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<td>Provider Nominee:</td>
<td>Colin McIlrath</td>
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<tr>
<td>Lead inspector:</td>
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<td>Support inspector(s):</td>
<td>Thelma O'Neill</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.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

The inspection took place over the following dates and times
From: To:
19 January 2017 09:00 19 January 2017 19:00
20 January 2017 09:00 20 January 2017 16:00

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 10: General Welfare and Development |
| Outcome 11: Healthcare Needs |
| Outcome 12: Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |

Summary of findings from this inspection
Background to the inspection:

Following ongoing failure by the provider to address areas of non compliance which were impacting on the safety and quality of life for residents, HIQA issued the provider with a Notice of Proposal to cancel the registration of the centre on 6 December 2016. As allowed for in the Health Act 2007 (the Act), the provider made representation to the chief inspector setting out the actions that had been put in place to respond to the grounds for proposing to cancel their registration. The purpose of this inspection was to verify whether the actions taken by the provider had been implemented, were effective in improving the safety and quality of life for residents and to inform a final decision by HIQA on the registration of the centre.
As part of this inspection, inspectors reviewed the proposed actions as detailed in the provider’s representation response to the notice of proposal to cancel their registration for this centre. These actions will be discussed throughout the report. Inspectors also reviewed the 27 actions the provider had undertaken since the previous inspection. Inspectors found that 10 of these actions had not been addressed in line with the provider's response and remained non-compliant on this monitoring inspection.

How we gathered our evidence:
As part of the inspection, inspectors met with eight residents in the designated centre. Inspectors met with several staff members, including the chief operations officer and the person in charge. Inspectors observed interactions between residents and staff and work practices. Documentation such as personal plans, risk assessments, medication records, healthcare plans and emergency planning within the centre was also reviewed. Inspectors also met with six staff members, the clinical nurse manager, the quality partner and the chief operations officer.

Description of the service:
The designated centre comprised a single story dwelling that accommodated up to twelve residents. Each resident had their own self contained studio apartment which had an en-suite bathroom. The centre had an adequate amount of shared bathrooms and toilets, which were equipped to cater for the needs of residents. There were also adequate communal rooms available for residents to have visitors, such as family and friends. The designated centre was located within walking distance of a large town where public transport such as buses and taxis were available. Some residents provided their own transport, which they used to access the local community. The designated centre also provided transport for residents.

Overall judgment of our findings:
The inspector found that while some aspects of the provider’s representation had been implemented, critical aspects in relation to the governance and oversight of the centre had not been implemented. As a result, the provider was not identifying areas of service that required improvement. For example, while the specific healthcare risks that inspectors identified on the previous inspection had been mitigated, inspectors identified further healthcare risks on this inspection. There continued to be issues in relation to the support of residents and the provider still did not have a plan to address these issues. In addition, other areas of non compliance related to ongoing staffing issues and to safeguarding arrangements such as ensuring all staff had Garda vetting.

Inspectors did note improvements in a number of areas such as arrangements in relation to the complaints procedures and improvement in the consultation with residents.

These failings are further detailed in the body of the report and Action Plan at the end
Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Findings:
On previous inspections, inspectors found that the provider had not put adequate arrangements in place to enable residents or interested parties to make complaints, and did not have sufficient arrangements in place to respond to those complaints.

In the representation in response to the notice of proposal to cancel their registration, the provider set out actions that they had taken to address this aspect of the service. On this inspection, the inspector found that they had implemented those actions and the arrangements for making and responding to complaints was now clearer.

Inspectors found that staff interacted in a warm and caring manner with residents throughout the inspection process. Residents who met with inspectors also complemented staff and the care that they receive.

Judgment:
Compliant

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

**Findings:**
On the day of inspection, inspectors found that residents' communication was promoted within the designated centre. On the previous inspection, inspectors found that residents’ communication plans did not support residents to effectively communicate. Following the previous inspection, the provider had effectively implemented a review of the communication needs for all residents with the support of a speech and language therapist. On this inspection, inspectors found that the updated communication plans supported the residents to communicate.

