

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Camphill Community Carrick on Suir
<b>Centre ID:</b>	OSV-0003608
<b>Centre county:</b>	Tipperary
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Camphill Communities of Ireland
<b>Provider Nominee:</b>	Adrienne Smith
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	16
<b>Number of vacancies on the date of inspection:</b>	1

## **About monitoring of compliance**

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

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

Regulation has two aspects:

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

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

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

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

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

**The inspection took place over the following dates and times**

From:	To:
20 June 2017 09:00	20 June 2017 19:30
21 June 2017 08:30	21 June 2017 15:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

**Summary of findings from this inspection**

This was the third inspection of this centre which forms part of an organisation which has a number of designated centres in the region. This was an unannounced monitoring inspection undertaken to ascertain the continued compliance with the regulations and standards. The centre was granted registration on 27 November 2015.

Concerns regarding overall safeguarding systems and governance arrangements in the organisation resulted in meetings being held with the provider in April 2016 and on 16 October 2016. Following these meetings warning compliance notices were issued.

The provider was requested to and submitted a plan to improve safeguarding systems within the organisation as a whole.

How we gathered the evidence:

The inspector met with 12 residents and spoke with 6 and they allowed the inspector to observe some of their daily life and routines. Residents who could communicate

told the inspector they were very happy living in the centre and in their accommodation, it was their home, they had access to activities, occupation and recreation that they enjoyed. They had as much independence and choice as they wished and were making plans for future accommodation which would give them further independence.

The inspector also met with staff members and the person in charge.

Description of the service:

The statement of purpose describes the service as providing long term residential services to people with intellectual disability, people on the autism spectrum and physical and sensory disabilities. There are up to 10 day service placements provided and the services encompass a small social farm, art and weaving workshops and cookery workshops. The care practices and systems were found to be reflective of the statement as outlined.

The centre is comprised of 10 units, two residential houses which accommodate four and five residents respectively and 6 other units located in a number of areas in a rural town.

Three of these units are designated as supported semi-independent accommodation and accommodate between 1 and 2 residents and a number of co-workers also live in the units.

The grounds contain vegetable gardens and various workshops which are used by the residents.

Overall judgement of our findings:

The provider did not have satisfactory fire safety management systems for a number of the units. The deficits included suitable fire alarms, emergency lighting and fire doors. On the day of the inspection the person in charge was required to implement systems to minimise the risks to residents on an interim basis. These were undertaken promptly and satisfactorily.

Prior to registration written evidence of compliance with the statutory fire authority had been forwarded to HIQA. This did not however take the semi independent units and three other units into account.

Plans were given to the inspector during the inspection to fully address these deficits.

Despite this finding the provider was in compliance with a number of regulations which had positive outcomes for the residents. There were effective governance and oversight systems in place.

Good practice was observed in the following areas;

- Residents activities and routines were based on their own preferences and

development which ensured they had interesting and varied experiences which suited their needs ( outcome 5 )

- Residents had good access to healthcare services and multidisciplinary specialists pertinent to their needs (outcome 5)
- Numbers and skill mix of staff were suitable which provided good levels of support and continuity for the residents (outcome 17)
- Good personal planning systems were evident which resulted in a positive and supportive experience for the residents (outcome 5)

Some improvements were required in the following areas to improve the overall outcomes for residents;

- Fire management systems and equipment for 6 of the units were not satisfactory (outcome 7)
- Systems for identifying and responding to risks to promote residents safety ( outcome 7)
- Safeguarding systems and investigation of incidents did not promote resident safety (outcome 8).

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) With Disabilities).

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

**Outcome 05: Social Care Needs**

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

**Theme:**

Effective Services

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that the provider was fully compliant with this regulation. Residents had good access to a range of multidisciplinary assessments and supports pertinent to their assessed needs.

Assessments which were undertaken and regularly reviewed included speech and language, physiotherapy and behaviour supports and sensory supports. The details of these assessments were incorporated into the residents personal support plans and staff were familiar with the interventions. Where further assessment or intervention was deemed necessary plans had already been made to access these.

Quarterly and annual reviews took place which were attended by family members and or the residents themselves. The reviews were found to be a comprehensive oversight of all aspects of the resident's lives, needs and aspirations. The personal plans and support plans were very detailed and correlated to the assessed needs of the residents. The inspector saw that objects of reference, social stories and sign language were used effectively to communicate with and support residents in regards to their choices and care needs.

