resident who wishes to do so.

Proposed Timescale: 28/02/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some parts of the agreements for the provision of services were not factually accurate and the fees to be charged were not detailed.

7. Action Required:
Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

Please state the actions you have taken or are planning to take:
· Currently the contract for the provision of services is under review. The fees charged to the residents will be clearly identified and added to their contract. The new contracts will be available and issued to all individuals.

Proposed Timescale: 31/01/2017

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 comprehensive assessment of the personal needs of a resident was not carried out prior to admission to the designated centre.

8. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
All assessments of the personal needs the resident have now been carried out, transfer and admission documentation are now completed.

Proposed Timescale: Complete 31st December, 2016

Proposed Timescale: 31/12/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessment, by an appropriate health care professional, of the personal and social care needs of each resident was not carried out as required to reflect changes in need and circumstances.

9. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
· A complete audit of all of the assessments that have been completed was carried out. Any outstanding assessments will be completed.
· In addition a Supports Intensity Scale Assessment of Need was completed in 2015 for all residents in the centre and additional profiling support work has been completed in preparation for the move from the campus.

Proposed Timescale: February, 2017

Proposed Timescale: 28/02/2017

Theme: Effective Services

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

10. 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:
· A complete audit of all of the assessments that have been completed is being carried out to assess the effectiveness of each personal plan and take into account changes in circumstances and new developments.

Proposed Timescale: 30/03/2017

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the centre had suitable soft furnishings and was suitable decorated.

11. Action Required:
Under Regulation 17 (1) (c) you are required to: Provide premises which are clean and suitably decorated.

Please state the actions you have taken or are planning to take:
· Since the inspection, work continues on providing suitable soft furnishings and decoration in all residents' bedrooms and communal areas are decoratively upgraded.
· Since inspection a significant program of painting, decorating and grounds work has been completed. Further paint work is required and to be completed in the specified time frame.

Proposed Timescale: 30/04/2017

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The provider failed to ensure that all control measures were listed on fire risk assessments and that staff were suitably informed of these control measures. The provider also failed to ensure that all recommendations of a report generated by a fire consultant had been implemented in the designated centre.

12. 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:
· All control measures are now listed on fire risk assessments and that staff are suitably informed of these control measures.

· All recommendations of a report generated by a fire consultant are being implemented in the designated centre. A system is in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

· A further risk assessment of the service has been completed by a competent person. Estimates have been submitted and are awaiting approval at a national level. However it is envisioned that some of the individuals currently residing in this Centre will transition off the campus. The service has upgraded the fire alarm system to enhance the detection of fire, all staff has a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire. Deep sleep fire evacuations have been completed and the fire policy has been updated.

Proposed Timescale: 06/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that staff were guided by individualised personal emergency egress plans.

13. 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:
· PEEPs have been updated for all residents to reflect the individual needs of each person. The fire policy has also been updated to ensure optimal fire safety management (October, 31st, 2016).
· Education piece to be done with residents around fire and fire safety and the evacuation process lead by Speech and Language Therapist (31st March, 2017).

· The Fire Service have visited residents and management will continue to engage with the Fire Service arranging visits at intervals to alleviate fears and anxieties and improve the evacuation process.

Proposed Timescale: 31/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that fire doors were in place for the containment of fire.

14. Action Required:
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
· Fire Doors and compartmentalisation funding request has been submitted nationally. The service expects to be in receipt of funding and for this work to be completed within the proposed time scale.

Proposed Timescale: 06/05/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that all residents could be evacuated from the designated centre and brought to an area of safety.

15. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
· A further risk assessment of the service has been completed by a competent person. There is some emergency lighting in place but it does not meet with current regulations. Estimates have been submitted and are awaiting approval at a national level (7th May, 2017).
· The service has upgraded the fire alarm system to enhance the detection of fire, all staff have now have torches, a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire by day and by night.
· Deep sleep fire evacuations have been completed, PEEPs have been updated for all individuals to reflect this and the fire policy has been updated (October, 31st, 2016).

Proposed Timescale : 6th May, 2017

Proposed Timescale: 06/05/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that emergency procedures were clearly displayed and stated where residents were to be evacuated to.

16. Action Required:
Under Regulation 28 (5) you are required to: Display the procedures to be followed in the event of fire in a prominent place or make readily available as appropriate in the designated centre.

Please state the actions you have taken or are planning to take:
· Revised emergency procedures are clearly displayed and state where residents were to be evacuated to.
· A further risk assessment of the service has been completed by a competent person.
· The service has upgraded the fire alarm system to enhance the detection of fire, all staff have now have torches, a panic alert and pager system which is checked regularly and will provide an additional alert to staff in the event of a fire.
· There are adequate numbers of staff available to evacuate residents in the event of fire by day and by night.
· Deep sleep fire evacuations have been completed with all residents in this centre.

Proposed Timescale: Complete November, 30th, 2016

Proposed Timescale: 30/11/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that chemical restraint used within the centre was administered in line with best practice.

17. 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:
All medication prescribed and administered and used within the centre is administered in line with best practice.