**Judgment:**
Compliant

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

**Findings:**
On the previous inspection, inspectors found that there was poor support for residents to engage in social and community activities that were meaningful to residents.

- In their representation, the provider stated that they would ensure that residents have opportunities to increase their levels of community access during quarter one 2017 according to their wishes.

The inspector found that insufficient progress had been made on this action at the time of the inspection.

While residents, who had support from personal assistants, families and friends, enjoyed a range of activities, other residents had minimal opportunity to engage in activities, most of which appeared to occur in the designated centre. One resident's activities for one given week were to watch television and listen to music on Saturday and Sunday, with the rest of the week left blank. Another resident had their activities listed as having a visit from a friend on Friday and a family visit on Saturday, with no other activities listed for the remaining days. These residents both indicated to inspectors that they would like to get out more in the community for music and sporting events.
Judgment:
Non Compliant - Major

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

Findings:
A sample of residents care plans were reviewed which revealed that some residents did not have written agreements or tenancy agreements in place, as required by the regulations. This area of non-compliance was also highlighted on the previous inspection. Inspectors also found that where there were written agreements; they did not reflect the current service provision. The written agreements stated that tailored supports will be available to implement residents' personal plans and that supportive connections with the community will be maintained. Inspectors noted that current arrangements within the service failed to meet these aspects of some residents' written agreements.

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:**
On previous inspections, inspectors found that the person in charge had not ensured that residents were appropriately supported and that there was an inadequate assessment and individual planning process for residents.

In their representation, the provider informed HIQA that key worker staff support had been implemented, that an initial assessment of support had been conducted and that a full assessment of support for each resident would be completed by 15 February 2017.

Inspectors found that the initial assessment of support had been completed but that there had been minimal progress on implementing the outcomes of that assessment. Inspectors also found that there had been minimal progress on conducting the full assessment of support. Where plans for residents had been identified, it was not clear who would support the resident to achieve them and there was inadequate progress on implementation.

The lack of progress in taking action to provide appropriate support to residents was having a negative impact on the quality of life of residents. For example, some residents continued to have no planned or meaningful day time activities during the week, either in the centre or in the local community. Weekend plans for these residents focussed on watching television or listening to the radio. In another example, a resident who had a plan to go shopping with a personal assistant on the day of inspection in order to buy food for the week. The personal assistant was unable to attend the centre and no contingency plan was put in place to support the resident with their shopping.

**Judgment:**
Non Compliant - Major

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### 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

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

**Findings:**
On the day of inspection, inspectors found that the premises met the assessed needs of residents. The actions from the previous inspection were addressed with up-to-date
service records available for residents' wheelchairs.

The designated centre comprised 12 self-contained apartments. Inspectors found that each apartment promoted the independence of residents and was readily accessible. Residents' apartments had an en-suite bathroom, small kitchenette available and suitable amounts of storage. Inspectors found that the centre was warm, clean and suitably decorated throughout. Inspectors found that each apartment had individual access, which promoted the independence of residents.

The centre was warm and suitable furnished throughout. Maintenance were also on-site decorating and painting a vacant apartment on the day of inspection. A suitable amount of reception rooms were available, which residents could use to meet family and friends. The centre was also suitable equipped with hoists and mobility aids to meet the needs of residents. Inspectors found that this equipment was appropriately serviced.

Judgment:
Compliant

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

Theme:
Effective Services

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

Findings:
The inspector found that the provider had made progress in addressing issues relating to risk management since the previous inspection. In their representation, the provider had stated that care related risks and environmental risks in the centre would be reviewed by the national health and safety officer in conjunction with the person in charge, the nurse manager and the senior care worker.

The inspector found that this had happened and found that the process for identifying and managing risk had been improved. However, further improvements were required. The provider’s policy required that the management of all risks rated as high would be reviewed by a designated person within one week and this had not happened.