Residents who lived in the supported independent units had chosen to do so following a relevant assessment. Further consultation was ongoing with other residents in regards to their wishes in relation to this type of accommodation.

Personal and care related goals were identified with the residents and planned for following the reviews. It was confirmed by residents that the goals identified were achieved for them and if not there was a reasonable rationale for this.

Resident's preferences for activities, meaningful occupation and social engagements were well supported and elicited according to their preferences and dependencies. There was a significant ratio of one to one staff available at optimum times to ensure these took place. Residents were involved in arts and crafts, working on the small farm and doing gardening and weaving. These activities were tailored to their need and wishes and regularly reviewed to ensure the residents were still happy to participate. Basic life skills were developed and all had a role in participating in the life in the centre and in their own units.

They had good access to the community with a lot of local events including a pub night, swimming, horse riding, shopping and holidays. They had good social interaction within the community also and went to other units for meals with their friends.

**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):**

No actions were required from the previous inspection.

**Findings:**

Overall the inspector found that the centre took a balanced and proportionate approach to risk management which respected resident rights. However, a substantial risk was found in relation to fire safety.

The centre is comprised of two residential dwellings and seven houses/ apartments' for either one or two residents. The residential dwellings and one of the houses were fully equipped with fire management equipment including fire doors, suitable fire alarms and emergency lighting.

However, the systems in the remaining units were not satisfactory. There was no emergency lighting, fire doors in relevant locations and only domestic style smoke alarms. The risk was further compounded by the fact that there were no staff present in three of units overnight. There were however staff available in adjacent units.

On the day of the inspection the management team were requested to implement immediate additional safety measures in the absence of such systems. These was satisfactorily implemented.

The inspector was also not assured that the safety measures for these individual arrangements had been sufficiently considered. Open fire and candles were used and

arrangements for residents to quickly alert staff to any incidents in general were not robust.

Unauthorised access to the units via the street outside had not been considered.

These single occupancy and independent living arrangements were made with due regard for residents' preferences. However, in order to ensure they were safe the measures for identifying potential risk and managing them while supporting the residents independence required review.

Fire drills were held frequently in all but they were not carried out in manner which would provide sufficient practice for a number of eventualities which might arise. For example, if a fire was in the kitchen the exits from these areas could not be used and the alternatives were not considered in the drills. While there were master keys to the individual units there was no clarity as to how these could be located in an emergency.

Where fire safety equipment was available there was documentary evidence that this was serviced and maintained as required. Residents took part in fire safety training including the use of extinguishers,

In other respects resident's safety was well managed in accordance with the centre's policy. A risk register was maintained which encompassed a wide variety of risks across the centre, including risks associated with the activities and equipment in the centre. Risk registers for individual residents were pertinent to their identified needs and these were detailed. The mitigating actions were balanced to allow residents continue their chosen activities.

An emergency plan was in place and this included arrangements in the event the centre had to be evacuated. Emergency phone numbers were also easily accessible to staff.

Data was collated on significant events such as accidents or incidents which also promoted ongoing review by the health and safety officer and the management team. For example, eleven medication errors had taken place in 2017. Actions taken included retraining of staff ,relocation of the medication storage and altering the administration chart.

The centre had access to a number of vehicles. Records demonstrated that driving licences for staff were kept on file and driver assessments had been undertaken on staff to assure the centre of the driver's ability to drive safely. Policies were not reviewed as part of this inspection.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the protection of residents was prioritised and that their personal autonomy was supported. However, some improvements were required in a number of areas to support this. A local investigation "trust in care" into allegations of verbal abuse was undertaken and overseen. From records seen and discussions held with the manager who participated in the investigation the process was not comprehensive and the outcome was not satisfactory or to the benefit of the resident. The inspector formed the view that this was due to lack of experience / training in the management of such issues, a failure to seek advice or to take all relevant factors into account. It was however re-assuring that staff reported this matter in the first instance.

A policy on visitors to the centre including persons staying over nights in units with access to residents was being devised at the time of the inspection which was required in the organisation overall. However, the policy available at the time of inspection was a generic policy and did not sufficiently detail safeguarding arrangements.