Proposed Timescale: Completed December 31st , 2016

Proposed Timescale: 31/12/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the care requirements of residents were carried out as detailed in their healthcare plans.

18. 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:
· Since the inspection all changes in residents' healthcare needs and their nursing care plans have been reviewed and updated. All care provision and practice is carried out ad detailed in healthcare plans.

Proposed Timescale: Completed 14th October, 2016

Proposed Timescale: 14/10/2016

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:
The provider failed to ensure that appropriate prescription sheets were maintained within the designated centre.

19. 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:
· Medication audits to include revision of prescription sheets have been carried and are available with actions in the centre.

Proposed Timescale: Complete 31st December, 2016

Proposed Timescale: 31/12/2016

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the statement of purpose accurately reflected to service being delivered in the designated centre.

20. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
· The extent of complex needs that the centre can cater for, e.g
Age criteria of residents
· The review of residents' personal plans in light of any changes to the residents' support needs
· The arrangements for residents to attend education, training and development
· The use of personal emergency egress plans and the availability of emergency lighting.

Proposed Timescale: 31/01/2017

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to carry out an annual review of the quality and safety of care and support in the designated centre.

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

Please state the actions you have taken or are planning to take:
· The Annual review is currently being completed and there will be a report on the Centre from January 1st 2016 until December 31st 2016.

Proposed Timescale: 14/02/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that designated centre was safe in terms of fire precautions.

22. 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 remaining actions from the audits are being implemented in relation to fire precautions.
· A further risk assessment of the service has been completed by a competent person.
· Estimates have been submitted and are awaiting approval at a national level.
· The service has upgraded the fire alarm system to enhance the detection of fire, all staff have a panic alert and pager system which is checked regularly and will alert staff in the event of a fire. There are adequate numbers of staff available to evacuate residents in the event of fire.
· Deep sleep fire evacuations have been completed and the fire policy has been updated.

Proposed Timescale: 06/05/2017

Outcome 16: Use of Resources

Theme: Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the designated centre was adequately resourced to meet the social care needs of residents.

23. Action Required:
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
On the dates of the inspection there were a number of staff on unplanned leave. The HR department have been working extensively with the management of the centre to address and reduce any attendance management issues. As a result this reduced the centres ability to adequately meet the social care needs of the residents on the day of the inspection. In addition there have been challenges in the retention and recruitment of staff, which makes this centre reliant on agency staff. The appointment of new care

assistants who are currently going through the recruitment process will assist with this process and ensure that the centre is adequately resourced at all times to ensure that the social care needs of the residents are meet at all times.

Proposed Timescale: 30/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not evident the number and skill mix of staff was appropriate to the number and needs of residents.

24. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
On the dates of the inspection there were a number of staff on unplanned leave. The HR department have been working extensively with the management of the centre to address and reduce any attendance management issues. As a result this reduced the centres ability to adequately meet the social care needs of the residents on the day of the inspection. In addition there have been challenges in the retention and recruitment of staff, which makes this centre reliant on agency staff. The appointment of new care assistants who are currently going through the recruitment process will assist with this process and ensure that the centre is adequately resourced at all times to ensure that the social care needs of the residents are meet at all times.
The appointment of new care assistants who are currently going through the recruitment process will assist with this process.

An independent needs assessment has been completed with all residents in this centre. It has identified the support needs of all individuals. The service is working towards ensuring that the skill mix meets the support needs of all individuals residing in the centre. The service has ceased the recruitment of some grades of staff and increased the recruitment of other grades to ensure that the skill mix is appropriate and meets the needs of the individuals.

Proposed Timescale: 30/06/2017

Theme: Responsive Workforce

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

staff.

Evidence of Garda vetting was not in place for one staff member.

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

Please state the actions you have taken or are planning to take:
· Since the inspection a full audit of the Schedule 2 information is underway for Centre 1. All Schedule 2 information is now on file for all staff working in Centre 1.
· All staff working in Centre 1 have been Garda vetted. A vetting form for 1 staff member in Centre 1 who is currently on long term leave was not on file, but there was clear evidence that this person had been through the HSE Garda Vetting process and that there were no concerns.
· A new Garda Vetting form has been sent to the individual for completion and processing.

Proposed Timescale: 31/03/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff had not received required training. For example, training in responding to behaviour that is challenging, including de-escalation and intervention techniques and manual handling.

26. 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 formal training needs analysis is being conducted for all outstanding staff to be released for training in responding to behaviour that is challenging, including de-escalation and intervention techniques and manual handling and any outstanding mandatory training. Outstanding training is expected to be complete by 31st May, 2017

Proposed Timescale: 31/05/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The formal staff supervision system had not yet commenced in the centre.

27. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
· Formal Support and Supervision training has been rolled out with all senior and middle managers. Information sessions have also been conducted with frontline staff.
· Initial learning support and supervision sessions are being completed by managers before the 23rd of January.
· Formal support and supervision will be rolled out with all grades of staff quarterly or more often as needs arise.
· In addition the service is also developing a service specific policy in the area of Support and Supervision.

Proposed Timescale: 30/04/2017