The provider had an emergency plan but had not updated it to reflect new fire evacuation arrangements that had been developed since the previous inspection.

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:**
While there had been improvements in the detection, reporting and investigating of safeguarding concerns, the provider had failed to adequately assess and put behaviour support plans in place for residents with behaviours that challenge. This action had been brought to the provider’s attention during the previous inspection.

The person in charge told the inspector that these had not been completed due to a change in the residents’ routine which had reduced the occurrences of behaviours that challenge. The inspector found that these mitigating actions had not been introduced as a result of an evidence-based behaviour management approach.

**Judgment:**
Non Compliant - Moderate

### Outcome 10. General Welfare and Development

Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

**Theme:**
Health and Development

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

**Findings:**
On the day of inspection, inspectors found that each resident had been assessed at a one-to-one meeting in regards to their preferences for further education and training.
This action had been highlighted on the representation response submitted by the provider.

Of the 11 residents, one resident indicated that they would like to take part in education or classes outside of the centre. The person in charge indicated that all residents will continue to be offered access to education and possible employment. One resident in the centre was currently availing of educational activities outside of the designated centre. The centre also had a policy on accessing education.

**Judgment:**
Compliant

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

**Findings:**
Improvements to the healthcare support for residents had been made by the provider since the last inspection. However, during this inspection it was found that the provider failed to ensure that the nutritional needs of residents were being adequately planned for and met.

On the day of inspection, a personal assistant was unable to work with a resident as the person in charge had no record that the personal assistant had completed a vetting disclosure in accordance with the National Vetting Bureau. A planned activity for the resident to go shopping could not take place. Inspectors noted that they resident said that they had to get a takeaway as they had limited amounts of food in their apartments. Inspectors also observed that another resident had a limited amount of food available. This was brought to the attention of the person in charge on the day of inspection.

**Judgment:**
Non Compliant - Major

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**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:
The provider told the chief inspector in their representation response that:

• Prescription sheets were reviewed by the clinical nurse manager post inspection in September 2016 for all residents and now contained the required information.

The inspector found that while improvements had been made, further improvements were required, in relation to the prescribing and administration of medications. For example, inspectors noted that prescribed, as required medications, did not contain the maximum dose to be administered as stated in the centre's medication policy.

Inspectors also reviewed the log of medication errors within the centre. One recent error noted by the inspector involved a staff member administering medication without having the necessary prescription sheet. This was brought to the attention of the person in charge on the day of inspection.

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:
On the day of inspection, inspectors found that improvements were required in relation to the designated centre's statement of purpose (SOP).

The statement of purpose for the designated centre was revised prior to the monitoring inspection. Inspectors found that this document did not reflect the current service provider in the designated centre. The SOP did not identify the current person in charge and did not accurately describe the numbers of staff employed in the designated centre. The SOP also stated that supports are provided 24 hours a day and seven days a
week to meet the needs of residents. However, inspectors found that the designated centre was failing to meet the social need of all residents. The SOP also failed to highlight the dependence on personal assistants to help residents socialise and integrate into the local community. Emergency procedures also needed to be updated to reflect where residents had chosen to go in the event of a centre evacuation.

**Judgment:**
Non Compliant - Moderate

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**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:**
The inspector found that the provider had failed to adequately implement the action plan within their representation response for the oversight and monitoring of governance and management within the centre. In addition the provider had failed to address actions arising from their six monthly unannounced visits and annual review documentation, in line with their agreed timeframes.

Inspectors found that improvements continued to be required in relation to the governance and management of the designated centre.

The inspector met with the outgoing person in charge of the designated centre to review actions submitted on the representation response from the provider. The person in charge stated that several actions from this response had not been implemented as stated.

- Monthly audits of residents’ community access had not been completed.
- Fortnightly reports which were to be sent to the regional manager had not been completed.
- Monthly reports on care plan reviews were not completed.
- Planned fortnightly visits by the regional management team to address areas of non-compliance had not occurred

The last six monthly audit made available to inspectors on the day of inspection had

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occurred 16 February 2016. The annual review of quality and care was also unavailable and the inspection day. These reports were made available to inspectors in the days following the inspection.