There were no children residing in any unit at the time of this inspection but two children of co-workers were living in separate accommodation on the main site. A safeguarding officer had visited the centre to implement safeguarding plans for such arrangements but there were no details of these available.

An allegation of potential financial abuse was being robustly investigated at the time of the inspection.

A number of safeguarding plans were in place and these were comprehensive and demonstrated good internal practice and inter agency cooperation in the protection of residents.

Intimate care plans for vulnerable residents were detailed and there were systems to ensure that staff followed them in order to maintain residents dignity and integrity.

Only one restriction was being used and the inspector was satisfied that the rationale was clear and there was oversight and review of the restriction.

It was apparent from a review of all notifications forwarded and behaviour support plans and interventions that the use of such practises had been reduced by virtue of additional staffing and of the consideration of alternatives.

There was good access to clinical psychology and mental health supports and the

inspector found that practises were guided by the direction of these specialists. There had been a reduction in both the severity and number of incidents of challenging behaviours. Chemical restrictions if prescribed were guided by a strict protocol.

Where the provider was acting as de-facto-guardian for residents there was a decision making protocol in place. However, there was no oversight of this. When this was discussed with the local management team and the national safeguarding officer the inspector was informed that consideration was being given to seeking a legal guardianship in such instances. An advocate had been sought.

Residents told the inspector that they felt safe and were also attending a relationships training course which they found helpful.

There was also evidence that staff and managers regularly spoke with residents to ascertain any concerns they may have.

Where residents were less able to communicate the house coordinators took responsibility for their safety. Detailed accidental injury or bruising charts were maintained and these were seen to be monitored by team leaders to ascertain any potential causes.

Records demonstrated that all current staff in the centre had received up to date training in the prevention of and response to abuse and the designated officer had also undertaken the relevant training.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Notification of Incidents**

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**

Safe Services

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

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

**Findings:**

A review of the accident and incident logs, residents' records and notifications forwarded to the Authority demonstrated that the person in charge had complied with his responsibility to forward the required notifications to the Authority. However, notification of the change to the person in charge had not been received from the provider. This was identified as an administrative error and was rectified during the inspection.

**Judgment:**

Non Compliant - Moderate

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<b>Outcome 11. Healthcare Needs</b> <i>Residents are supported on an individual basis to achieve and enjoy the best possible health.</i>
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<b>Theme:</b> Health and Development
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<b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.
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<b>Findings:</b> The inspector found evidence that residents healthcare needs were being met with regular access to general practitioner services and allied healthcare reviews.  There was evidence of regular referral and frequent access to allied services such as chiropody, dentistry, ophthalmic care, physiotherapy and speech and language therapist. Staff followed the guidance provide by the clinicians and were well informed in regard to the residents healthcare needs.  The inspector saw evidence of active health promotion and monitoring with regular tests and interventions to manage specific healthcare needs or vulnerabilities. These included age and gender specific needs.  The inspector saw from records and speaking with staff that families and residents themselves were consulted and kept fully informed in an appropriate manner in regards to healthcare issues and appointments. Staff attended all such appointments with residents. Residents’ nutritional needs were assessed and monitored. There was documentary evidence of advice from dieticians and speech and language therapists available and staffs were knowledgeable on the residents’ dietary needs. Residents helped staff to do the shopping and cooking according to their wishes and abilities.  The residents had numerous choices at meal times. The meal times as observed were very social and shared experiences between staff and residents .Those residents who needed support were provided with this in a sensitive and dignified manner. End of life planning was not reviewed on this inspection.
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<b>Judgment:</b> Compliant
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<b>Outcome 12. Medication Management</b> <i>Each resident is protected by the designated centres policies and procedures for medication management.</i>
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**Theme:**

Health and Development

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

No actions were required from the previous inspection.

**Findings:**

Practices in relation to the storage, administration and dispensing of medicines were satisfactory. Medicines were appropriately identified and prescriptions were available for dispensing and administration. Systems for the receipt of, management, administration, storage and accounting for medicines were satisfactory. There were appropriate documented procedures for the handling, disposal of and return of medicines.

Where medicines errors were noted these were appropriately addressed. No controlled medication was being used at the time of the inspection. Staff managed medicines for most residents or offered the appropriate level of assistance where necessary. Alternative medicines were not being used at the time of this inspection. The deputy person in charge informed the inspector that if such were used it was only with the agreement of the GP and or pharmacist to ensure they were safe and suitable for use. A number of residents had been assessed as suitable for self administration and the arrangements for this were satisfactory. Medicines were reviewed regularly by the dispensing clinician and pharmacist.

Regular audits of medicines administration and usage were undertaken which also noted errors or discrepancies.

**Judgment:**

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:**

The statement of purpose had been submitted at the time of registration, and was in compliance with the regulations. The person in charge agreed to forward a revised updated version available following the inspection to reflect the changes to the governance structures.

**Judgment:**

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:**

The inspector was satisfied that the governance arrangements were satisfactory and the residents care was effectively monitored.

A new person in charge had been appointed in April 2017. However, the person in charge did require some support in the implementation of the regulations and knowledge of safeguarding and risk management systems for this centre as detailed in outcomes 7 and 8.

This was being provided by the previous manager who had considerable experience in the centre and remained in post as deputy and the designated officer for safeguarding. This provided consistency and continuity for the residents.

There were staff supervision systems in place which were formal and frequent. All grades of staff including volunteers were subject to this. The records seen demonstrated that it focused on staff responsibilities and resident care and this was confirmed by staff spoken with.

The inspector was informed that the person in charge received regular managerial supervision from the national safeguarding officer.

Two unannounced visits had taken place on behalf of the provider with the most recent on 10 March 2017. A small number of actions were identified. The annual report for 2016 was also available. However, this report was not sufficiently detailed to reflect an understanding of the pertinent issues in relation to the quality and safety of care in the centre. This was discussed at the feedback meeting.

Further systems for governance and oversight were evident with frequent and detailed

local management and welfare meetings taking place. From a review of the records of these meetings, discussion with staff and residents care needs, the inspector was satisfied that these provided an effective forum for reviewing all incidents or general welfare of residents. Remedial actions were identified. The records of these indicated that they were comprehensive with each resident discussed. There was a satisfactory day and night time on-call system in place and staff confirmed that this was effective and responsive.

**Judgment:**

Substantially Compliant

**Outcome 17: Workforce**

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

**Theme:**

Responsive Workforce

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

**Findings:**

The workforce is comprised of long and short term co workers and employees. At the time of this inspection the ratios and skill mix were satisfactory and residents received continuity of care with an appropriate balance of qualifications and training and responsibilities. The residents were assessed as not requiring fulltime nursing care although there was a qualified and currently registered nurse employed as a support worker. Information given to the inspector indicated that there were 26 employed staff with seven long term and 7 short term co-workers at the time of the inspection.

According to the records provided four of the five house coordinators have qualifications in social care or a related discipline .Three of these persons are also employees.

A significant number of employed support staff also have or are completing relevant training. Additional qualified staff had been employed to provide one to one supports and overnight support for residents.

From a review of personal files all of the documentation and mechanisms for the safe recruitment of staff were satisfactory.

The training records available indicated that mandatory training including mobilising residents, safeguarding and fire safety was up to date for all personnel. Other training available included behaviours that challenge. A number of staff had training in sign language which was used frequently during the inspection.

A small number of relevant staff did not have training in emergency medicines and dates

for this were scheduled following the inspection.

Staff were observed to be supportive and very knowledgeable of the residents needs.

**Judgment:**

Substantially Compliant

**Closing the Visit**

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

**Acknowledgements**

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

***Report Compiled by:***

Noelene Dowling  
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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Camphill Communities of Ireland
<b>Centre ID:</b>	OSV-0003608
<b>Date of Inspection:</b>	20 June 2017
<b>Date of response:</b>	12 September 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 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 semi-independent supported accommodation was not sufficiently assessed to identify and manage potential risks to residents.

**1. Action Required:**

Under Regulation 26 (2) you are required to: Put systems in place in the designated

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



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:**

The measures for identifying risk and managing risk have been reviewed for residents in semi-independent living. New risk assessments have been put in place as required including risk in the use of candles and open fires. Completed: 24/07/2017.