The provider had generated an action plan in relation to deficits identified in the unannounced visit and annual review. The annual review indicated that personal plans and goals were to be developed with staff to be identified to support residents to achieve these goals; however, there was no evidence of this being implemented during this inspection.

The six-monthly audit rated actions identified in order of urgency, with completion dates ranging from one week to three months from the date of the audit. However, inspectors found that not all actions had been implemented as stated, such as staff training and social activities for residents.

**Judgment:**
Non Compliant - Major

### 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:**
On the day of inspection, inspectors found that the centre was inadequately resourced to ensure the effective delivery of care and support in accordance with the centre's statement of purpose.

The Chief Operations Officer (COO) met with inspectors and stated that the centre was not resourced to provide support for all residents to achieve their goals and everyday normal activities, such as utilising facilities in the local community. The COO stated that they planned to close the day centre and respite service, which was currently offered to residents, and reallocate the resources from these services into providing social supports for residents. However, the COO was unable to clearly demonstrate what effect this would have for residents in terms of everyday life. The COO was also unable to clarify the extra whole time equivalents in terms of staffing, which would be reallocated to supporting the social needs of residents following the closure of respite and day services.

The COO detailed that the provider was engaging with the funding body to seek extra resources to meet the assessed needs of residents. However, inspectors found little
evidence to suggest that this application for extra resources had been sufficiently progressed. The proposed time scale for securing this resource was June 2017. However, the COO stated that the provider had met formally with the funder on one occasion prior to the inspection. The provider also submitted correspondence from the funding body following the inspection, however, this correspondence failed to be specific in terms of actions and timelines in responding to the lack of resources within the centre. Overall inspectors found that the provider was unable to demonstrate that the issue of lack of resources had been appropriately addressed on this inspection.

**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:**
The inspector found that the provider had failed to fully implement the actions within their representation response within the agreed timescales, and found that significant improvements were required in relation to this outcome.

Inspectors found that the overall staff numbers failed to meet the assessed needs of residents which resulted in residents' unable to access the community and achieve personal goals.

Inspectors reviewed training records and found that some staff had not completed training in fire safety, positive behavioural support, infection control and first aid. Three staff had not received safeguarding training. This was also brought to the attention of the person in charge on the day of inspection.

Staff employed by the provider attended regular supervision and staff meetings; however, personal assistants deployed in the centre were not receiving support and supervision. This was again brought to the attention of the provider who indicated that personal assistants were not subject to the management structures of the provider. Inspectors also noted that volunteers were not receiving support and supervision.
Judgment:
Non Compliant - Major

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
Provider’s response to inspection report

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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 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:
The provider failed to ensure that residents were supported to access the community.

1. 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

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

Please state the actions you have taken or are planning to take:
- The Provider and Funder have made an additional 60 hours per week available to provide social support hours to residents from 6th February 2017. Delivery of these hours has commenced. These additional hours are ring-fenced and used to provide social supports and community access only. A tracking document will record the amount of hours delivered to each resident.
- A recruitment process has begun for additional social support staff and interviews have been scheduled for 13/3/17.
- A keyworker system has been introduced in the centre giving identified staff members responsibility for the progression of actions contained in care plans. All service users have a Keyworker of their choosing. Key Workers will track and review actions on care plans quarterly or according to dates contained and report any non-action to the PIC.
- The Provider’s Future Planning Process will be rolled out in March and April 2017. This will guide keyworkers in their role and support them to work with Service Users to realise Goals and put steps in place to ensure these goals are achieved and reviewed. The Regional Quality partner will train staff and the PIC will oversee the process.

Proposed Timescale: 30/04/2017

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:
The provider failed to ensure that all residents had written agreements and tenancy agreements in place.

2. Action Required:
Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:
- The PIC will ensure that all service users have the relevant written agreements and Tenancy Agreements

Proposed Timescale: 17/03/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that the service for residents was delivered in accordance with written agreements.
3. **Action Required:**
Under Regulation 24 (4) (b) you are required to: Ensure the agreement for the provision of services provides for, and is consistent with, the resident’s assessed needs and the statement of purpose.

**Please state the actions you have taken or are planning to take:**
- Service agreements will be reviewed and updated where required. The PIC will ensure that all residents will have written agreements or tenancy agreements in place, as required by the regulations.
- Initial social needs assessments are being enhanced, with the support of the HSE to include more specific attainable person centred goals which will have review dates, deadlines and will give responsibilities to staff/keyworker and management.
- The PIC will ensure that written agreement will reflect the current service provision. Tailored supports will be available to implement residents' personal plans. This will be managed with the introduction of key worker system, action orientated personal plans and regular scheduled reviews of personal plans.
- The Statement of purpose was reviewed as part of an HSE audit. Appropriate changes to include current staffing arrangements, use of personal assistants, the current person in charge and accurate emergency procedures are being included. The revised SOP will be confirmed in conjunction with the HSE and in place by 17/3/17

**Proposed Timescale:** 30/04/2017

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that arrangements were in place to meet the assessed needs of residents.

4. **Action Required:**
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
- The Provider and Funder have made provision for up to 60 hours per week to provide social support hours to residents. This has commenced. These additional hours are ring-fenced and used to provide social supports and community access. A tracking document will record the amount of hours delivered to each resident.
- Initial social needs assessments are being enhanced, with the support of the HSE to include more specific attainable person centred goals which will have review dates, deadlines and will give responsibilities to staff/keyworkers and management.
• A keyworker system has been introduced in the centre giving a staff member responsibility for the progression of actions contained in care plans. All service users have a Keyworker of their choosing. Key Workers will track and review actions on care plans quarterly or according to dates contained and report any non-action to the PIC.
• The Provider’s Future Planning Process will be rolled out in March/April 2017. This will guide keyworkersons in their role and support them to work with Service Users to realise Goals and put steps in place to ensure these goals are achieved and reviewed. Regional quality partner will train staff and the PIC will oversee the process.
• Weekly planning meetings take place between the PIC/PPIM and other lead staff as required to ensure the supports required for the following week are in place to meet accessed needs of service users.

**Proposed Timescale:** 30/04/2017

**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 sufficient progress had been made on conducting the full assessment of support for all residents. The provider also failed to effectively implement identified actions to empower residents to achieve their chosen goals.

5. **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:**
• Initial social needs assessments are being enhanced, with the support of the HSE to include more specific attainable person centred goals which will have review dates, deadlines and will give responsibilities to staff/keyworker and management.
• A keyworker system has been introduced in the centre giving identified staff members responsibility for the progression of actions contained in care plans. All service users have a Keyworker of their choosing. Key Workers will track and review actions on care plans quarterly or according to dates contained in the care plan, and report any non-action to the PIC.
• The maintenance and timely review of care plans will be monitored by the Provider through site visits by the Regional Clinical Partner and through 6 monthly unannounced audits of the centre by the Provider’s audit team.
• The Provider’s Future Planning Process is being rolled out in March/April 2017. This will guide keyworkers in their role and support them to work with Service Users to realise Goals and put steps in place to ensure these goals are achieved and reviewed. The Provider’s Regional Quality Partner will train staff and the PIC will oversee the process.

**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 also failed to ensure that risk management plans were reviewed in line with the centre's risk management policy.

#### 6. 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:**
- Environmental Risk assessments are undergoing a full review in line with the centres Risk Management Policy. This will be completed by the 10th of March
- Service user specific risk assessments will be reviewed along with the review of each Service User and their care plans.
- Risks will be reviewed monthly as part of the set agenda during the Monthly management meetings.
- The timely review of Risk Management plans will be audited during monthly site visits by the Provider’s Regional Clinical Partner and by the audit team during 6 monthly unannounced audits. Any concerns will be reported to the PIC and Regional Manager.