In addition, residents have had a new assessment identifying capacity and risks in respect of living semi-independently and ensuring that they have the supports to do so safely. A "keeping Safe Booklet" allied to keeping safe training is being developed and will be delivered by 31/08/2017

**Proposed Timescale:** 31/08/2017

**Theme:** Effective Services

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

Six of the units did not have suitable fire alarms and systems to contain fire should it occur.

**2. 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 alarm systems have been commissioned, designed and installation will commence in the houses, starting with the houses where individuals live semi-independently, progressing to the three outlying supported houses.

Quotations for fire doors were sought during inspection and have been ordered. Installation will commence 31/07/2017 starting with the houses where individuals live semi-independently, progressing to the three outlying supported houses. Completion date takes into account builders holiday.

**Proposed Timescale:** 31/10/2017

**Theme:** Effective Services

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

Six of the units did not have emergency lighting.

**3. Action Required:**

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**

Emergency systems have been commissioned and will be installed in the houses starting with the houses where individuals live semi-independently, progressing to the three outlying supported houses

**Proposed Timescale:** 31/10/2017

**Theme:** Effective Services

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

Fire drills undertaken did not provide sufficient practice in evacuating all units.

**4. 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:**

Protocol for conducting fire drills has been reviewed addressing different eventualities. Fire drills will be more frequent, scheduled at varied times and will provide practice in evacuating the houses in varied scenarios.

3 fire drills have taken place using the revised protocol since the inspection (21/06/2017 – 26/07/2017 ) and learning from these will be incorporated into a final protocol document.

**Proposed Timescale:** 15/08/2017

**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:**

An investigation into an allegation of misconduct had not been undertaken in a robust and considered manner to ensure the resident was protected and the issue addressed.

**5. Action Required:**

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

**Please state the actions you have taken or are planning to take:**

The safeguarding plan has been reviewed to strengthen guidance to staff in support of resident. The plan has been implemented and rolled out to staff.

The Trust In Care process was reviewed and practice issues were subsequently addressed with the staff member who was required to retrain in Safeguarding

Awareness. This has been completed.  
The PiC and DSO attended Trust in Care training on 26/07/2017

**Proposed Timescale:** 26/07/2017

**Theme:** Safe Services

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

Put in place robust arrangements to ensure residents are protected from abuse by external persons.

**6. Action Required:**

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

**Please state the actions you have taken or are planning to take:**

Visitors Policy has been revised adapted and localised with specific safeguarding measures included on keeping residents safe from external persons. This policy has been distributed and implemented.

A copy of the revised Visitors Policy will be distributed to all families by 31/07/2017.

**Proposed Timescale:** 31/07/2017

#### **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:**

Additional supports are needed to ensure the person in charge has sufficient knowledge as to the implementation of the regulations.

**7. Action Required:**

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

**Please state the actions you have taken or are planning to take:**

A review of the supports to the PiC has taken place with the Provider Nominee. Additional supports have been put in place for the person in charge to improve the PiC's knowledge as to the implementation of the regulations. These include scheduled monthly supervision, six monthly appraisals and a training programme for the PiC

The Person in Charge is actively participating and monitoring performance outcomes, to ensure implementation of regulations e.g. recruitment, medication, performance

improvement plans, accidents and incident reporting and analysis, safeguarding plans.

**Proposed Timescale:** 20/07/2017

**Theme:** Leadership, Governance and Management

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

The systems for addressing actions identified during unannounced visits were not satisfactory.

**8. Action Required:**

Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

**Please state the actions you have taken or are planning to take:**

The systems for addressing actions identified during unannounced visits have been improved through a review of the inspections undertaken. Improvements have been made to the Provider six month Unannounced Inspection and the Annual Review templates that are in use by referencing these to HIQA guidance documentation.

The scheduling and undertaking of inspections will be strengthened through the planned appointment of suitably qualified regional managers who will undertake such visits.

An unannounced inspection visit will take place to the Centre prior to the 10/09/2017 in which required actions arising from the pertinent care and welfare issues in the Centre will be evident in the report.

**Proposed Timescale:** 10/09/2017

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

A small number of staff did not the necessary training in the administration of emergency medicines.

**9. Action Required:**

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

**Please state the actions you have taken or are planning to take:**

All relevant staff have received training in the administration of buccal midazolam.

**Proposed Timescale:** 30/06/2017