**Proposed Timescale:** 30/04/2017

**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 all emergency evacuation plans were updated to reflect practice within the designated centre.

#### 7. 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:**
- The Emergency evacuation plan has been updated to reflect practice within the designated centre.
- Health and safety will be a set agenda on monthly management meetings. Any future updates will be actioned during these meetings.

Proposed Timescale: Completed 3/3/2017
### Proposed Timescale: 03/03/2017

#### Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that residents had behavioural support plans in place to guide staff in relation to their care.

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

**Please state the actions you have taken or are planning to take:**
- The Provider’s Regional Quality Partner in conjunction the resident, PIC and HSE Neuropsychologist is developing a Positive Behavioural Support Plan for one individual. A draft behavioural plan has been created to be reviewed at the resident’s quarterly Multi-Disciplinary Team meeting in March and agreed with the resident.
- The Provider’s Clinical Partner and Quality Partner are supporting the PIC to implement evidence based monitoring of one resident's occurrences and frequency of behaviours that challenge.
- Positive behavioural support training is scheduled for care staff on 7/03/17

### Proposed Timescale: 31/03/2017

#### Outcome 11. Healthcare Needs

**Theme:** Health and Development

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that systems were in place to ensure that residents had access to appropriate quantities of food.

**9. Action Required:**
Under Regulation 18 (2) (c) you are required to: Provide each resident with adequate quantities of food and drink which offers choice at mealtimes.

**Please state the actions you have taken or are planning to take:**
- Nutritional assessment will be part of the enhanced needs assessments that are being carried out with the support of the HSE. Nutritional plans and systems will be put in place that, while respecting the Service Users wishes, will also ensure the provider has worked with the SU to ensure their Nutritional and health needs are being met.
- A meal plan has been agreed with one Service User and a record sheets of nutritional
intake being completed by staff with the agreement of the resident

- An MDT Meeting was held on 24/02/17 involving a dietician, CNM1 and advice worker to discuss actions required to improve the Service Users diet.

**Proposed Timescale:** 30/04/2017

**Outcome 12. Medication Management**

**Theme:** Health and Development

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

The provider failed to ensure that prescription sheets were available for the safe administration of medications. The provider also failed to ensure that as required medications had a maximum dose stated on prescription sheets.

**10. 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:

- Every Service user requiring it has a prescription sheet which is reviewed by their GP monthly. Staff are trained to ensure they only give medication as per prescription sheet. If the prescription is not present procedure states that staff must ensure there is a prescription in place before administering medication.
- If staff do not adhere to policy around medication management the CNM1 will hold follow up supervisions with staff and retrain staff where necessary
- The CNM1 has worked with the pharmacist to ensure PRN medications have a maximum dose stated on the prescription sheet. This is now in place

Proposed Timescale: Completed 3/3/2017

**Proposed Timescale:** 03/03/2017

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The provider failed to ensure that the statement of purpose contained:
- the current staffing arrangements
- the use of personal assistants
- the current person in charge
- accurate emergency procedures.
The provider also failed to ensure that the designated centre was ran in accordance with its statement of purpose.

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

**Please state the actions you have taken or are planning to take:**
- The Statement of purpose was reviewed as part of an HSE audit. Appropriate changes to include current staffing arrangements, use of personal assistants, the current person in charge and accurate emergency procedures are being included. The revised SOP will be confirmed in conjunction with the HSE and in place by 17/3/17.
- The Statement of Purpose is being amended to reflect the required information and will be confirmed with the HSE Audit Team, Provider and PIC and in place by 17/3/17.

**Proposed Timescale:** 17/03/2017

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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 provider failed to ensure that the representation response was implemented as stated and that effective management systems were in place to address areas of non-compliance within the designated centre.

12. **Action Required:**
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents’ needs, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
- A revised management structure is being implemented to enhance local governance in the centre consisting of a PIC and 3 PPIMS (CNM1 and 2 senior care workers working 5/7 days). Recruitment is under way for a Senior Care Support Worker.
- A schedule of one to one meetings is in place between the PIC/Designate with all staff. Discussion items include training and development needs, service issues workplace performance. Meetings are documented.
- The PIC/Designate will complete a fortnightly report which is forwarded to the Regional Manager/Provider Nominee, HIQA and HSE. This will be submitted to HIQA by 1pm every second Friday to evidence progress.
- The Provider’s Regional Support Team, which includes Quality, HR and Clinical Partners each attend the centre monthly (site visits), providing advice, support, and oversight in the following areas: Care planning, quality supports/advocacy, money
management, clinical supports, HR and staffing supports.
• All Regional Support Team site visits will be recorded and actions required or completed noted in the Operational Plan and discussed by the Provider Nominee, PIC and HSE Disability Manager to ensure progress
• The PIC holds a weekly meeting to plan care delivery, social supports and weekly service operations with his local management team from which actions are recorded and assigned.
• The Regional Manager/Provider Nominee will provide a monthly report to the Chief Operations Officer detailing progress on the Operational plan.
• The Chief Operations Officer will visit the service on a quarterly basis.
• The Annual Review for year 2016 is to be published 6/3/2017.
• A six monthly internal audit is carried out in the service. Progress on addressing actions required is completed by the PIC on the audit report. The Regional Manager and PIC evidence the work completed on actions through Monthly supervision/support meetings.
• The PIC, Regional Manager and HSE representative hold a weekly progress meeting/call.
• The Regional Manager and PIC will hold monthly supervision/support meetings.

Proposed Timescale: Completed 6/3/2017

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 centre was appropriately resourced to meet the assessed needs of residents.

13. 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:
• The Provider and Funder have made provision for up to 60 hours per week to provide social support hours to residents. This has commenced. These additional hours are ring-fenced and used to provide social supports and community access. A tracking document will record the amount of hours delivered to each resident.

• Centre staff are being rostered to provide social support hours. In addition a recruitment process has begun for additional social support staff for the centre. Interviews are taking place on 13/3/17. New staff are projected to be in post by 15/4/17
Proposed Timescale: 15/04/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that appropriate numbers of staff were employed to meet the assessed needs of residents.

14. 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:
The Provider and Funder have made provision for up to 60 hours per week to provide social support hours to residents. This has commenced. These additional hours are ring-fenced and used to provide social supports and community access. A tracking document will record the amount of hours delivered to each resident.

• A recruitment process has begun for additional social support staff for the centre. Interviews are taking place on 13/3/17. New staff are projected to be in post by 15/4/17
• A Senior Care Support Worker is being recruited, advertisement placed.

Proposed Timescale: 30/04/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that staff had received appropriate training.

15. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
• Training will be planned out in advance per quarter to ensure all staff have received the required training.
• The training matrix will be kept up to date and reviewed at monthly management meetings.
Trainings scheduled/ taken place first quarter
• Manual Handling 30/3/2017
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that personal assistants were subject to supervision by the person in charge.

16. 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:
• The PIC will meet with Service users who are supported by PA’s on a monthly basis to discuss PA’s and their roles and document any concerns, feedback or other issues for action
• The PIC will hold a joint meeting with Service Users and the PA’s who support them quarterly to offer support in supervision- this meeting will documented.
• A protocol is in place detailing the requirements for all external support staff: documentation, reporting, training, and information transfer. This protocol is agreed with the external provider
• Any concerns raised with the service being provided will be brought to the attention of the External Provider Service Co-ordinator and the Regional Manager by the PIC

Proposed Timescale: 03/03/2017
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider failed to ensure that volunteers within the centre received support and supervision.

17. Action Required:
Under Regulation 30 (b) you are required to: Provide supervision and support for
volunteers working in the designated centre.

Please state the actions you have taken or are planning to take:
- The PIC will ensure that the correct information is kept on any volunteers within the service.
- The PIC will meet quarterly with any volunteers and document the meeting.

**Proposed Timescale:** 31/03/2017